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Hospitable Meals in Hospitals

Co-creating a passion for food with patients

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Publication date:
2014

Document Version
Accepted author manuscript, peer reviewed version

[Link to publication from Aalborg University](#)

Citation for published version (APA):

Justesen, L. (2014). *Hospitable Meals in Hospitals: Co-creating a passion for food with patients*. Aalborg Universitet.

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Hospitable Meals in Hospitals

Co-creating a passion for food with patients

Ph.D. thesis by Lise Justesen

Alborg University 2014



Hospitable Meals in Hospitals

Ph.D. thesis

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List of published papers:

- o Paper 1: Justesen, L., Mikkelsen, B. E., & Gyimóthy, S. (2014). Understanding hospital meal experiences by means of participant-driven-photo-elicitation. *Appetite*, 75:4, 30-39.
- o Paper 2: Justesen, L., Gyimóthy, S., & Mikkelsen, B. E. (2014). Hospitality within hospital meals – Socio-material Assemblages. (Submitted to *Journal of Foodservice Business Research*)
- o Moment of hospitality, rethinking hospital meals through a non-representational approach, *Hospitality & Society*, 4:3, 231-248 (In press).

This thesis has been submitted for assessment in partial fulfilment of the Ph.D. degree. The thesis is based on the submitted or published scientific papers which are listed above. Parts of the papers are used directly or indirectly in the extended summary of the thesis. As part of the assessment, co-author statements have been made available to the assessment committee and are also available at the Faculty. The thesis is not in its present form acceptable for open publication but only in limited and closed circulation as copyright may not be ensured.

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PREFACE

The idea behind this Ph.D. project was formed on the basis of my professional life as a Food scientist and Senior Lecturer at Metropolitan University College in Copenhagen. During 18 years of teaching within the fields of food science, foodservice technology and sensory science, the idea of exploring hospital meals has emerged and developed. In the beginning, the focus was placed on subjects such as food quality, foodservice systems, culinary quality, meal science and more recently, the notion of hospitality. This focal point was pursued through an idea to encourage students to address and enhance the quality of public meals, including hospital meals. However, my engagement within the field of hospital meals became challenged by a lack of sufficient scientific knowledge about how hospital meals could be more broadly conceptualised. This included a need for transcending the conceptualisation of meals as a linear causal phenomenon towards the conceptualisation of meals as multidimensional and contextual.

Holding a M.Sc. in Food Science, my professional lecturing life was based upon a positivist and linear causality logic where I tried to clearly distinguish the researcher from the researched and the subject from the object in search for a kind of universal truth on how to achieve ‘good hospital meals’. At the start of my teaching career, my focus was placed on food quality, the impact of different foodservice systems on satisfaction, and food intake in hospitals. While writing and editing a Danish textbook on food quality (Justesen, Uebel, & Østergaard, 2007), students in Catering Management were reading interventions and comparative studies examining foodservice systems’ impact on patients food intake while I conceptualised and presented good hospital meals through the saying: *we do not eat nutrition – we eat food*.

Previous studies of satisfaction with hospital meals have focused on sensory and culinary aspects. The notion of ‘culinary quality’ has been difficult to introduce as an academic discipline as existing scientific literature is rather sparse. In the beginning, I approached the notion of culinary quality through the field of sensory science. Students were introduced to descriptive and discriminative analysis and physiological and psychological foundations of sensory functions (Lawless & Heymann, 1998). This knowledge presented the opportunity to discuss and train students to develop a sensory descriptive language connected to food and meals as a means to relate to the notion of culinary quality. I later introduced Brillat Savarin’s different aphorisms to the students (Brillat-Savarin, 1996 p. 22). This permitted a discussion of the notion of gastronomy as a reflective enjoyment of food and cooking and provided a space for discussing the difference between enjoyment (a gourmand) and reflectivity (gourmandise). However, just as Hans Jørgen Nielsen writes in the preface to the Danish edition of Brillat Savarin’s book *La Physiologie du Goût* (1825), the book is based upon a positivist thinking reflected in a basically physiological approach, but despite this Hans Jørgen Nielsen claims that *La Physiologie du Goût* is a playground for the tension between mind and matter (Brillat-Savarin, 1996 p. 20).

My engagement with Brillat Savarin’s work and with the field of molecular gastronomy (Risbo, Mouritsen, Frøst, Evans, & Reade, 2013) provided a legitimate space for an enhanced focus on meals as a theatrical sensory experience and on cooking science. Being introduced to the scientific work of Klosse et al. (2004) on the six culinary success factors (Klosse, 2004; Klosse, Riga, Cramwinckel, & Saris, 2004) presented the opportunity to introduce a scientific yet positivist approach based upon linear causality thinking towards culinary quality. My pre-understanding and focus remained on the intrinsic qualities of foods and my scientific approach still founded in presuppositions of a kind of universal static, but I also began to look further into the cultural palatability of food.

Gradually, however, I realized that in order to understand the complexity of hospital meals, I might need to consider or reconsider the phenomena of meals and so I turned towards the notion of meals and to the new multi-disciplinary research discipline of Culinary Art and Meal Science (Meiselman, 2000 p. 1). The students were introduced to research by Meiselman (2003) and Edward et al. (2003) into how institutional

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meals were rated differently depending on the meal situation and on where meals were served (Edwards, Meiselman, Edwards, & Leshner, 2003; Meiselman, 2003). Furthermore, they were introduced to the Five Aspect Meal Model (FAMM) which presented the opportunity to consider the multidimensional aspects of meals involving surroundings, people, management systems and the phenomena of atmosphere (Gustafsson, 2004; Gustafsson, Öström, Johansson, & Mossberg, 2006).

During this time, two Ph.D. theses published in Denmark emphasised the aesthetic aspect of meals. Carlsen (2004) addresses the aesthetic experiences of food and the aesthetic language of symbols (Carlsen, 2004 p. 77) and Fisker (2003) explores the analogy of architecture and meals emphasising the value of retaining dreams, rituals and myths in the design process (Fisker, 2003 p. 343). While discussing the FAMM model with students, it was possible to include the language of symbols and to discuss how to stage the surroundings but it was difficult to elaborate the notion of atmospheres and to include emotional and situational aspects of meal experiences underpinned by existing scientific literature. The focus on situational and contextual meal experiences was further strengthened as the notion of hospitality was introduced. However, I became challenged by a lack of scientific literature on the notion of hospitality in hospitals. Furthermore, I questioned my own stable ontological thinking as well as the epistemological positions that the existing literature on hospital meals was based upon. Even though my sayings at that time became extended to *we do not eat nutrition, we eat food and participate in meals*, I realized that there is a need for producing scientific knowledge that enables us to expand and transcend the static linear causality conceptualisation of hospital meals. This includes opening up new ways of conceptualizing meals as multidimensional and contextual which might provide a better platform for addressing ‘good hospital meals’ and undernutrition at hospitals. This Ph.D. project addresses this quest.

This Ph.D. project was conducted at the Department of Development and Planning, Research group for Meal Science & Public Health Nutrition (MENU) at Aalborg University and was supported by a scholarship from Aalborg University and Metropolitan University College in Copenhagen. The empirical research was carried out at Holbæk Hospital, at the gynaecology ward and medical cardiology ward.

ACKNOWLEDGMENTS

Throughout this project I have received invaluable assistance and support from many individuals. I would like to express my sincere gratitude to everyone that contributed to this project and would especially like to thank:

Professor Bent E. Mikkelsen, my main supervisor for your ongoing support and especially for allowing me to pursue my ideas and for having faith in my ability. I thank you for the patience and guidance you have given, especially during the paper-writing processes. I have certainly progressed with the project.

Associate Professor Szilvia Gyimóthy, my co-supervisor for sharing your extensive knowledge and inviting me to engage with different ontological and epistemological thinking so different from my point of departure. Your advice and interdisciplinary perspectives have truly helped me grow as a researcher.

Holbæk Hospital, (gynaecology and medical cardiology department), including staff members. I thank you for your hospitality, your willingness to engage with my project and for allowing me to become part of your daily life. Also, a very special thank you goes to the many patients that participated in the study. Many thanks to Koncern Service Holbæk Kitchen for being the gatekeeper and for making me feel so welcome. A special thank you goes to Catering Manager Hanne Jensen and all the wonderful kitchen professionals who generously shared their meal practices with me.

Principal Lecturer Enni Mertanen, JAMK University of Applied Sciences, Finland, for sharing your extensive knowledge on intuitional foodservice, the priceless advice you have given along the way and for the enjoyable chats and scientific discussions and for somehow always being there to boost my morale when I needed it most.

Senior Lecturer, Ulrik Houliind Rasmussen, Metropolitan University College, Copenhagen, for your comment on my final thesis. Lone Struve for graphic support and Jenny Sutherland for proof-reading.

Metropolitan University College, Ernæring og Sundheds Uddannelserne (ESU), and colleagues for letting me pursue my ideas and for having faith in my ability and for financial support.

Colleagues at Research group for Meal Science & Public Health Nutrition (MENU), for creating a work environment which always is based upon hope, recognition and laughter. Special thanks to Associate Professor Armando Perez-Cueto for support when I needed it most.

Also, a very special thank you goes to my family, neighbours and friends. You have all so generously followed my progress, and so generously shared your time listening and commenting my work. A special thank you goes to Poul Struve Nielsen.

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RESUME

Kvaliteten af hospitalsmåltider opfattes som ringe, og ca. 30-40 procent af de patienter, som er indlagt på hospitalerne, er i risiko for at blive underernærede under opholdet. Denne Ph.D. afhandling fra Ålborg Universitet og Professionshøjskolen Metropol viser, at en ny tilgang til måltider, der bygger på værtskaber og på, at patienter er medskabere af måltidsoplevelserne, kan bidrage til skabe mere madlyst og dermed at imødekomme underernæring på hospitaler.

Ph.D. afhandlingen har sit udspring i værtskabsbegrebet, et begreb som har været anvendt i forbindelse med offentlige måltider, men som endnu ikke er studeret og diskuteret videnskabeligt i forbindelse med offentlige måltider. Desuden tager Ph.D. afhandlingen afsæt i en kritik af den eksisterende videnskabelige litteratur om hospitalsmåltider. Litteraturen kritiseres for at tage udgangspunkt i en videnserkendelse, der er baseret på mundtlige eller skriftelige metoder og baseret på en forståelse af måltidet, hvor mennesker, maden og deres omgivelser betragtes som statiske aktører. I stedet har denne afhandling til formål at undersøge, om andre erkendelsesmetoder, i form af visuelle og sensoriske metoder, og andre mere dynamiske forståelser af måltider og deres aktører kan skabe nye forståelser af hospitalsmåltider for derigennem at bidrage til bedre måltidsoplevelser på hospitaler og herunder at adressere underernæring.

Afhandlingen er baseret på et etnografisk studie på gynækologisk og hjertemedicinsk afdeling på Holbæk Sygehus i 2012. De indsamlede empiriske data er baseret på visuelle metoder, observationer og semistrukturerede interviews. Patienters måltidsoplevelser blev studeret ved brug af Participant Driven Foto Elicitation (PDPE). PDPE er en visuel metode, som tager udgangspunkt i patienternes egne billeder af måltidsoplevelser og er baseret på billedernes evne til at fremmane følelser og hukommelse bedre end mundtlige og skriftlige metoder. Måltidspraksis og måltidsprocesser blev undersøgt med henblik på at studere værtskaber og med udgangspunkt i, at måltider kan betragtes som dynamisk skabte mellem mennesker, organisationer og det omgivende miljø. Det blev også studeret, hvordan værtskaber kan opstå i forskellige atmosfærer på afdelingerne og i uventede events både i måltiderne og uden for måltiderne.

Resultaterne viser, at PDPE er en metode, der er i stand til at øge indsigten i patienternes måltidsoplevelser. Hospitalsmåltider blev oplevet som sociale, som imaginære, og maden blev en repræsentant for hospitalets værtskab. PDPE kan anvendes til at få indblik i måltidsoplevelser, men metoden skal videreudvikles, hvis den skal anvendes som evalueringsredskab fremover. Måltidspraksis kan beskrives som *pop-up-restauranter*, hvori hospitalsrummet fysisk som sensorisk forandres til et måltidsrum, og hvori patienter forandres til måltidsgæster. Disse forandringsprocesser bliver forhandlet medskabende, bl.a. ved at give artefakter nye meninger og ved at give mulighed for, at patienter kan agere både vært og gæst. En værtsskabstilgang kan være udfordret af effektive-, hygiejniske- og ernæringsmæssige rationaler samt kulturelt tillærte måltidspraksisser, men værtskaber opstår primært på basis af sundheds- og køkkenprofessionelles egne initiativer. Gode måltidsoplevelser medskabes også gennem skiftende atmosfærer og i stemningsfulde events, hvor ritualer samt humoristiske og sociale events bringer håb og latter ind i måltidsoplevelserne. Evnen til at balancere mellem struktureret klinisk praksis og uforudsigelige events med fokus på medskabelse i måltidsprocesserne og mulighed for skiftende vært-gæst roller kan bidrage til gode måltidsoplevelser og skabe mere madlyst og dermed imødekomme underernæring på hospitaler fremover.

Denne afhandling giver nye perspektiver på, hvordan madlysten kan skabes i hospitalsmåltider. Værtskabsbegrebet kan bidrage til at artikulere måltidet som mere end bare en oplevelse af maden, og det giver mulighed for at betragte hospitalsmåltider som åbne og dynamisk skabte. Afhandlingen konkluderer at visuelle metoder kan øge indsigten i måltidsoplevelse, og at patienters evne til at medskabe måltiderne kan bruges som platform for fremtidige måltidsstrategier og praksis, herunder praksis, der giver madlyst og adressere underernæring.

ABSTRACT

This Ph.D. project is based upon a public meal discourse and a quest for improving hospital meals as 30-40 percent of hospitalized patients are considered to be at risk of undernutrition. The project responds to the notion of hospitality, which has been increasingly implemented as a concept within hospital meals. Despite this, the notion of hospitality lacks abstract scientific debates and perspectives connected to hospital meals. Existing scientific literature related to hospital meals is often based on knowledge gained from verbal or written methods whereby food, people and the environment are considered static agents. This project explores hospital meals through other ways of gaining knowledge such as visual methods and through conceptualising hospital meal experiences as dynamically constructed. The aim is to reconsider hospital meals and to develop a new conceptual framework which might add value to future hospital meals, including undernutrition.

The project is an empirical study reflected in an ethnographic study of hospital meals served in gynaecological and cardiological departments at Holbæk Hospital in 2012. The empirical data was collected using visual methods, observations and semi-structured interviews.

Insight into patients' hospital meal experiences was gained with the use of Participant Driven Photo Elicitation (PDPE). PDPE is a visual method based on patients' self-produced images of meal experiences and grounded in an image's ability to trigger emotions and memories better than verbal and written methods. Hospital meal practices were studied in order to explore hospitality within these meal practices while considering meals as dynamically constructed, involving humans, organisations and the environment. Finally, hospitality events articulated as unexpected events or as events that affected meals experiences were studied.

Findings revealed that PDPE is a method capable of providing insight into patients' meal experiences. Hospital meals were experienced as convivial, imaginary, material, and sociable situations. PDPE can be applied in future attempts to explore hospital meals but the approach needs to be strengthened. Hospital meal practices were found to be conceptualised as *pop-up restaurants* whereby the hospital room was transformed into a meal room and patients were transformed to guests. Hospitality became co-creatively negotiated by giving artefacts new meanings and through shifting host-guest roles. A hospitality approach is generally contested by effective, hygienic and nutritional rationales, but arises from healthcare and kitchen professional's own initiatives. Unexpected hospitality events became co-created in shifting atmospheres and through disruptive micro-events in which aesthetic form symbols, humorous and social performances brought hope and laughter into hospital meals experiences. The ability to strike a balance between structured clinical practices and unpredictable events built upon co-creation and hospitality while considering shifting host-guest roles in the process of co-creating pop up restaurants might provide opportunities for food passion, adding value to future hospital meal experiences.

This thesis offers new perspectives on how to bring value into hospital meals framed by the notion of hospitality's ability to articulate hospital meal experiences beyond food per se and to conceptualise hospital meals as open and dynamically constructed. The thesis highlights the ability to consider co-creation as a future platform for creating a passion for food and for supporting nutritional care strategies.

GLOSSARY

Aesthetic	Aesthetic is inspired by Kant's articulation of aesthetic as the 'nature of art, beauty, and the good taste' based on the subjective learned experience (Carlsen, 2004p. 36).
Affect	Set of flows moving through the bodies of humans and other beings composed of pre-personal intensities explained as unconscious experiences which differ from emotions. Affect is manifested as every form of communication whereby facial expressions, respiration, tone of voice and postures are perceptible (Thrift, 2009 p. 88).
Affordance	An affordance cuts across the dichotomy of subject-object and is equally a fact of the environment and a fact of behaviour. It points both ways, to the environment and to the observer (Gibson, 1979 p. 129).
Agency	Refers to the sense of what one (human, artefacts) can do in terms of power.
Alterity	The state of being other or different; otherness.
Analysis	A process of bringing together a series of things in ways that make them mutually meaningful' (Pink, 2009 p. 120).
Assemblage	An engagement that attends to the messiness and complexity of phenomena; an ethos that is committed to process-based ontologies that challenges conventional explanations by focusing on materially diverse configurations; and an ethos that emphasises an open-ended unfinished nature of social formations (Anderson, Kearnes, McFarlane, & Swanton, 2012)
Atmospheres	A certain mental or emotive tone permeating a particular environment but also the atmosphere spreading spatially around me in which I participate with my mood' (Böhme, 2002).
Bricolage	Bricolage is a 'do-it-yourself' problem-solving activity that creates structures from resources at hand e.g. by giving artefacts new meanings (Lévi-Strauss, 1966 p. 22).
Carnavalesque	Signifies the idea of a caricature of the life that opposes hierarchy and authority. It is a free space for laughter where conventional norms are abandoned (Bakhtin, 1984, cited in Sheringham and Daruwalla, 2007).
Co- creation	The process by which mutual value is expanded together (Ramaswamy 2011 cited in Grönroos & Voima, 2013). Co-creation emphasises a process that includes actions by both the service provider and customer (and possibly other actors). Some of this expansion may reflect true co-creation activities in direct dyadic interactions, but parts of it may be based on independent activities by the parties in a business engagement, where the focus is on the mutuality of value creation.
Communitisque moments	A concept to explain 'anti-structure experiences' in terms of a liminal space of symbolic detachment from societal norms built out of short-lived emotional bonds (Lugosi, 2008).
Conditional hospitality	Conditions of duties, obligations and reciprocity reflected in traditional hospitality encounters through fixed and asymmetrical host-guest relations where the host has the sovereign authority of his/her house and where he/she defines the condition of hospitality (Brown, 2010).
Conviviality	A friendly, lively, and enjoyable atmosphere or event.
Crystallization	Crystallization combines multiple forms of analysis and multiple genres of representation into a coherent text or series of related texts, building a rich and openly partial account of a phenomenon that problematizes its own construction, highlights researchers' vulnerabilities and positionality, makes claims about socially constructed meanings, and reveals the indeterminacy of knowledge claims even as it makes them' (Ellingson, 2009, p. 4).

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Disruptive micro events	Micro events that change everyday practices, opening up different enacted temporary hospitalityscapes, which then opens up boundaries for experiencing hospital meals as relations to home, as ritualized and aesthetic performances, and as joy and laughter whilst temporarily downplaying the medical and nutritional aspects of meals.
Doings and Sayings	Warde (2005) elaborates practices as ‘doings and sayings’ composed of three components; Understandings, Procedures and Engagements (Warde, 2005). Here, understandings refer to the practical interpretations of what and how to do, knowledge and know-how in a broad sense. Procedures refer to instructions, principles and rules of ‘how to do’ and engagements refer to the emotional and normative orientations related to ‘what and how to do’ (Halkier, Katz-Gerro, & Martens, 2011).
Enactment	With the term ‘enactment’ we put emphasis on activities where both persons and material elements are involved bringing new temporal structures and possibilities into existence (Weick, 1988).
Event	As a continual differing, if only in modest way (breaks), that takes-place in relation to an ever-changing complex of other events (Anderson & Harrison, 2010 p. 20).
Emotions	Addresses inter-subjective expressions of intensities as anger, joy and fear (Edensor, 2012).
Experiences	Most customer practices and experiences are every-day, mundane, sometimes even spontaneous activities, which may be more or less unconscious (Schatzki 1996 in Grönroos & Voima, 2013).
Feelings	Feelings mean anything that can be experienced via touch, smell, sight or any other sensory organ. Emotion is used to describe psychophysiological expressions, biological reactions, and mental states.
Foodservice	A system in which meals are produced and served for hospital patients in a professional context. The system includes the foodservice premises, the production and distribution technology, and human resources involved in management, production, distribution and serving (Council of Europe, 2003).
Guest	The body (humans, artefacts, organisations) that in the instant receive hospitality. Refers to a person who is away from their home environment, and for whom hospitality is provided at someone else’s house or in a commercial hospitality establishment.
Health Care Professionals	Includes service personal, health-care assistants, and clinical staff as nurses and doctors.
Home	An experience, a space of belonging a territory.
Host	The body (humans, artefacts, organisations) that in the instant provides hospitality.
Macro-ethical	Concerns the ethical considerations of societal interest and considerations in relation to the researcher (Brinkmann, 2010 p. 439).
Materiality/ artefacts	Materiality sometimes act as solid ground, but also a ‘vague essence’ as ‘continuous variation’ and ‘continuous development of form’. Food reveals materiality’s instability and, activeness (Bennet, 2010 p. 135). Artefact act as more solid grounds.
Micro-ethical	Concerns the ethical considerations related to research design, data-generating and analysis (Brinkmann, 2010 p. 439).
Mood	A mood is an emotional state. Moods differ from emotions in that they are less specific, less intense. Moods generally have either a positive or negative valence.
Nostalgia	Imagined mind-travelling forth and back in time and place.
Nutritional risk	Risk of complications and adverse and outcomes to disease that can be related to insufficient nutritional intake (Holst, 2010).
Performativity	Performativity provides a particular focus to the possibility of opening up, in a Deleuzian sense, to the unexpected and the divergent in the ‘excess’ of multiple possibilities of what people do (Dewsbury, 2010).
Post-structuralism	Post-structuralism is a broad historical description of intellectual developments in continental philosophy and critical theory originating in France in the 1960s. The prefix ‘post’ refers to the fact that many contributors such as Jacques Derrida, Michel

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	Foucault, Gilles Deleuze and Félix Guattari were highly critical of structuralism. In direct contrast to structuralism's claims of culturally independent meaning, post-structuralists typically view culture as integral to meaning. Post-structuralism rejects definitions that claim to have discovered 'truths' or facts about the world (Wæver, 2010 p. 207).
Pre-cognitive	Intensions or decisions, that are made before the conscious self is aware of them (Thrift, 2000 p. 7)
Provision	Emphasises rational aspect of services and is based upon the idea that persons need to be motivated or to be acted upon in accordance to a predetermined food-culture, staff appearance or by staged surroundings and atmospheres.
Reflexivity	An awareness of the researcher's contribution to the construction of meanings throughout the research process, and an acknowledgment of the impossibility of remaining 'outside of' one's subject matter while conducting research. It considers an engagement on how the process of collecting data may have affected the reality observed and the collected data as well (Pink, 2007 p. 23)
Reciprocity	Actions that are not purely 'other-regarding', but they need not be purely self-regarding either (Telfer, 2000 p. 43).
Rituals	As bound in social and normative interactions as "a perfunctory, conventional act through which an individual portrays his respect and regard for some object of ultimate value to that object of ultimate value or to its stand in" (Goffman, 1971 p. 62).
Routines	Structuring a recognizable everyday life, and as practices which could be organisational prescribed or as material bodies of work or styles that has gained enough stability over time to become a routine (Thrift, 2000 p. 8).
Service design	More than a product design, it involves a series of co-creation experiences based on a set of active interactions and transactions that take place repeatedly, anywhere and at any time (Zomerdijk & Voss, 2010)
Service satisfaction	The satisfaction with a service and the state reached if his/her expectations have been met or exceeded.
Space	Spatial relations and the way in which we imagine to think (Thrift, 2000 p. 16).
Undernutrition	A condition where the intake of protein and- or energy is reduced to an extent where measurable effects of body composition and tissue is seen, and where this influence the patient's clinical course (Holst, 2010).
Value creation	Value creation is the customer's creation of value-in-use during usage, where value is socially constructed through experiences and a function of interaction. Value creation entails a process that increases the customer's well-being, such that the user becomes better off in some respect (Grönroos & Voima, 2013).

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1 INTRODUCTION AND BACKGROUND

1.1 Creating the gap

One of the Global Grand Challenges, presented in the Lund Declaration, addresses undernutrition among elderly and hospitalized patients and the rising prevalence of overweight and obesity (European Parliament, 2009; Kondrup, 2001; Richelsen et al., 2003). An estimated 30-40 per cent of hospitalized patients are at risk of undernutrition (Kondrup, 2001; Rasmussen et al., 2004; Thibault et al., 2011). Both hospitals and the foodservice sector are therefore considered key areas for public policy interventions due to their significant contribution to public health and nutrition outcomes (Mikkelsen, 2011).

The foodservice sector and the phenomena of institutional meals are often criticized with strong negative attitudes towards food quality and acceptability, complaints of insufficient variety, poor food presentation and undesirable physical dining room settings. The institutional meal setting has often been considered a place for eating for necessity rather than for pleasure (Cardello, Bell, & Kramer, 1996; Edwards & Hartwell, 2009; Warde & Martens, 2000). Such criticism, as well as reports of high rates of undernutrition unrelated to a disease or medical treatment (Thibault et al., 2011), is in contrast to a number of studies that indicate high patient satisfaction with meals, with estimates of approximately 80 percent of patients rating hospital meals as *good* or *very good*. Within such studies, food quality is found to be an important factor for satisfaction (Burns & Gregory, 2008; Fallon, Gurr, Hannan-Jones, & Bauer, 2008; Naithani, Thomas, Whelan, Morgan, & Gulliford, 2009). Addressing this paradox, Cardello et al. (1996) concludes that there must be something more that has to be considered than simply the intrinsic food quality:

Institutional foodservices may be better served by addressing the causes and potential solutions to poor consumer attitudes and expectations for institutional food, than by continued efforts to improve the intrinsic quality of foods whose quality may already be quite high (Cardello et al., 1996 p. 19).

Further, these satisfaction studies have been criticized for relying upon a management approach towards service provision, emphasising rational aspects of services and deriving satisfaction from cognitive evaluations rather than emotional aspects. They have also been criticized for their failure to recognize hospital meals as part of a broader situational context, leading to a questions about the validity of these surveys (Johns, Hartwell, & Morgan, 2010; Morgan, 2006). A lack of an ability to include a broader situational context can also be found in existing studies on hospital meal foodservices, which tend to focus on the impact of foodservice systems on nutritional quality and patient food intakes. This is articulated through a linear causality thinking in which food consumption and reduced elements such as foodservice systems, menu systems or communication systems influence experiences, are explored (Hartwell & Edwards, 2001; Hartwell & Edwards, 2003; Hartwell & Edwards, 2009).

The *something more* and the complexity of institutional meals has been addressed by Edwards (2013) and expressed in Gustafsson's (2004) introduction of the Five Meal Aspects Model (FAMM) in 2004 (Edwards, 2013; Gustafsson, 2004). The model represents elements that frame experiences of eating out in contextual situations, but the model can be criticized for representing a static *container model*. A container model considers experiences that take place in a certain time and place, leaving out any possibility to consider aspects outside the physical surroundings and the physical time as part of an experience (Ek & Hultman, 2007 p. 20).

Recently, the notion of hospitality has been introduced into the field of institutional foodservice and adapted for a hospital meal context, where it is introduced as a conceptual framework aiming to improve hospital meal experiences and a patient's nutritional recovery process. This has been achieved by introducing a 'meal host' function or by changing the surroundings into a more hotel-like environment (Beermann, Mortensen,

Skadhauge, Rasmussen, & Holst, 2011). However, the conceptualisation of hospitality can be criticized for being based upon a static hospitality approach, e.g., by treating patients as static guests and health care professionals (HCP) as static hosts. As a result, it fails to consider the possibility that hospitality might be more dynamically constructed and that materiality in itself might create agency and contribute to different meal experiences (Lynch, Germann Molz, McIntosh, Lugosi, & Lashley, 2011).

This scientific gap highlights a need for a broader conceptualisation of hospital meals in order to address better hospital meals and reduce undernutrition in hospitals. The following paragraph aims to address this gap in a quest for the reconsideration of hospital meals. This will be accommodated by unfolding and discussing the complex and ambiguous construction of hospital meals based upon the existing scientific literature. It argues that existing literature is predominantly based upon a conceptualisation of meals as a linear-causality phenomenon and that a broader conceptualisation, in which meals are considered as more than food, multidimensional and contextual, might open up a broader conceptualisation. Furthermore, it will be argued that this calls for a shift in ontological and epistemological positions and for paying tribute to methodological pluralism, allowing empirical data to speak in different ways.

The Acute Care Hospital Foodservice Patient Satisfaction Questionnaire (ACHFPSQ) has been developed to identify the need for quality improvement and for the evaluation of interventions in several studies related to hospital meals. It consists of 21 statements in which patients have to rate their satisfaction through a 5-point Likert scale (Burns & Gregory, 2008; Capra, 2006; Fallon et al., 2008; McLymont, Cox, & Stell, 2003; Messina et al., 2009; Naithani et al., 2009; Porter & Cant, 2009; Wright, Connelly, & Capra, 2006). The 21 statements relate to food properties in terms of flavour, temperature and variety. The service quality statements are related to properties of crockery, missing items on the serving tray. Service issue statements relate to properties such as cleanliness, friendly staff, and the ability to choose (Capra, Wright, Sardie, Bauer, & Askew, 2005). Results from these studies indicate an overall patient satisfaction with hospital meals. In accordance with other studies, food quality was found to be the best predictor of patients' meal satisfaction (Burns & Gregory, 2008; Fallon et al., 2008; Naithani et al., 2009; Porter & Cant, 2009; Wright et al., 2006), while other studies highlight staff service and interpersonal aspects as the most important (Belanger & Dube, 1996; Mahoney, Zulli, & Walton, 2009; McLymont et al., 2003; Sahin, Demir, Celik, & Teke, 2006). Further, it can be argued that these studies have not brought any novelty into the scientific field of hospital meals, despite being conducted over several years.

These satisfaction studies have been further criticized for representing a rational linear and causal way of thinking, failing to consider hospital meals as emotional or as means for the individual to achieve pleasure or identity. In addition, neither do they consider hospital meals in a broader situational context. Finally, the embodied aspect is only represented in parameters as friendly or clean staff. The lack of inclusion of the emotional aspect has been raised in Johns et al. (2010), with reference to Morgan (2006). Both argue for an expanded comprehension of patients' meal experiences by adopting a holistic approach which contrasts satisfaction studies. Further, they claim that traditional satisfaction studies are based upon a management approach towards service provision which emphasises the rational aspect of services and where satisfaction is derived from cognitive evaluations rather than emotional aspects (Johns et al., 2010; Morgan, 2006). Johns et al. (2010) asked patients to write down their own meal experiences without pre-defending any functional meal properties connected to hospital meals. They found food quality and choice to be mentioned most frequently as most important to hospital meal experiences. This was followed by service staff, a factor which also was most positively mentioned. However, these findings also revealed hospital meals to be expressed as parallel with normal life, especially to life at home, through emotional aspects in terms of boredom, fear and relief and as a situation where there is a possibility to engage with other people who are detached from the medical treatment. The authors finally suggest that hospital meals should be seen in a broader ward context (Johns et al., 2010).

Other studies exploring hospital meals and hospital meal experiences are based upon other methods of collecting empirical data such as verbalised, open-ended, semi-structured, or focus group interviews (Hartwell, Edwards, & Symonds, 2006; Holst, Rasmussen, & Laursen, 2010; Lassen, Kruse, & Bjerrum, 2005; Naithani, Whelan, Thomas, Gulliford, & Morgan, 2008).

A focus on the eating environment has been addressed but tends to focus on functional properties. Naithani et al. (2010) points to physical barriers in relation to improved food intake in terms of inappropriate eating positions, food left out of reach, sounds and smells that negatively affect food intake and staff's insufficient focus on meals (Naithani, Whelan, Thomas, & Gulliford, 2010). Edwards & Hartwell (2004) found energy intake to improve among patients eating at a table rather than in bed. Lassen et al. (2005) requested proper furniture and comfortable eating conditions, while Rapp (2008) suggests family surroundings, the creation of atmosphere and to change the physical eating location in order to improve healthy eating (Edwards & Hartwell, 2004; Fallon et al., 2008; Larsen & Uhrenfeldt, 2012; Lassen et al., 2005; Rapp, 2008). Hartwell, et al. (2006) found empathy to be important for meal experiences. However, this was connected to food quality properties and to environmental properties such as quiet and peaceful mealtimes in combination with an ability to eat with others (Hartwell et al., 2006). The social aspect of hospital meals has been considered in other hospital studies with divergent findings, as some patients express an unwillingness to participate in meals with other patients due to an inability to eat properly (Larsen & Uhrenfeldt, 2012). In a recent study on group dining facilities for patients, it was suggested that a home environment might promote feelings of belonging and togetherness while supporting patients' rehabilitation process (Hartwell, Shepherd, & Edwards, 2013).

Other interventions and comparative studies have studied the impact of foodservice systems on food intake. Findings from these studies reveal that food intake could be improved when multiple choices are combined with high food quality (Cheung, Pizzola, & Keller, 2013; Edwards & Hartwell, 2004; Edwards & Hartwell, 2006; Hartwell & Edwards, 2003; McLymont et al., 2003; Wadden, Wolf, & Mayhew, 2006; Williams, Virtue, & Adkins, 1998). From this perspective, food intake is thought to be highly related to food and the availability of food, alike findings from existing satisfaction studies.

However, the majority of these studies represent an epistemological position that tends to focus on rational and cognitive aspects rather than emotional aspects. Similar to the satisfaction studies, they are based upon written or verbal discourses, neglecting the possibility that hospital meal experiences could be elaborated further emotionally by adapting other epistemological positions such as visual methods. Finally, they are based upon a static and linear causality ontology considering the patients or the environment as stable agents.

Within the last six years the notion of hospitality has been introduced into the field of institutional food. The Copenhagen House of Food introduced the notion of 'meal host' in 2008 and articulated it as a person who is responsible for creating good meal environments (Københavns Madhus, 2008). In the following years, the notion became adapted for a hospital meal context where it was introduced as a conceptual framework aiming to improve hospital meal experiences and the patients' nutritional recovery process (Beermann et al., 2011; Lund, 2012). The idea of applying a hospitality approach in a hospital meal context is, however, not new. Hepple et al. (1990) and recently Hartwell et al. (2013) introduce their studies as based upon a hospitality approach (Hartwell et al., 2013; Hepple, Kipps, & Thomson, 1990). However, the introduction of hospitality within hospital foodservice practice has only partially been subject to abstract scientific debates and investigations. These practices are also based upon culturally determined hospitality practices manifested in the semiotic structure of service speech in words such as *guest* and *hosts*, in prevailing hospitality discourses such as welcome trays and welcome information brochures, and as a list of attributes aiming to make people feel at ease. Further, they are based upon a conditional and asymmetrical hospitality approach reflected in predetermined meal structure practices, where hosts are represented by health care professionals

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(HCPs) and kitchen professionals (KPs) are responsible for providing a specified foodservice quality, based upon nutritional and food cultural values. This perspective considers meal experiences and host-guest relations as static, exemplified by the host's ability to stage a defined home environment by scripting physical interiors or staff appearance (Edwards & Gustafsson, 2008; Hartwell et al., 2013). Criticism of this normative and static perspective of hospitality includes its failure to consider the possibility that hospitality, including host-guest relations, might be more dynamically constructed and that materiality in itself might create agency and contribute to different experiences of atmospheres and hospitality meal experiences (Lynch et al., 2011).

The scientific gap representing a quest for expanding the conceptualisation of hospital meals is further articulated in the following vignette. The vignette displays different aspects of hospital meal experiences which the existing scientific literature finds it difficult to address. This includes considering the dynamic aspect of hospitality, meal relations and the aspects of materiality. The vignette is extracted from field notes from the Gynaecology ward, representing a cancer patient, named Jane in this thesis, and her relations to meals during her stays:

The first day I meet her, Jane's relations to hospital meals could be characterised as *the white days*. The white days was characterized as moments in which her body demanded her full attentions and consequently her articulation of meals was reflected in meals that did not to any circumstance need her attentions towards sensory elements and expressions, so she articulated good hospital meals in terms of well-known simple dishes and simple arranged meal components on the plate and she valued the white napkin, the white serving tray and the white walls in the room and soft and light food that were easy to swallow. She was becoming a nutritional safety eater. Another day when I interviewed her, her relations to meals was different. She described good hospital meals in sensory terms however still by taking a point of departure in a traditional well known food culture represented by meat balls and fried fish fillets and she continued by elaborating on the importance of sensory properties such as colourful napkins with a reference to her stay during Christmas in which her hospital room became transformed to a Christmas party room. She was becoming a cultural sensuous eater. However one day, she called me into her room where her daughter was visiting her. Her daughter was at that time eating a salad with broccoli, raisins and carrots and with a powerful voice she said: 'Look Lise, this is my food, this is my food, and this is what I eat at home, however I normally steam the broccoli'. She was becoming the mother and the home eater.

These three episodes represent a patient's different dynamic and transforming relations to hospital meals and to the act of eating intertwined into unexpected events, her own bodily conditions and her temporal multi-relations to the hospital, to home life, traditions, to her daughter and broccoli salad and to different host and guest roles. These stories raise the following new questions on meal experiences and the conceptualisation of hospital meals.

How can patients' shifting dynamic relations to hospital meals be explored?

How can patients' relation to materiality be explored?

How can patients' emotional and sensuous relations towards meal experiences be explored?

These questions also underpin the critique of the existing literature on hospital meals and hospital meal experiences, including the critique on the FAMM model (Edwards & Gustafsson, 2008). They highlight the need for challenging the ontological and epistemological boundaries in future studies of hospital meals. Reconsideration and expanded understandings of hospital meals and meal experiences might therefore respond to the quest for considering how to achieve better hospital meals in the future. An expanded

conceptualisation of hospital meals calls for epistemological positions which are centred on patients and that enable us to consider non-verbal embodied, emotional and contextual aspects of meal experiences. It also calls for an ontological shift towards a more dynamic and fluid thinking, assigning a more active role, e.g., to patients but also to materiality in the construction of hospital meal experiences. This also enables the transcendence of a static place and time perspective. A dynamic and socio-material ontological shift further demands an epistemological position which is based on the study of real-life situations and practices.

1.2 Presenting aim and research questions

A reconsideration of hospital meals is the focal point of this Ph.D. The aim of this study is:

To develop a new conceptual framework for understanding hospital meals and to introduce a hospitality approach as means to contribute to better hospital meal experiences in the future.

Findings from this Ph.D. project will open new paths for future research on hospital meals and help create a potential conceptual frame for hospital and foodservice organisations. Furthermore, an underlying assumption is that the conceptualisation of good hospital meal experiences is a precondition for the ability to organise and serve healthy hospital meals which also might address the issue of undernutrition.

Patients' perspective on hospital meal experiences:

The new conceptual framework is based upon a critique on existing satisfaction studies and their tendency to focus on cognitive evaluations rather than emotional aspects. Furthermore, it is based upon a critique that hospital meals are articulated through functional properties and on patients' difficulties in verbally expressing meal experiences. Visual methods might provide a new approach to gaining knowledge and insight into how patients experience hospital meals. This can be expressed as:

How can visual methods as a research method that seeks to transcend a verbal approach to experiences, be applied in a hospital meal context and contribute towards a richer insight into patients' hospital meal experiences?

The patient's perspective allows a phenomenological approach but does not integrate all actors, processes, practices and understandings in the construction of hospital meals. This calls for exploring hospital meals as socio-materially constructed and this includes a hospitality framework.

Hospital meals explored as socio-materially constructed and through a hospitality framework:

Based upon the complex character of hospital meals and the critique of existing literature, this project explores hospital meals through new ontological and epistemological positions that consider the world as dynamic, multi-relational, temporal and socio-materially constructed. This can be studied through methods based upon transformative processes. Furthermore, with inspiration from the notion of hospitality and the quest for considering hospitality as part of a conceptual meal framework, a hospitality approach will be included. This creates an opportunity to articulate and discuss how 'good hospital meal experiences' come into being in a variety of social and material relations. This leads to the following research question:

How is hospitality constituted within social and material transformative meal processes? How might a hospitality approach add value to hospital meal experiences?

However, considering how the phenomenon of 'good hospital meals' might be constructed in unexpected hospitality events and manifested in different atmospheres that are not necessarily placed in structured meal times, this project explores:

How is hospitality constituted in social and material events and explored through unexpected events and daily hospital life? How might this approach add value to hospital meal experiences?

These main research questions will be the point of departure for this Ph.D. thesis.

2 CONCEPTUAL AND THEORETICAL FRAME.

This chapter continues by introducing the conceptual and theoretical frame. Both of these inform the project but also constitute and support the development of different analytical grips based upon various ontological and epistemological perspectives in the search for transcending static linear causality thinking. Firstly, a hospital foodscape will be presented as an overall conceptual framework. This is followed by an introduction to the notion of hospitality as part of the hospital foodscape and as a focal point for the analytical framework of this thesis. Finally, the notion of meals and meal experiences will be presented and discussed in relation to the analytical hospitality framework.

2.1 Presenting hospital foodscape

Several scholars have claimed that a foodscape perspective offers a convenient and holistic framework for viewing complex settings and complex social systems in which humans, artifacts and environments interact with foods, referring to the anthropologist Appadurai's scape approach (Adema, 2009; Mikkelsen, 2014; Winson, 2004). As a result, the notion of *foodscaapes* has increasingly been utilised in the academic literature (Johnston & Baumann, 2009 p. 3). However, despite the increased use of the notion of foodscape and the suggested establishment of Foodscape Studies within the field of health and food research (Mikkelsen, 2011), a stringent ontological frame is still discussed (Johnston & Baumann, 2009 p. 3; Mikkelsen, 2014; Panelli & Tipa, 2009). A ontological static foodscape approach has been applied in foodscape studies exploring the availability and distribution of food in retail, urban or rural areas (Burgoine et al., 2009; Cummins & Macintyre, 2002; Sobal & Wansink, 2007; Wenzer, 2010; Winson, 2004), but this approach has been criticized for limiting the opportunity for a nuanced understanding of the place of food in different populations and cultures (Panelli & Tipa, 2009).

A dynamic foodscape approach inspired by a post-structuralist thinking has been adapted by the philosopher Dolphijns (2004). Dolphijns articulates his foodscape approach as "continually created in concrete events where different substances meet, whereof some become eaters and others become food" (Dolphijn, 2004). Dolphijn (2004) is inspired by the philosopher Deleuze's ethics of consumption where focus is placed on mutual compositions that are embedded in the processes of creation, being, and understanding (Adema, 2007; Dolphijn, 2004 p. 31). This dynamic foodscape approach is adapted by the FINE research group (Foodscape, Innovation Networks) at AAU which articulates it as "the encounter between food, space, people and systems as a dynamic interaction" (FINE, 2014). In contrast, the research group of Meal Science & Public Health Nutrition (MENU) articulates Foodscaapes studies as "the interactions between the food, the people and the places" (MENU, 2014).

Being enrolled in the research group of Meal Science & Public Health Nutrition and its description of foodscaapes as "the interactions between the food, the people and the places", the conceptual frame of this Ph.D. project will be articulated as a hospital foodscape and qualified by articulation of the notion of *place* inspired by the articulation of place by Ek and Hultman (2007), Ingold (2008) and Massey (2005). Ek and Hultman (2007) introduce a place as a precondition and a context for material and social interaction in a world that can't be seen as a single geographic physical location and therefore a place cannot be studied in isolation (Ek & Hultman, 2007 p. 20). Instead, a place is articulated as "a meeting place" which is "online

and porous” and where “the sum of social and material relations are events”. This is alike Dolphijn’s (2004) foodscape approach, and thereby not ontological, stable and fixed (Ek & Hultman, 2007 p. 20). Similarly, Ingold (2008) articulates place as unbound, transcending a bound time and place conceptualisation (Ingold, 2008). Massey (2005) describes a place through the notion of space as “simultaneity of stories-so-far” in which a place is a collection of these stories (Massey, 2005 p. 130), thereby introducing places as constellated by processes in terms of how things come together, stay together or reconstitute in other relations (Pink, 2012 p. 25). Therefore, the conceptual hospital foodscape approach is in line with a dynamic foodscape approach and consequently hospital foodscapes ascribe an ontological argument that transcends an understanding of patients or HCPs as stable persons with fixed identities, experiences and meanings. Instead, they are considered as social beings, with socially constructed identities where meanings and experiences are intersubjectively co-created (Wæver, 2010 p. 198). These meanings and experiences can be physical, mental as well as imaginary and it leaves relations between persons, artefact or other agents and structure in a constantly changing flow (De Landa, 2006 p. 19). Neither the hospital nor hospital meals are stable physical entities or locations but active participants in the co-creation of meanings and experiences. This leaves hospital foodscapes as multi-relational, temporal and socio-materially constructed. In addition, it leaves this Ph.D. project to be built upon a post-structuralism paradigm which is inspired by French poststructuralist philosophers such as Deleuze and Derrida (see next paragraph). This challenges a food scientist’s realist thinking to accept the complexity and messiness of hospital meals. Furthermore, a post-structuralism paradigm sets the stage for considering and questioning dominated scientific static paradigms and invites researchers to engage with and reflect on knowledge created on the basis of different and maybe contradictory analytical frameworks (Wæver, 2010p. 197).

2.2 Knowing hospitality

This paragraph will introduce and discuss the notion of hospitality as part of a hospital foodscape. The inherent dualities of hospitality will be presented. It will be argued that these dualities and contradictions broaden the understandings of hospitality and contribute to the construction of an analytical framework that enables the exploration, elaboration and discussion of hospitality in a hospital meal context. Furthermore, it will be argued that the notion of hospitality enables a shift away from a focus on food or food properties towards a broader meal conceptualisation. Two analytical hospitality frameworks will be presented based on different epistemological positions drawing on an assemblage approach and non-representational thinking.

The notion of *hospitality* has traditionally been concerned with the management of commercial hospitality organisations related to tourism, hotel and restaurants and conceptualised as social glue, referring to its ability to establish or promote a relationship in the course of exchanging goods and services between those who give and those who receive (Lashley, 2007; Selwyn, 2000). Tracing the historical and etymological meaning of hospitality, the word has a much broader significance. The word hospitality emerges from the Latin *hostis*, meaning *enemy*, *army* or *stranger* and can be received as a guest or as an enemy (Friese, 2004). The notion of hospitality can therefore be understood in terms of receiving and protecting a stranger but also to be protected from the stranger (O’Gorman, 2007) . This duality highlights the contradictions of hospitality as a notion. This is further underlined as *hostility* and *hospital* are connected to the word of hospitality and this also includes antonyms such as *stranger/friend*, *inclusion/exclusion*, *welcome/non-welcome* *duty/pleasure* and *morality/transgression*, as well as the notion of reciprocity (Lynch et al., 2011).

From a historical and cultural perspective, hospitality and hospital are also closely related. From the Greek and Roman period and up to the Age of Enlightenment, the notion of hospitality was mainly perceived as a sacred unselfish obligation. For Christians, the notion of hospitality was also correlated with a Christian duty, with a reference to the bible where the lesson of Lot claims that any stranger could be an angel in disguise (Heal, 1990). As such, it was generally agreed that hospitality should be extended to offering care and provision to the poor but also to protect the stranger. Other people perceived hospitality and their duties

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as host as a way of achieving increased social status, honour and political influence. Heal (1990), and Telfer (2000) argue that private hospitality based upon charity moved towards a commercialized form of hospitality, motivated on the basis on political and economic considerations (Telfer, 2000).

The connection of hospital to the word of hospitality is materialised in previous description of hospitals. In the mid-13th century, hospitals were described as “shelters for the needy” and in the early 15th century as “charitable institutions to house and maintain the needy” (Hospital, 2010). It was not until the 16th century that a focus on providing protection and shelter for the needy changed to a focus on the sick body as hospitals were described as “institutions for sick people” (Hospital, 2010). From then onwards, emphasis was placed on treatment of the sick bodies rather than on hospitality transactions protecting the ‘needy’ through the act of serving food (Risse, 1999 p. 80). Hospitality in hospitals has a long cultural history which underpins its contemporary interpretations in both private and public settings alike and further underpins its relevance for being re-introduced into a hospital meal context again.

Despite the close connection of hospitality with the word of hospital, few studies address hospitality within a hospital context and even fewer address hospitality within a hospital meal context. One of them is the study by Hepple et al. (1990) on the identification of hospitality factors as a mean to evaluate satisfaction among patients (Hepple et al., 1990). Four-hundred patients from three different hospitals were asked to consider aspects important for feeling ‘at home’ and subsequently ten important hospitality factors were identified and ranked in a survey. The ten hospitality ranked factors were friendly medical and non-medical staff; a smooth admissions procedure; information regarding daily routines; a varied menu choice; plain cooking; privacy; comfortable furniture; recreational facilities; and attractive décor. Varied menu choice and plain cooking were found to be fifth and sixth most important hospitality factors. The study concluded that hospitality as a concept could be applied and be useful as a basis for hospital management in the future (Hepple et al., 1990).

Neither meals nor food are mentioned by Patten (1994) as she argues that an increased market oriented and competitive environment for healthcare services in the United States has forced hospitals to develop hospitality business strategies that address patients’ wellbeing and satisfaction by treating patients as customers in a service context (Patten, 1994). She evolves a concept of hospitality in terms of three distinct levels: public, personal and therapeutic. She describes the public level as basic politeness characterized by brief personal interactions in a short service interaction. The personal level consists of a voluntary personal invitation in which the interactions go beyond a brief exchange and where the roles of host and guest and their boundaries emerge clearly. The therapeutic level signifies a service to humankind on a broader level and encompasses a more moral, ethical and meta-physical dimension. Patten claims that an understanding of these levels could be helpful in integrating various dimensions of guest relation programmes. She also argues that the therapeutic level could form a basis for developing a nursing framework of hospitality in a search for enhancing patient satisfaction and therapeutic progress (Patten, 1994). It has also been suggested by Severt et al. (2008) that these three levels of hospitality should be adopted as part of a hospitality-centric philosophy in which “hotel- like service” practices can be transferred into a hospital context in order to address patients’ wellbeing and satisfaction (Severt, Aiello, Elswick, & Cyr, 2008).

These studies consider hospitality as representative of a broader hospital experience and do not specifically address hospitality in connection to hospital meals. Further, it can be argued that these studies represent a static and linear causality way of thinking, ranking and categorizing hospitality factors as functional properties. For example, by varied menu plans and plain cooking or by categorizing hospitality transactions into stable hospitality exchanges. As a result, these studies represent an ontology based upon a stable and predictable homogeneous world which considers host and guest relations as asymmetrical and articulated through cognitive factors. Such factors neglect the fact that improved hospital meal experiences could be

gained from embodied and sensory experiences and from epistemological positions that build upon knowledge gained from other methods such as written or oral methods.

The inherent dualities in the notion of hospitality opens up a broader approach towards the understanding of hospitality and it is within this frame that hospitality scholars such as Lashely, Lugosi, Lynch, Morrision and Molz, have established the interdisciplinary field of hospitality studies carried out from a social science point of departure and manifested in books such as *In Search of Hospitality* and *Hospitality A Social Lens*, and in 2011 the new established English scientific journal named *Hospitality & Society* (Lashley, 2000; Lugosi, 2008; Lynch et al., 2011).

A concise definition of hospitality is still being discussed but the definition introduced by Brotherton & Woods (2000) is often highlighted (Lashley, 2000; Lynch et al., 2011):

“A contemporaneous human exchange, which is voluntarily entered into and designed to enhance the mutual well-being of the parties concerned through the provision of accommodation, and/or food, and/or drink” (Brotherton & Wood, 2000).

This broad definition enables hospitality to be framed using a social science approach but can also be applied from a commercial hospitality perspective. Further, this definition provides an important argument for considering a hospitality approach in this Ph.D. thesis as the definition links hospitality to the “provision of accommodation, and/or food and/or drink”. The first part of the definition “A contemporaneous human exchange” can be elaborated as social interaction from different perspectives. Brotherton & Wood (2007) divide the social exchange of hospitality into two different themes in which hospitality can be perceived as a way to achieve social control or as social and economic exchanges (Brotherton & Wood, 2007). Within the theme of perceiving hospitality as social control, the German philosopher Kant’s idea of ‘universal law of hospitality’ has been highlighted (Molz & Gibson, 2007 p. 4). From *Toward Perceptual Peace*, written in 1795, Kant describes cosmopolitan conditional hospitality as:

Under the law of hospitality, individuals should have the right as a foreign visitor to be treated without the threat of hostility, false imprisonment, fraud, theft or banishment as long as that visitor behaves in a peaceable manner in the place he happens to be (Kant, 1795 in Brown, 2010).

Kant emphasises the juridical and political right of the strangers to visit, but also their obligations as a guest to obey duties and reciprocity defined by the host. These conditions are often reflected in traditional hospitality encounters through fixed and asymmetrical host-guest relations where the host has the sovereign authority of his/her house and where he/she defines the condition of hospitality. As such, by conceiving hospitality as a process of managing the stranger, whether it concerns nations, institutions or private or commercial domains, he describes the act of hospitality as social and cultural, dealing with duties, obligations and moral virtues (Telfer, 2000). Telfer (2000) adds to the work on hospitality by suggesting that a good host is not just skilful and attentive but also hospitable. Being hospitable is a genuine desire to care for and please others out of motives appropriate to hospitality (Telfer 2000).

Conversely, hospitality as a social and economic exchange considers hospitality as ethical through feelings of altruism, beneficence and the exchange of honour, sharing generosity and respect. This leaves hospitality to be understood as an acceptance of the stranger and of differences (Lashley, 2000; Lynch et al., 2011). The French philosopher Derrida conceptualises hospitality as ethical in contrast to Kant’s juridical and political conditional hospitality (Derrida, 2000; Derrida & Dufourmantelle, 2000 p. 23). Derrida (2000) opens up the notion of hospitality by claiming that hospitality has to be seen as unconditional (Derrida, 2000; Derrida, 2005). Although Derrida asserts unconditional hospitality as impossible in practice, he claims to welcome anyone and to see hospitality as infinite, absolute and open. (Derrida, 2000; Dikeç, 2002). Dikeç (2002)

elaborates on Derrida's hospitality approach by taking a point of departure in Derrida's four statements of hospitality, expressed as "we do not know hospitality", "hospitality is not present being", "hospitality as not yet" and "hospitality as self-contradictory" (Derrida, 2000; Dikeç, 2002). As such, Derrida (2000) claims makes the claim that hospitality is an experience beyond objective knowledge as we do not know how to meet a stranger with hospitality beforehand, and therefore we do not know hospitality. Further, Derrida claims hospitality to be temporal as the experience of receiving or giving hospitality can only last an instant and is therefore not a present being (Derrida, 2000; Dikeç, 2002). The statement of hospitality as "not yet" refers to the need for opening up the notion of hospitality and to transcend the traditional way of understanding hospitality as conditionally reflected in duties and obligations. In other words we do not know hospitality "yet". The last of Derrida's statements refers to the self-contradictory nature of hospitality as a host who, in order to be able to receive a stranger, must have sovereignty of his house which in principle make purely unconditional hospitality impossible (Derrida, 2000; Dikeç, 2002). Based upon these statements, Dikeç (2002) elaborates on Derrida's hospitality approach as an act of engagement through "mutual recognition of each other's alterity" (Dikeç, 2002). In doing so, Dikeç (2002) wants to transcend the conventional and stable understanding of host-guest relations as distinct and stable categories towards an open conceptualisation in which hosts and guests are in a constant process of engagement and negotiation. This leaves hospitality to be conceptualised as dynamic, temporal and relational so that hosts and guests are constitutive of each other, blurring host-guest relations.

Other contemporary hospitality scholars have worked with the aspect of hospitality as social exchange. This is presented in O'Mahony's (2007) description of how the guests of Irish immigrant become enrolled in the hospitality sector as hosts (O'Mahony, 2007) as well as in Bell's (2007) description of train hosts' and passengers' interchangeable host-guest roles (Bell, 2007).

The relational aspect of host-guest relations is also presented in Lugosi's (2008) attention to guest-guest relations in which individuals may be both hosts and guests simultaneously (Lugosi, 2008). The temporal, emotional and unpredictable aspects of hospitality are presented by Lugosi (2008) in terms of *communitasque moments*. Such a concept is used to explain anti-structural experiences as a liminal space of symbolic detachment from societal norms built out of short-lived emotional bonds (Lugosi 2008). Additionally, Sheringham and Daruwalla (2007) introduce an anti-structural space of hospitality by introducing hospitality as a *carnavalesque* social construction with reference to the Russian philosopher Bakhtin (Sheringham & Daruwalla, 2007). Here, a carnivalesque social construction signifies the idea of a caricature of the life that opposes hierarchy and authority. It is a free space for laughter where conventional norms are abandoned (Bakhtin, 1984, cited in Sheringham and Daruwalla, 2007).

Returning to Brotherton & Wood's (2000) definition of hospitality, the voluntary aspect can be interpreted through Derrida's hospitality approach as giving the guest an ability to remain a stranger rather than becoming another in order to empower the stranger. However, on the basis of the sociologist Goffman's (1961) introduction to the notion of "total institutions" (Goffman, 1961), it cannot be neglected that the involuntary aspect of being hospitalized and of being enrolled into a captive hospital foodservice system must be considered as challenged and paternalistic in terms of disempowering patients' (Holm & Smidt, 2000).

The wellbeing aspect assumes hospitality to be a desirable quality (Lynch et al., 2011). Within a hospital setting this implies that hospital meals are good, pleasurable experiences providing value for the patients, e.g., materialised as meaningful situations and adequate food intake. However, due to hospitality's close connection to hostility, it can be questioned whether the term hospitality should contain and conceal an oppressive element as the stranger cannot be respected unconditionally, given the hospital settings as discussed above.

The last element in Brotherton and Wood's (2000) hospitality definition is concerned with "food". This underlines that hospitality is closely associated to food and therefore there is a materiality aspect to hospitality. However, hospitality scholars have suggested that by providing artefacts with agency, which is not only attributed to food, the materiality aspect merits further attention and debate as only few hospitality scholars have addressed this aspect (Lynch et al., 2011). Di Domenico & Lynch (2007) found that hospitality venues as commercial home enterprises can be considered as performative settings in which artefacts and symbols are staged, not statically staged, but where participants are active in the host-guest processes (Di Domenico & Lynch, 2007). In addition, the hospitality scholar Grit (2010) addresses the aspect of materiality in commercial home enterprises (Grit, 2010 p. 31) and Eksell (2013) discusses hotel keys as symbolic and sensuous representations connected to the activity of handing over hotel keys, given the hotel keys agency (Eksell, 2013 p. 160). The aspect of materiality as giving artefacts agency has been addressed by the political scientist Bennett (2010). In her book, *Vibrant Matter*, she advocates for the "vitality of things" in terms of their capacity as quasi-agents with "trajectories, propensities or tendencies of their own" (Bennett, 2010 p. viii).

The theoretical background presented above provides an analytical framework for studying social interactions and socio-material constructions in different hospital meal contexts. As such, it provides ontological positions in accordance to the hospital foodscapes presented above. Further, by adapting Derrida's hospitality approach it provides an ethical and normative understanding of hospitality as "mutual recognition of each other's alterity", contrasting conditional hospitality. Furthermore, it provides an analytical framework in which hospitality can be considered in different commercial, private or social contexts and through aspects such as empowerment, communiquesque moments and carnivalesque hospitality. However, Derrida's hospitality approach is limited as it is rooted in social interactions alone, ignoring the significance of materiality, including spatial aspects. Therefore, other theoretical approaches are needed in order to develop an analytical hospitality framework that enables us to relate to the research questions. The next paragraphs will present two different approaches that underpin Derrida's hospitality approach involving materiality. One approach enables a focus on daily transformative meal processes in terms of an assemblage approach and the other focuses on events, representing a non-representational approach.

2.3 Presenting hospitality as socio-material

The notion of assemblage has been introduced by scholars within the area of human geography as an alternative way of studying dynamic social and material relations and processes (Adey, 2012; Anderson et al., 2012; Marcus & Saka, 2006). Anderson et al., (2012) describe assemblage as:

...an engagement that attends to the messiness and complexity of phenomena; an ethos that is committed to process-based ontologies that challenges conventional explanations by focusing on materially diverse configurations; and an ethos that emphasises an open-ended unfinished nature of social formations (Anderson et al., 2012).

An engagement as assemblage allows a focus on hospital meals as constituted by processes in line with Derrida's hospitality approach. Further, an assemblage approach emphasises an "open-ended unfinished nature of social formations" which is in line with Derrida's (2000) articulation of hospitality as "we do not know hospitality – yet". This allows the transcendence of hospitality as simply conditional, manifested in asymmetrical host-guest relations, or as a culturally-learned property aimed at making people feel at ease.

Focusing on "materially diverse configurations", an assemblage approach expands Derrida's hospitality approach by considering a flat ontology. A flat ontology depletes a hierarchical thinking, therefore assigning agency not only to humans but also non-humans and therefore to materiality. This allows the consideration of all different entities to have agency and to take part in the process, e.g., by giving artefacts such as napkins

temporary host agency. Swanton (2010) explains assemblage as “a particular conjunction of material and immaterial elements in an encounter” (Swanton, 2010). Assemblage is therefore process-based but also concerned with how a particular conjunction in dynamic and temporal relations is assembled, held together and changed through transformation processes (Adey, 2012; Marcus & Saka, 2006; Swanton, 2010). These conjunctions could be temporary processes such as the processes of transforming a hospital room into a dining room, or they could be an assemblage constituted by temporary relations such as different host-guest relations or materiality such as a serving tray. Furthermore, these conjunctions are not separated entities but instead intertwined into each other. Engaging in an assemblage approach enables the broadening of a linear causality thinking as well as a focus on how hospital meals become constructed and assembled and how these conjunctions create possibilities for hospitality based upon empowerment and “mutual recognition of each other’s alterity”.

An assemblage approach has only been applied in few health and food studies. On the basis of existent literature, Voelkner (2011) explores how a health assemblage of carbon dioxide emissions, viruses, computers and airplanes constructs human security situation in relation to migrant health (Voelkner, 2011). Folye (2011) examines the holy well as a therapeutic assemblage adapting ethnographic and visual methods in an attempt to get closer to the objects and the practices around the wells (Foley, 2011). Outside food and health studies, socio-material assemblage has been adapted by Swanton (2010). She explores how the road becomes the conjunction for the socio-material constructions of race. Additionally, Schönian (2011) explores the intranet as a socio-material assemblage based upon an empirical study founded in practice theory (Schönian, 2011; Swanton, 2010).

In order to explore the multiple, dynamic and changing ways in which hospital meals are “brought about” as socio-materially constructed, the assemblage approach needs to be complemented with an analytical frame which supports the identification of the conjunctions that are intertwined into a hospital meal assemblage. Inspired by Folye (2011) and Schönian (2011), an analysis of practices would be helpful.

The philosopher Schatzki defines practices as “a set of doings and sayings organised by a pool of understandings, a set of rules and a teleo-affective structure” (Schatzki, 2001 p. 53). This definition has been operationalised by the sociologist Warde (2005). Warde elaborates practices as *doings and sayings* composed of three components: *understandings*; *procedures*; and *engagements* (Warde, 2005). Here, understandings refer to the practical interpretations of “what and how to do, knowledge and know-how” in a broad sense. Procedures refer to instructions, principles and rules of *how to do* and engagements refer to the emotional and normative orientations related to “*what and how to do*” (Halkier et al., 2011; Warde, 2005). Studying practices provide an analytical frame which allows the identification of processes and relations and subsequently different socio-material assemblages (see the Assemblage paper in Appendix 2).

In order to pursue the third research question - how to explore hospitality within hospital meals as socio-materially constructed through events in everyday practices and in which meals are considered as more than just a reproduction or representation - non-representational theory (NRT) will be applied. A non-representational approach allows the consideration of hospitality within hospital meals as socio-materially constructed, similar to the assemblage approach, but a non-representational approach also contrasts the assemblage approach by placing emphasis on conjunctions, focusing more on *breaks* in everyday practices in terms of unexpected events, affects and atmospheres.

Non-representational theory (NRT) is a way of thinking within human geography, developed largely through the work of the human geographers Thrift and Dewsbury (Cadman, 2009). NRT is, alike an assemblage approach, founded on a post-structuralism paradigm and distinct from social constructivist theories by allowing a focus on dynamic socio-material relations, thereby claiming a flat ontology that assigns agency to

both humans and non-humans. NRT is distinct from an assemblage approach by considering pre-cognitive actions that cannot necessarily be interpreted as intentional or cultural representations structured by symbols and meanings. Therefore, non-representational thinking allows a focus on pre-cognition (Anderson & Harrison, 2010; Thrift, 2007 p. 6). Anderson & Harrison (2010) argue that a focus on pre-cognitive actions in NRT thinking must be conceived via embodied and environmental properties and therefore on practice. However, it also must be conceived on breaks within these practices, and the breaks which lead to changes. McCormack (2002) emphasises the focus on practice by quoting Deleuze and Guattari: “We know nothing of a body until we know what it can do” (Marcus & Saka, 2006; McCormack, 2002). A body in a Deleuzian world represents both human and non-human elements and the focus on what bodies can do underpins the relationally-materially constructed aspects of NRT. Based upon the focus on precognitive actions, a NRT way of thinking draws attentions to “affects and atmospheres” (Anderson & Harrison, 2010). Affect is defined by Thrift (2009) as a “set of flows moving through the bodies of humans and other beings” which, in NRT thinking, are composed of pre-personal intensities explained as non-conscious experiences which differ from emotions (Thrift, 2009 p. 88). Emotions and affects can be considered as embedded into each other and inherent in the notion of atmosphere (Anderson, Harrison 2010). According to Böhme (2002), atmosphere can be characterized by “a certain mental or emotive tone permeating a particular environment but also the atmosphere spreading spatially around me in which I participate with my mood” (Böhme, 2002). This means that the phenomenon of atmosphere is placed as an intermediate between the subjects. It is therefore not only possible to experience atmosphere in terms of one’s own emotional state, but also to approach atmosphere from a side in which atmosphere has been staged (Böhme, 2002; Böhme, 2013). Consequently, a non-representational approach allows a focus on “a sense the now”, on the immediate, embodied, present moments and a focus on agency and events that disrupt everyday practices, focusing on the possibility for new experiences (Dewsbury, 2010) (see the NRT paper in Appendix 3).

2.4 Knowing meals

Throughout this Ph.D., the notion of meals has been connected to the notion of experiences. This paragraph will elaborate on these notions and include the different epistemological frames presented above. Inspired by Lalonde (1992), this paragraph will be structured into two themes, one of which is related to *meals-as-objects*, representing a cultural and structural frame, and one to *meals-as-events* which is related to the situated experiences of meals (Lalonde, 1992).

The American consumer researcher Meiselman (2008) introduces the meal-as-object theme by claiming that meals can be explored through several dimensions in which physiological, psychological, nutritional, anthropological, sociological, culinary and economic dimensions are just some (Meiselman, 2008). A cultural approach to meals is introduced by the Finnish sociologist Mäkelä (2000). She introduces meals through three dimensions in terms of *format*, *eating pattern* and *social organisation of eating*. Format represents the content and order representing the composition of meal components and sequence of the whole meal. Eating patterns represents the structure, time, or the number of eating events and the alternation of hot and cold meals. Lastly, social organisation of eating relates to with whom and under what conditions we eat, highlighting the sharing of food with others as a necessary feature of a meal definition (Mäkelä, 2000 p. 7). In addition, Douglas and Nicod (1974) define meals as “food eating as part of structured events”, where structured events are articulated as “social occasions that are organised by rules concerning time, place and sequence of action” (Douglas & Nicod, 1974), thus taking as a point of departure the preconception of meals as socially constructed. Furthermore, their structured analysis of *the proper meal* is presented as a hierarchy of certain foods that are arranged and served in a specific order and at a specific time and characterized in the composition as a theatrical play (Carlsen, 2011 p. 70). The social aspect of meals has also been highlighted by the French sociologist Fischler (2008) through the notion of *commensality* and his description of the empire of snacks in which snacks replace ritualised and structured

meal norms in the act of eating in modern individualised living (Fischler, 1988; Fischler & Masson, 2008). Contrary to meals, snacks have been characterized as involving only few food items as they are often unplanned and characterized as an individual act of eating (Meiselman, 2008; Murcott, 1982). Further, the structured meal events take part in organising the day and life. Kjærnes (2001) writes that “eating takes place as an integrated part of everyday life and thereby contributes to ordering our days into segments: morning, midday, afternoon, evening” (Kjærnes, 2001 p. 31).

A meal definition that highlights meals as a social occasion has been criticized in an aim to seek the static and constant structures in meals and to ignore looking behind the flow and process of meals. Furthermore, it has been criticized for ignoring the physical sensory experiences (Bisogni et al., 2007; Lalonde, 1992). Nyberg (2009) highlights a problem in defining meals as structured in both time and construction as it prevents people who work irregular hours from participating in meals (Nyberg, 2009 p. 36). Douglas & Nicod’s (1974) perception of proper meals also takes the family meal as point of departure, similar to Lashley’s (2000) suggestion of understanding the private hospitality dimensions from a nuclear family perspective (Lashley, 2000). Fischler (2008), Murcott (1997) and Nyberg (2009) discuss whether structured meals are threatened or in transition due to changes in conditions and patterns of living, claiming that the ‘family meal’ has become an ideal of a proper meal (Murcott, 1997 p. 33; Nyberg, 2009 p. 33). Bringing the idea of the family meal as a proper meal into a frame of institutional meals is reflected in Warde & Marten’s (2000) study of eating out. Here, institutional meals are articulated in terms of *eating for necessity* whereas restaurants meals were articulated in terms of *eating for pleasure* and connected to social family occasions (Warde & Martens, 2000 p. 47). The idea of the ideally structured social and family meal is also embedded in the Danish Recommendations for Institutional Meals where meals are described: “A portion of food, eaten within a delineated time, is generally considered as a meal”. Good meals are further articulated as involving “well-known social context, intimacy and relevant ways of serving, welcoming surroundings and serving practices”, as well as ‘to eat in good company’ (translated from Danish) (Fødevarestyrelsen, 2009 p. 39). According to Nyberg (2009 p. 45) and Bisogni et al. (2007), the ideal understanding of meals challenges meals outside of the home but also creates new opportunities for new eating episodes which apparently lack culturally defined structure. It also might create new patterns and values based upon the circumstances. Further, Bisogni et al. (2007) suggest transcending the more normative and structural approach by defining meals as “eating episodes”. Nyberg (2009 p. 46) describes this as “what is eaten and drunk”, but also questions this definition as it deconstructs the notion of meals and raises the question: what is not a meal then?

In a hospital meal context, the definition of a proper meal as that of the social family meal is clearly challenged as some patients do not have an ability to socialise, some might prefer to eat alone, or some might not be able to eat at certain times (Larsen & Uhrenfeldt, 2012). As this Ph.D. project is founded on Derrida’s (2000) hospitality approach, Bisogni et al.’s (2007) and Nyberg’s (2009 p. 46) definition of meals is useful as it allows a whole day perspective on what eating and drinking episodes might bring forth while still claiming the cultural aspect of meals as something more than just fuel for the body or part of a recovery strategy. However, the approach does this without necessarily disclaiming the value of structured family and social meals either.

Further, this meal approach enables a focus on the contextual and immediate experiences of eating which brings in Lalonde’s (1992) approach towards meals as lived experiences in terms of meals-as-events. As such, Lalonde (1992) discusses the immediate taste and the sensuous experiences of eating while also acknowledging that these sensations are intertwined in cultural, social and individual constructions, making these senses less a matter of sensation but also a matter of perception. This is supported by Carlsen (2011), who claims that taste is not immediately experienced but contains cultural connotations that are symbolically constructed in aesthetical communication forms which also include rituals (Carlsen, 2011p. 12). These form

symbols arise from pre-understandings in terms of assumptions, personal experiences, cultural norms and traditions (Carlsen, 2011 p. 26). Carlsen is inspired by the American philosopher Korsmeyer, who claims that taste is emotionally dimensioned but also can have cognitive dimensions. Carlsen (2004) introduces aesthetical form symbols with inspiration from caring signs that requires knowledge, experience and insight to interpret and act upon meal experiences (Carlsen, 2004 p. 72). This is similar to Brillat Savarin's distinctions between the gourmand and gourmandise (Brillat-Savarin, 1996 p. 213). The conceptualisation of meals as events, as structured by symbolic communication forms and representations would, from a Derridian and a NRT perspective, be considered as static as it does not consider the possibility to focus on what eating episodes might bring forth. This includes an opportunity to explore contingency events and relations between structured meal formats and meal patterns as well as the processes of establishing new structures. Finally, it downplays the importance of assigning materiality agency, e.g., in terms of an ill body agency, as some patients struggle with nausea, lack of saliva production or an ability to swallow. These factors which might overrule the aesthetic symbolic experiences of a meal event, e.g., by letting a napkin become a temporal host.

Meals as events are also expressed in the Five Aspect Meal Model (FAMM) (Gustafsson, Öström, & Annett, 2009), which was developed in connection to the recently established multidisciplinary research field: Culinary Arts and Meal Science at Örebro University, Sweden in 2001. As previously described, the FAMM model provides a conceptual framework for meal experiences and is constituted by: the food (*The Product*), social interactions (*The Meeting*), physical settings (*The Room*), organisational aspects (*Management Control System*) and the atmosphere (*Atmospheres*) that are created by the other aspects (Gustafsson, 2004; Gustafsson et al., 2009). However, the FAMM model can be criticized for representing container thinking. This means that the FAMM considers meal experiences as bound in the eating time and eating place, while incoming elements such as patients, the physical meal room and the atmospheres are considered as passive subjects in the construction of meal experiences. This neglects an opportunity to consider patients or HCPs as being active co-creators of moods or atmospheres. It also leaves out an opportunity to consider food itself, like the philosopher Proust reliving the experience of a Madeleine cake (Dolphijn, 2004 p.13), or other artefacts as participating actively in the construction of meal experiences.

As with the nature of defining the notion of meals, there are various debates concerning the definition of experiences. In a Danish context, an experience can be understood as a result of learning outcomes but it could also be understood as a memorable or enjoyable event. Further, it could be understood as an all-embracing term commonly used to describe people's daily encounters in life (Carù & Cova, 2003). In addition, experience could be understood as multi-sensuous, involving emotional and affective components between relevant actors (Lugosi, 2014). This thesis conceptualises experiences as people's daily encounters with eating and drinking episodes, reflecting meal experiences as an event but also considering meals as emotional, affective and cognitive experiences.

This chapter introduced the hospital foodscape as an overall conceptual frame for a hospitality approach, taking a point of departure in Derrida's (2000) and Brotherton and Wood's (2000) hospitality definition. By considering hospitality as connected to the "provision of food", it transfers hospitality into a commercial hospitality meal frame in connection to institutional meals. As such, it allows meals to be considered as eating episodes which follow the ideal of a proper meal but also allow new opportunities for meaningful eating episodes to occur.

3 METHODOLOGY

Building on the Ph.D. project aims and the analytical framework, the following chapter presents the research strategy and connected research methods.

3.1 Exploring hospital meals

This Ph.D. is inspired by Ellingson's (2009) Crystallization framework, a framework in social science that is designed to explore a phenomenon through different epistemological positions and multiple methods. According to Ellingson (2009), this provides a deepened complex though partial understanding of a phenomenon (Ellingson, 2009 p. 3). Crystallization is defined below:

Crystallization combines multiple forms of analysis and multiple genres of representation into a coherent text or series of related text, building a rich and openly partial account of a phenomenon that problematizes its own construction, highlights researchers' vulnerabilities and positionality, makes claims about socially constructed meanings, and reveals the indeterminacy of knowledge claims even as it makes them (Ellingson (2009 p. 10).

Crystallization is rooted in a social constructionist approach but allows a broad range of approaches. An exception to this is positivism, which claims the existence of an objective and universal truth. From this stance, Ellingson (2009) introduces crystallization as messy and as a paradigm spanning research manifested in different genres along a continuum which originates from science or realist, middle-social constructionist, or impressionist positions (Ellingson 2009 p. 8).

The crystallization approach enables the exploration of hospital meals from different epistemological and ontological positions. By using different epistemological positions, insight into patients' hospital meal experiences based on visual methods can be gained by exploring hospitality through meal practices and by considering unexpected events as constitutive for meal experiences.

Ellingson (2009 p. 125) introduces two different types of crystallizations, one named *integrated crystallization* and the other named *dendritic crystallization*. The word dendritic is used by chemists when referring to crystal growths and crystal branches (Ellingson, 2009 p. 125). Integrated crystallization refers to one multi-genre text, whereas dendritic crystallization refers to multiple forms of analysis and representations based upon different epistemological positions and outlined in different single-genre texts, e.g., as published scientific papers (Ellingson, 2011 p. 605). This thesis follows a dendritic crystallization process which will be based upon different epistemological positions and outlined as three single texts. The single texts will be based upon traditional academic papers targeting foodservice and hospitality journals. The different epistemological and ontological positions connected to the research questions are outlined in Table 1.

However, dendritic crystallization requires more than adapting different epistemological positions outlined in single genre texts (Ellingson, 2009 p. 136). It is also characterized by a mindset which encourages the researcher to focus on possibilities for new directions in the entire research process. Dendritic crystallization is therefore characterized by an ongoing, open process connected to the data collecting process, to the process of analysing data and in the process of representing findings (Ellingson, 2009 p. 136). Furthermore, dendritic crystallization, alike qualitative research in general, puts the separate single genre texts into direct conversation with each other. These meta-analytical discussions between the produced single-genre texts involve a search for connections between the different findings and other researcher's findings and it involves adding a new theoretical perspective to illuminate new or unexpected ideas or consideration (Ellingson, 2009 p. 127).

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Table 1: Three different epistemological and ontological positions related to research questions.

Research questions	Epistemological positions	Ontological positions
Paper 1: How can visual methods as a research method that seeks to transcend a verbal approach to experiences, be applied in a hospital meal context and contribute towards a richer insight into patients' hospital meal experiences?	Here it is claimed that access to emotional knowledge can be gained through visual methods. Visual knowledge becomes a representation of how patients experience hospital meals. Further, it is claimed that knowledge is embedded in the subject and that this knowledge can be drawn from the subject.	The ontological position is here considered socially-constructed and is based upon a phenomenological user perspective.
Paper 2: How is hospitality constituted within social and material transformative meal processes? How might a hospitality approach add value to hospital meal experiences?	Here knowledge is considered to be placed in a co-created culture by humans and their individual knowledge but also by materiality as they are considered as having agency. Therefore it is claimed that access to knowledge on hospital meals can be gained by studying how relations and processes are transformed by studying everyday practices and actors and understanding on daily meal practices.	The ontological position is here considered as flat and socio-materially constructed, assigning equal importance to materiality and human actors. Further, it is based upon a hermeneutical approach.
Paper 3: How is hospitality constituted in social and material events and explored through unexpected events and daily hospital life? How might this approach add value to hospital meal experiences?	Here it is claimed that the world is socio-materially constructed and co-created. Further, it is claimed that access to knowledge can be gained through the researchers own and others affective engagement with the field and with a focus on experienced events that transcend the idea of representations. Further, it differs from the assemblage paper by claiming that knowledge can be gained from studying the 'breaks' in daily meal practices that leads to change.	The ontological position is here considered as flat and socio-materially constructed, assigning equal importance to materiality and human actors. Further, it is based upon a hermeneutical approach.

The dendritic crystallization process in terms of an ongoing process connected to the data collecting process and the process of analysing data will be presented and discussed in the following paragraphs.

3.2 Presenting the multi-scale ethnographic research strategy

Based upon the aim of this project and the chosen epistemological positions, it is relevant to choose a qualitative research strategy. A qualitative research position also allows the researcher to engage in the field whilst also acknowledging that the researcher becomes a part of the research process (Denzin & Lincoln, 2011 p. 3). An ethnographic research strategy would meet these requirements. Due to the project's claim that hospital meal experiences might be improved upon by including visual methods, this project will be inspired by visual ethnography. Pink (2007 p. 22) defines ethnography as:

“...a methodology and as an approach to experiencing, interpreting and representing culture and society that informs and is informed by a set of different disciplinary agendas and theoretical principles as well as a process of creating and representing knowledge based upon ethnographers own experiences.”

Pink (2007) defines ethnography as not only a research strategy but also a methodology understood as the procedures of the qualitative research. This regards ethnography as not only a method for collecting data but

also a process of creating and representing knowledge. The researcher becomes, as such, a part of the research process thus allowing the consideration of gained knowledge as partial, situated and reflexive (Pink, 2007 p. 69). Gained knowledge thereby becomes a version of the ethnographer's, however loyal, experiences of reality (Pink, 2007 p. 22). By introducing ethnography as a process involving the researcher, Pink (2007) also suggests that reflexive and collaborative methods become a part of the ethnographic research process. The definition of ethnography as the study of culture and society is broad in contrast to other ethnographic definitions but the definition does allow ethnography research to be seen as more than a study of culture and society bounded in a location. Conversely, it enables us to travel with the phenomenon of hospital meals to other hospitals or, e.g., to homes, consistent to this thesis' discussion of place and hospital foodscape perspective. Thereby, Pink (2007 p. 22) regards ethnography as a process of creating and representing knowledge, rather than just a method for collecting data. Similar to other ethnographic research, Pink (2007 p. 9) articulates the need for using theoretical frames to reflect on the experiences and representations of ethnographic knowledge.

With an interest in patient experiences and meal practices, it was relevant to choose a hospital as the location for the ethnographic field of study. Inspired by Pink's reflexive visual ethnography, it was considered important to identify a location where visual ethnography and dendritic crystallization would be accepted as a research methodology while also being allowed access to the hospital in order to follow relevant themes or actors whenever needed. Furthermore, it was important to gain access to different wards, not with the intention to conduct a comparative study, but as a way of creating a possibility for reflexivity and to gain insight into daily life and daily meal practices. Therefore, two wards were chosen.

Holbæk Hospital became the physical location for the ethnographic fieldwork. In September 2011 the first meeting was held with Koncern Service Køkken, the food-service-organisation providing hospital meals in the western part of Region Zealand. Holbæk Hospital is one of four acute hospitals in Region Zealand, located in the northwest part of Zealand, 60 kilometres from Copenhagen and with approximately 27,000 inhabitants. The hospital was built in 1844 as a mental hospital but changed into a somatic hospital in 1890. It was rebuilt several times and in 2013 it was rebuilt to house the acute part of the hospital, including the gynaecology (GW) and the cardiology ward (CW). Currently, the hospital has 301 beds for inpatients and also has ambulatory activity (Holbæk Sygehus, 2013; Region Zealand, 2013). The kitchen at Holbæk Hospital was rebuilt in 1983. Here, the existing cook-serve system was maintained and the bulk trolley system was implemented. The kitchen provides meal services to 350 patients each day.

The kitchen became the gatekeeper, inviting other departments at the hospital to become the location for the project fieldwork. The GW and the CW expressed an interest and became the location for this fieldwork as they represented two different wards. The first part of the fieldwork was conducted at the GW from January 2012 to April 2012 and the second part was conducted at the medical CW between August and October 2012.

The GW is an acute department with 7 hospital rooms and 13 beds. Patients are mainly cancer patients from the local area in which some are at risk of undernutrition, but as the ward is specialized in surgery related to Vulvar Vestibulitis, patients from all of Zealand attend the ward. Sometimes pregnant women with prolonged nausea are also hospitalized at the ward, however only for a few days.

The CW is divided into two sub-wards, with each ward containing 20 beds and 12 patient rooms. Patients are mainly locals and hospitalized for on average five days due to ischemic heart disease. Both sub-wards contain patients at risk of undernutrition who are provided with an energy-dense hospital diet.

The GW and CW were comparable in relation to the foodservice provided, including the concepts, foodservice organisation, buffet trolley system and the physical locations in the newly built acute part of the

hospital. However, they did differ from each other as the GW was considered to be a quiet ward by HCPs and kitchen professionals (KP)s, whereas the CW was considered a busy ward. The GW was a larger ward, a larger organisation, it required a higher workload and patients at the CW were on average hospitalized for a longer period. They were also more local and upward patients and so the patient to patient interactions around the sitting area were more pronounced.

The study of daily life and practices at the two different wards was possible as both were based upon the same foodservice provision. The different patients and different groups of HCP's therefore had the same approach towards foodservice provision. This provided an opportunity to focus on patients and HCP's experiences related to the meals rather than the food itself and it extended the reflexive space for considering hospital meal experiences and the constructions of hospital meals. As the buffet serving system at Holbæk is similar to other foodservice systems in Denmark and to those used in other countries, the transferability of this study was enhanced. A protocol for each period of fieldwork was produced containing information on the background, aim, research strategy and methods, economical resources, responsibilities and ethical considerations of the study.

Patients at Holbæk Hospital are offered three main meals a day and various meals in-between. The main meals are served from a buffet trolley placed at the ward corridor. Patients who are not condemned to bed help themselves, choosing from the buffet. In the morning, breakfast is served by a service assistant connected to the ward whereas the lunch and the dinner are served by kitchen professionals (KP). During breakfast there is a choice of white or brown bread and options of fruit juice, porridge and cereals. At lunch, which is the hot meal of the day, there are two different menus representing the *normal diet* and the *hospital diet* (Fødevarestyrelsen, 2009 p. 67). The hospital diet contains a higher energy density than the normal diet. The lunch menu includes a starter, two main courses and a dessert. The main courses include two meat dishes, two different carbohydrate-based meal components, and sauce, vegetables and salads. In the evening there is a choice of soup, open sandwiches and a small side dish. A weekly menu plan is placed on the noticeboards at the ward corridors. Fruit and coffee are served from a coffee trolley in the morning and in the afternoon a variety of snacks or sandwiches are available. Drinks are available from a refrigerator located in the sitting area. From the satellite kitchens it is possible to store bread and milk products and it is possible to order other dishes during the day as frozen menus are kept at the satellite kitchen. A kiosk wagon with chocolate, sweets, magazines and newspaper visit the wards each day.

The different ward organisations are responsible for ordering the different menus and the choices of in-between meals 24 hours in advance. Due to an internal economic exchange between the foodservice organisation and the ward organisations, it is the ward's decision to decide what to be ordered. The GW organisation found it important to have an opportunity to offer meals whenever needed which resulted in the availability of a variety of frozen prepared meals and open sandwiches throughout the day. The CW had a focus on main meals and in between meals.

3.3 Presenting ethnographic fieldwork

The ethnographic field study at Holbæk Hospital took place from January 2012 to February 2013. The fieldwork was divided into two periods. The first period took place at the GW from January to April 2012 and. The second part took place from August 2012 and continued during the winter.

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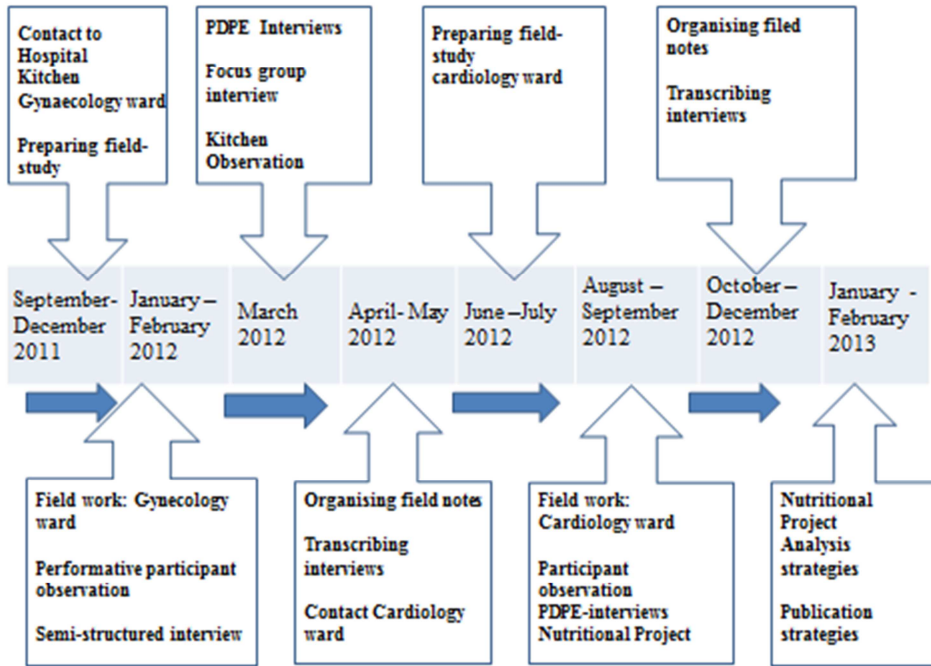


Figure 1. Flow diagram representing the time process of the ethnographic field study at Holbæk Hospital

The idea of dividing the fieldwork into two periods allowed an extended explorative-integrative approach in terms of jumping back and forth between empirical findings and theoretical frameworks (Maaløe, 1996 p. 271), in line with a dendritic crystallization process (Ellingson, 2009 p. 136).

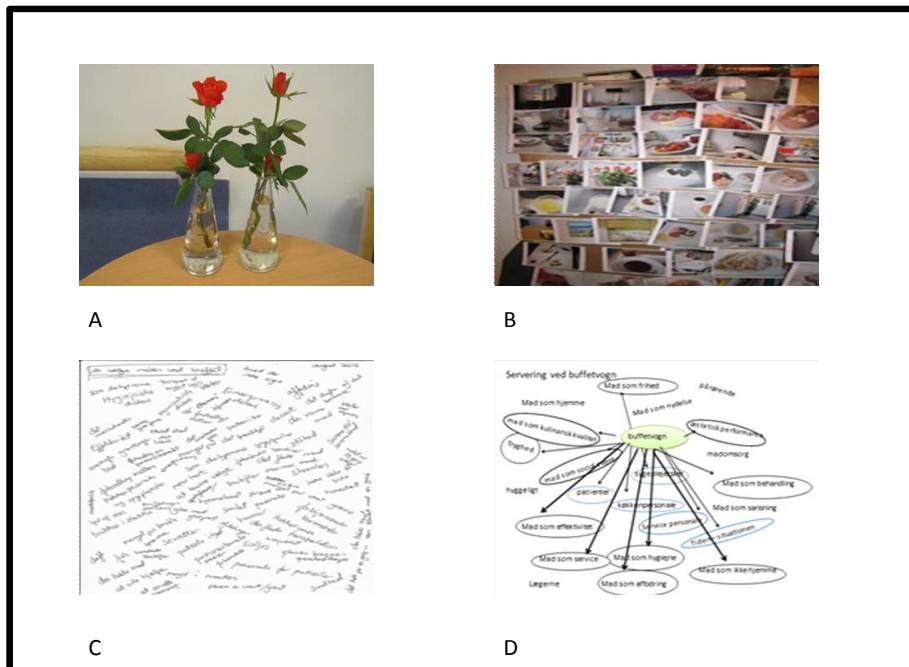


Figure 2. Picture Board, A: Roses, representing a can opener experiences. B: Images at wall papers in the office.

C: Messy maps. D: Relational maps.

Hospitable Meals in Hospitals

Figure 2 reflects the engagement with the field right from the beginning of the planning process in September 2011 to the last meeting in February 2013.

Based upon Pink's (2007) visual ethnography and in line with the presented hospital foodscape, the ethnography field study became diverse and multi-scaled, transcending and expanding time and location. The ethnographic place became the two different wards but also the respective groups of HCPs and patients at each ward and their visitors. It soon became the KPs and their kitchen organisation. Further, patients at the GW were followed to their home, to other related hospitals such as Rigshospitalet and to the Danish Cancer Society due to their nutritional recommendations for cancer patients. At the CW, the ethnographic fields of study were expanded to the Danish Heart Foundations and their recommendations along with the project group that worked with a nutritional research project. Additionally, the Danish Diet & Nutrition Association and the Danish Veterinary and Food Administration became a place for the ethnographic field of study due to their nutritional and foodservice recommendations. Finally, the dialog with other kitchen professionals arranged by the local department of the Danish Diets & Nutrition Association, the dialogs with students and academic colleges from the Nordic Countries through the Nord Plus Polaris Network, a Nordic network for teachers at higher education institutions engaged in in foodservice and health, became an ethnographic field of study as they provided a place for reflections. The multi-scale ethnographic field of study is presented in Table 2.

The connected research method at the multi-scale fields of study was based upon multiple methodological ways of using observations and interviews. Inspired by Pink's (2007) visual ethnography, visual observation methods became a part of the observation strategies as they provided access to an embodied and multi-sensuous space of encounters. This allowed a focus on the context, embodied interactions and temporal experiences including a possibility to consider the agency of materiality. Further, this enabled us to overcome the limitation of verbal discourses and allowed emotional and memorable experiences to be reflected upon (Cederholm, 2004; Pink, 2007 p. 91; Rose, 2012 p. 305).

Table 2: Multi-scale ethnographic study at Holbæk Hospital

Institutions	Organisations	Associations	Professionals	Individuals
Holbæk Hospital	Gynaecology ward at Holbæk Hospital	Danish Diet & Nutrition Association	Kitchen Professionals at Holbæk	Patients in hospitals
Koncern Service, Region Sjælland	Cardiology ward at Holbæk Hospital	The Danish Cancer Society	Health Care Professionals, Holbæk	Patients at home
Danish Veterinary and Food Administration	Hospital Kitchen, Holbæk	The Danish Heart Foundation	Dieticians Holbæk Hospital	Visitors at Holbæk
Rigshospitalet	Nutrition Project at Holbæk		Academic colleagues	Foodservice and Health Students

Roskilde Hospital

The photographing act provided a neutral identity. "The food researcher doing images" and the act of photographing served to explain and justify the research as it was perceived as a way of collecting "real data" in contrast to "just observations". As with written field-notes, images became visual notes documenting and representing episodes or experiences from the field. An image of the roses (see figure 2)

became a ‘can-opener’ to the field as the act of photography presented an opportunity for interactions to the field and worked as a collaborative visual method (Pink, 2007 p. 82). Hence, it provided access to the informants’ understanding of hospital meals. In addition, the images were used as a tool for reflection in the daily engagement, allowing a renegotiation and re-representation of the images. Video documentation was also applied as it allowed access to fairly comprehensive non-verbal bodily micro doings in a defined period of time (Raudaskoski, 2010 p. 87). Small video sequences therefore underpinned the possibility to study micro- social and material interactions around the serving event.

The observations strategy was also supported by other ways of participating in the field which depended on the purpose of the gained knowledge but also on the field’s invitation to do so. The first period of the fieldwork at the GW worked as an “experimental studio” where a performative participant observation strategy was adapted in line with a dendritic crystallization process. This allowed engagement with the wards as the ‘food researcher and images producer’ focused on the immediate, embodied and sensuous, sensing *the here and now* and reflecting on different atmospheres and events that changed everyday meal practices (Dewsbury, 2010; Hamera, 2011 p. 320).

A temporary working place at the end of the ward corridor at the GW was established and, similar to the ward secretary, it provided a possibility to become part of the daily working routine, visiting patients and helping whenever needed. This approach would not have been possible if the ward and the HCP’s would not have invited us to do so. The “experimental studio” became a place for reflections in which immediate, embodied, and sensuous experiences could be negotiated and articulated.

The observations in the institutional kitchen were characterized as *participant-as-observer* (Gold, 1958). They helped equalise power relations and created a shared professional frame for further discussion and negotiations on practices and experiences of producing and serving hospital meals. Finally, the observation days at the institutional kitchen allowed following “the actors”. This provided knowledge into how KP transformed themselves from food producers to serving professionals and it provided knowledge on materiality transformations, e.g., in terms of how buffet trollies were transformed from transport devices to serving devices.

The last part of the field work at the CW was characterized as a more focused observation approach, where focus was put on practices related to meal processes and the serving event around the buffet trolley. Like the GW, the observation was conducted at the ward but this time in close connection to the patients sitting area which allowed informal interactions and negotiations of meals and meal events with patients and visitors. Further, it was possible to become the “photographing and writing researcher”, while sitting writing, and alike the photographing act, this became a can opener to the field. Conversely, the engagement with the HCP’s became more distanced.

By being invited to taste the provided lunch or dinner if there were left-overs, it was possible to evaluate sensory properties and qualities. These experiences allowed a reference frame when engaging with patients and it allowed a discussion with the KPs on sensory qualities.

As a food scientist acting as participant-as-observer in the Nutrition Project Group, it became possible to observe how the group represented and negotiated different understanding of hospital meals. The group was represented by medical doctors, nurses, kitchen managers and a dietician.

The different types of observations were transformed into different field notes. The field notes were written as concrete, detailed and as accurate as possible. During the first period of field work and with inspiration from Richardson’s (1994) writing approach towards creative analytic writing practices (Richardson, 1994 p. 941), other field note methodologies were adapted in terms of methodological and theoretical field notes.

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They provided a place for specific reflections regarding methodological and theoretical considerations. Further, with inspiration from Grith's (2010) event recording notes (Grit, 2010 p. 145), event recording notes were used in connection to the serving event. They enabled reflections on experiences based upon the researchers own expectations. Comments made by patients, HCPs, KPs and visitors during the different observation methods are presented as statements in connection to the field notes (see Table 3).

The interview strategy was based upon Participant Driven Photo Elicitation, semi-structured interviews and a focus group interview with the KP.

Semi-structured interviews were conducted if the camera was not available, for patients who were not interested or capable of handling a camera or for those not participating in the PDPE study. The aim of the semi-structured interviews was mainly to gain knowledge on patients' experiences of how hospital meals come into being and are practiced. The interviews were inspired by Sequential Incident Techniques which focus on informants' experiences of usual but also unusual service processes (Stauss & Weinlich, 1997), thus allowing a focus on meal processes, relationships, or any event transforming or changing meal practices. Interviews were conducted in a range of participant-selected locations, often by their beds or by the table at the ward. The interviews were continued until the informants did not provide with any new knowledge. All interviews were tape-recorded.

Inspired by Pink's (2009) introduction to sensory ethnography, in which she suggest to explore the relationship with other senses (Pink, 2009 p. 14), it was decided to invite HCPs to participate in lunch interviews, especially HCPs who stood out most in relation to meals. The interviews were based upon semi-structured interviews with a focus on meals processes. However, this turned out to be fairly difficult. The physical act of eating and the connected noises disrupted the conversations and the attentions towards bodily movements and non-verbal communication and the recorded interview became noisy and difficult to hear. Secondly, the idea of bringing home-produced lunch turned out to affect the informant as a focus became placed on the "why exactly this lunch" rather than their understanding of meal processes. Interviews continued until no new knowledge was gained. All interviews were tape-recorded (see PDPE paper in Appendix 1).

Table 3. Multiple methods adapted in the Ph.D. project. The numbers in brackets represent the number of interviews conducted.

Interviews Health Care Professionals	Interviews Patients	Participant Driven Photo Elicitation	Focus group	Statements	Participant Observations	Serving Observations	Documents
Lunch interviews (10)	Semi structured interviews (10)	Patients interviews (8)	Kitchen professionals (1)	Kitchen professionals	Hospital kitchen	Buffet (18 videos)	Menu-plans
Semi-structured interviews (2)				Patients	Gynaecology ward 3 month	Event recording (6)	Information Brochures
				Visitors	Cardiology ward 3 month	Taste panel (18)	
				Health Care Professionals	Nutrition project		

The focus group interviews with KPs enabled an increase in knowledge into how the group negotiated their understandings of practices of “good hospital food production” and ‘good hospital meals’ together. The empirical data gained from the multiple research methods is presented in the Table 3.

3.4 Presenting analytical strategies

The qualitative research process and the process of analysing empirical data were in line with a dendritic crystallization process. This was not a linear process but rather a cyclic and messy process expressed in a continuous series of reflexive dialogues with the data, ideas, informants and colleagues (Coffey & Atkinson, 1996 p. 192; Ellingson, 2009 p. 40). It allowed a reflexive space where the importance of subjectivity to the production and representation of ethnographic knowledge could be recognized (Pink, 2007 p. 23). The analytical methods applied in this Ph.D. project ranged from systematically and stringent methods, such as semiotic analysis and content analysis, to more intuitive forms of thinking in intensities and working with props such as images and messy maps.

The analysis became enrolled and developed during the engagement with the field. The engagement with the camera, both within the photographing act and in the following process of uploading and reviewing the images, provided a reflexive space for analysing experiences and the negotiation of a reality connected to hospital meals. Furthermore, it created opportunities to verbalize experiences that were initially difficult to verbalize. The images of roses, presented in figure 2, came to represent hospitality. Other images also became more than a documentation of hospital foodscapes. They provided a reflexive space to focus on meal processes as well as the research process. Furthermore, they participated in the production of new knowledge as they acted as props for negotiations of good hospital meals with HCPs, KPs and patients.

The use of different field notes, e.g., in terms of theoretical and methodological notes, also became part of the analysis process, allowing the consideration of new ideas, new focus areas and the development of new questions. They became a reflexive experimentarium, facilitating a socio-material and sensuous thinking similar to dendritic crystallization. These ideas and questions were subsequently explored continuously, tested in my daily engagement with the field and integrated in the following semi-structured interviews. They developed a focus on sound and smells connected to the meals. Deleuze’s idea of *what bodies can do* further led to a focus on how humans as well as non-humans moved spatiality around (Marcus & Saka, 2006).

At the end of the first period of fieldwork at the GW and towards the beginning of the period at CW, messy mapping was adapted as a method for gathering and sorting data gained from interviews, field notes, diaries, and images (Clarke, 2005 p. 83). Messy mapping is a tool for decomposing hierarchical reflections while also allowing both human and non-human actors to be valued. The messy maps became blackboards, allowing me to add new elements and to restructure others during the analysis process. These messy maps were further continuously transformed into relational maps which provided an opportunity to reflect, create knowledge of explicit relations, and develop new ideas and new questions as well as to discover hidden connections (Clarke, 2005 p. 102). It was found that many relations were connected to the serving event around the buffet trolley and to “as home or other places”. While messy mapping became blackboards for reflections during and after the fieldwork, images became props during the following analysis process as patient-produced images and images of serving trays were printed and placed on wall papers at the office. The idea of printing images evoked memories and imaginations from the period of fieldwork and enabled the sensuous and emotional reality to be reencountered (Pink, 2009 p. 121). See picture board in Figure 2.

The software program NVivo 09/10 supported the research process by serving as a management tool, enabling documents, records and images used in the analysis process to be sorted, organised and structured. Furthermore, Nvivo 9/10 was used as a platform for transcribing interviews and for describing serving

practices from the video sequences. Nvivo 9/10 was also used to code, categorize and cluster the transcribed interviews from the PDPE study and patient-produced images were also categorized and clustered with patients' engagement with the camera and the images.

In the process of exploring whether PDPE is capable of giving new insights into patients' hospital meal experiences, different analytical methods were applied. The idea of using different analytical methods was motivated by both Ellingson's (2009) idea of crystallization and the tendency for most of the existing PDPE literature to use the produced photos as tools in the interviews producing a text, which is based upon patients' re-negotiation of the photos. This approach neglects patients' first-hand expression and the epistemological position that patients' engagement with the camera and photos themselves could represent other knowledge related to patients' hospital meal experiences (see the PDPE paper in Appendix 1).

The second part of this Ph.D. project explores how hospitality in a hospital meal environment is established and constituted in social and material practices, based upon Derrida's (2000) hospitality approach and by considering hospitality to be socio-materially constructed. This analytical strategy is, in contrast to the analytical strategies adapted in the PDPE study, less reductive and enables a better representation of the complexity of hospital meals. However, the analytical strategy and the analytical process are also more iterative and complex without any well-defined analytical method to follow. As such, other analytical tools, e.g., from practice theory, were included to facilitate the identification of socio-material assemblages. The analysis strategy was based upon empirical data gained from the different data collecting methods as presented in table 3 (see the Assemblage paper in Appendix 2).

The third part of this Ph.D. project explores how hospitality becomes enacted within hospital meals and discusses how a NRT approach might bring new opportunities into the hospital foodservice and to hospital meal experiences. As in the assemblage study, this study also takes a point of departure in a flat, ontological position by considering hospitality to be socio-materially constructed and with inspiration from Derrida to explore hospitality as dynamic, relational and temporal. However, an NRT approach is also based upon an ontological position that considers social actions as pre-cognitive and thereby as more than intentional actions, which is traditionally interpreted in terms of given intentional meanings. This position is different from the two previous studies and demands an epistemological position in which knowledge on hospital meals and hospitality can be gained from non-articulated practices and by focusing on unexpected events, affects and atmospheres. The analytical strategy is therefore based upon an analytical frame of hospitalityscape which takes an epistemological position in which the focus, in contrast to the assemblage study, is not placed on everyday practices but on 'breaks' in terms of socio-materially enacted unexpected events and atmospheres that occur within these everyday practices (see the NRT paper in Appendix 3).

3.5 Presenting ethical considerations

The importance of reflecting and describing the ethical considerations penetrates the whole Ph.D. project. From a macro-ethical perspective, the consideration is bound in health-political perspectives as the project advocates for giving voice to a broader understanding of hospital meals as far more than a service or part of nutritional care strategies. Foodservice organisations and unions like the Danish Diet & Nutrition Association might also use this Ph.D. project politically in order to accumulate more resources into hospital foodservice organisations, or to increase recognition of institutional meals in general.

From a micro-ethical perspective, the process of crystallization itself can be considered ethical as the reader, by being introduced to different genres automatically, will be forced to reflect on different epistemological positions and to ask what counts as knowledge. This also contributes to strengthen the transparency of the created knowledge (Ellingson, 2009 p. 37). Ethical research aspects were considered right from the beginning of the Ph.D. project. Here, focus was put on codes of conduct and project plans in order to claim

high scientific standards. The National Committee on Health Research was contacted and with a reference to the Danish legislation on ethics in health research Act 593 (2011) it was informed that notification was not required as the study was only based on interviews and observations. As no sensitive personal data were collected, reports to The Data Protection Agency were not required. As a result, reference to the Helsinki declaration and the Danish Code of Conduct of research within Social Sciences (Statens Samfundsvidenskabelige Forskningsråd, 2002) was made as well as Aalborg University Guidelines on the treatment and storage of confidential data material.

All informants were informed of the study's purpose, their rights to full confidence and their right to withdraw from the study at any time. Several notices were placed at the entrance doors and on notice boards at the wards. These notices contained information about the purpose of the project and the researcher. Further, it was possible to distribute hand-outs with written information on the project. Informants who participated in interviews and in the Participant Driven Photo Elicitation study were further informed orally before signing consent. The informants were informed about the voluntary aspects; the confidentiality aspects in terms of the opportunity to see the contexts, that interview tapes would not be published, that informants' names would be anonymous and replaced by other names, and that they may at any time revoke their consent and withdraw from the study. The fact that access to medical journals was renounced did also enhance confidentiality and the engagement with the research created a space where the patient could become detached from their daily medical treatment. Finally, dealing with vulnerable patients' daily contact with HCPs helped avoid patients too ill to participate in the project. In addition, Ellingson's (2009) and Pink's (2007) introduction to 'situational ethic', in which they emphasise that ethical consideration is not only a matter of following codes of conduct but that it is also important to reflect on power relations between the researcher and the informant and to reflect on how the researcher represents the field, was considered (Ellingson, 2009 p.45; Pink, 2007p. 54). In the PDPE study, the informants empowered themselves as they decided which images were to be framed and in the following open-ended interview they decided what to be said, or not said. In the semi-structured and the focus-group interviews, it was similarly sought to empower the informants by informing them about the purpose of the interview and on each topic that would be highlighted in the conversation.

Reading Derrida's (2000) hospitality approach alongside the fieldwork helped in the consideration of how to meet informants as 'the stranger'. This was achieved by letting patients as well as HCPs become temporary hosts for their knowledge and understandings of hospital meals. The host-guest relationship between the wards and the research was also considered. Most of the HCPs at the GW were far more interactive and interested in using the co-created knowledge in order to focus on and improve hospital meals whereas HCPs at the CW considered the observation a method for 'data collecting', detached from life at the ward. This opened up different possibilities for reflections on different research roles and positions.

One of the most difficult ethical considerations in the research process was the process of representing the informants during the analysis and the process of disseminating the findings. To quote Haraway (1988), knowing that "no innocent position exist", every claim that is made and quotations that are used is reflected upon with profound awareness (Rustad, 1998).

4 FINDINGS

This paragraph presents findings from each analytical framework crystallized into three single-genre papers articulated as: The PDPE paper, The Assemblage paper, and The NRT paper. The full text papers are placed in appendix 1, 2, and 3. The synergistic impact of these studies is based upon Ellingson’s (2009) dendritic crystallization process in terms of meta-analytical discussions between findings from this project in a search for adding new perspectives on hospital meals and hospital meal experiences.

4.1 Presenting findings

Findings from all three papers connected to this Ph.D. projects research questions are presented in Table 4.

Table 4: Findings related to this Ph.D. projects research questions

Research questions	Findings
How can visual methods as a research method that seeks to transcend a verbal approach to experiences, be applied in a hospital meal context and contribute towards a richer insight into patients’ hospital meal experiences?	<p>Understanding hospital meal experiences by means of Participant Driven Photo Elicitation</p> <p>Visual methods in terms of Participant Driven Photo Elicitation can provide insight into contextual, abstract understandings and emotional reactions towards meal experiences expressed as: an imaginary ability or ‘nostalgia’ to travel in time and place; the experience of food quality through artefacts; a proxy for an invisible host; and a meal as socially experienced, not just in relation to the eating event, but throughout the day. However, there is a need to develop PDPE as a more rigorous research method.</p>
How is hospitality constituted within social and material transformative meal processes? How might a hospitality approach add value to hospital meal experiences?	<p>Hospitality within hospital meals – Socio-material assemblages</p> <p>Hospital meals can be conceptualised as ‘pop-up restaurants’ in which the hospital room physical as well as sensory characteristics become transformed into meal rooms and in which patients are transformed into guests. These processes are negotiated co-creatively, e.g., as <i>bricolage</i>, where artefacts gain new meanings and through shifting host-guest roles which contributes to meal communities that go beyond the social act of eating. A hospitality approach is overall challenged by efficiency, hygienic and nutritional rationales and culturally learned meal practices but arises from health care and kitchen professionals’ own initiatives. There is a need for a systematic service design based on co-creation and on the physical environment.</p>
How is hospitality constituted in social and material events and explored through unexpected events and daily hospital life? How might this approach add value to hospital meal experiences?	<p>Moment of Hospitality – Rethinking Hospital meals through a Non Representational Approach</p> <p>Meal experiences became negotiated and co-created through different atmospheres and ‘disruptive micro-events’ articulated as carnivalesque moments in terms of a humorous caricature of the hospital stay but also through aesthetic form symbols, rituals and unforeseen events. By recognizing the potential of these disruptive micro-events and through an ability to balance between structured clinical everyday practices, these unforeseen disruptive micro-events opportunities for good hospital meal experiences can be established.</p>

4.2 Presenting Hospitable Meal Frame

The dendritic crystallization process and the synergistic impacts of this Ph.D.'s findings are based upon the notion of affordance, which is inspired from the psychologist Gibson's (1977) notion of affordance (Gibson, 1977). This allows consideration of the question *What can hospital meals?* This question creates a manifold of answers and opens up discussions on potential opportunities to create passion for food and add value to hospital meal experiences.

In the process of thinking about “**What can hospital meals**” three main affordances appear, manifested as *unconditional hospitality*, *co-creation* and *disruptive micro events*. However, these affordances are held in a field of tensions between hospitality as *conditional* and through a conceptualisation of hospital meals as *provision* and *routines*. Together, these fields of tension become core elements of a conceptual framework on hospital meals named as *The Hospitable Meal Frame*, presented in Figure 3. The term *hospitable* represents a conceptualisation of hospital meals which is based upon a genuine desire for hospitality to co-create hospitality within a hospital meal frame (Telfer, 2000). The idea behind The Hospitable Meal Frame is two-fold.

Firstly, the framework represents a conceptualisation of hospital meals which has to be considered within a field of tensions between a conditional and unconditional hospitality approach, within the field of tensions of either providing or co-creating meal experiences, and within the field of tension between a routine day and disruptive micro-events.

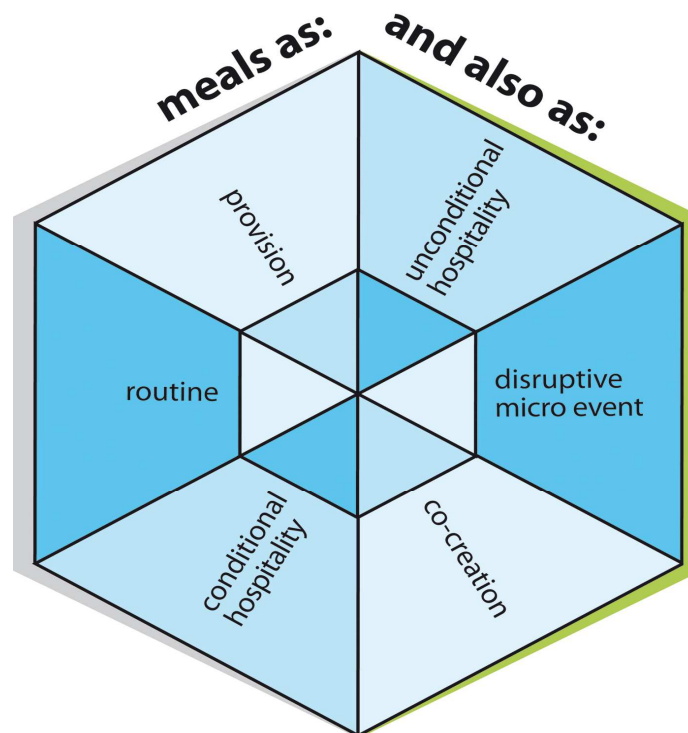


Figure 3. **Hospitable Meal Frame**. The frame represents hospital meal affordances spanned in a field of tensions. Affordances with the same colour represent connected field of tensions. Hospital meal affordance of *routine* is spanned in the field of tension with *disruptive micro-event*, the affordance of *provision* is connected to the affordance of *co-creation* and the affordance of *unconditional* is connected to *conditional* hospitality. The affordances of conditional hospitality, provision and routine are placed to the left representing the existent scientific literature's conceptualisation of hospital meals whereas the affordances of hospital meals as unconditional hospitality, co-creation and disruptive micro-event are placed to the right representing new concepts gained from this Ph.D. project. The open and unfinished nature of the conceptualisation of hospital meals is represented by the text *meals as* and *also as* which also is an attempt to acknowledge the unfinished and partial knowledge that this thesis presents.

All these affordances are intertwined and reflected into each other. This is visualized in the framework presented in figure 3 as each related field of tension is provided the same colour and are placed opposite to each other in order to visualize the tensions. Furthermore, The Hospitable Meal Frame is provided with the text *meals as* and *and also as* which represent an attempt to convey the open-ended approach towards hospital meals and to acknowledge the unfinished and partial knowledge that this thesis represents.

The field of tension between meals as conditional hospitality and meals as unconditional hospitality is framed by Kant's conditional and asymmetrical hospitality approach (Lynch et al., 2011). It is constructed by Derrida's (2000) unconditional hospitality approach as "mutual recognition of each other's alterity". The open and dynamic nature of hospitality was found in the significance of memories beyond food per se, articulated as nostalgia in the PDPE paper, which also underpins a need to transcend a container approach to meal experiences, as presented in the FAMM model (Gustafsson, 2004). The PDPE paper did further reveal hospitality to be connected to materiality as food or meal components became a proxy for a host. This underpins the claims of Cardello et al. (1996) and Johns et al. (2010) to transcend a conceptualisation of hospital meals as more than represented by intrinsic qualities such as food quality and it underlines the need for taking the aspect of materiality seriously (Cardello et al., 1996; Johns et al., 2010).

Unconditional hospitality allows the further transcendence of the traditional conceptualisation of hospitality as more than culturally-learned pre-understandings bound in asymmetrical host-guest relations. This became manifested in the Assemblage paper in which KPs and HCPs enacted shifting host-guest roles and in which patients became temporary hosts by creating their own café environment. It was also manifested in the NRT paper, where a napkin was assigned temporary host and where a whole ward enacted as host for a grieving community. An unconditional hospitality allows more than the static host-guest conceptualisation as opposed to the Meeting aspect of the FAMM model.

Derrida (2000) also claims unconditional hospitality to be impossible and contradictory (Derrida, 2000). Due to the manifold of hospital procedures and structured regulations as well as efficiency rationales, unconditional hospitality seems to be impossible in practice. However, Derrida's unconditional hospitality thinking is useful as it provides an opportunity to continually rethink the ethical question **How can we consider mutual recognition of each other's alterity?** before developing policies, strategies and regulations, before designing hospital dining facilities and not at least during the every-day negotiations of hospital meals. This thinking questions culturally-learned understanding or assumptions of how to create good hospital meals, instead focusing on "each other's alterity". Including the field of tensions of unconditional and conditional hospitality in the Hospitable Meal Frame qualifies the model as it allows the consideration of hospital meals as more than just nutrition whilst also being concerned with food and centred on eating episodes (Nyberg, 2009 p. 46).

The second field of tensions is represented by the affordance of hospital meals as a disruptive micro-event which is placed in a field of tension of hospital meals as routine.

The affordance of hospital meals as a disruptive micro-event can be conceptualised as a more fluid space, consisting of the unconsciousness, unexpected events and sensations. It is a space which deliberately seeks differences and contradictions and in which new opportunities and new knowledge can be created. Here, hospital meal experiences both enact culturally-learned understandings of meal patterns and formats, but also transcends those by creating new opportunities for new meal experiences and sociability. The co-created transformation of a dish of Goulash to a dish of stew presented in the Assemblage paper, the joyful atmosphere which was created by the dancing HCP and the carnivalesque breakfast-event in which cornflakes was transformed into a face, as presented in The NRT paper, represent disruptive micro events. These unexpected events created new opportunities for co-creating hospitality and a passion for food and

brought in a certain degree of unpredictability which contrasted hospital organisations' use of quality management systems and temporarily downplayed a focus on hospitalization and nutrition, expressed as the affordance of meals as routine. On the contrary, the affordance of hospital meals as routine represents a structured space, occupied with safety- and nutritional practices, and structured meal patterns and meal formats. Here, structure is characterized as intentional and controlled actions based upon already established knowledge, pre-understandings as well as practice norms, laws and regulations. The affordances of meals as *nutritional treatments* represent such structured space. This is reflected in nutritional recovery strategies and in the Danish Quality Model's screenings and monitoring procedures. This is also reflected in the Danish Recommendations for Institutional Meals (Fødevarestyrelsen, 2009; Sundhedsstyrelsen, 2008). The affordances of hospital meals as nutritional treatment sees hospital meals as cultural and social, bound in identity, symbols and meanings. This was found in the PDPE paper where the *Performance approach* was related to strategies for performing identity and was found in the Assemblage paper in which efficiency, hygienic and nutritional rationales challenged a hospitality approach. Furthermore, it was manifested in the NRT paper in which a yellow napkin became a representation for aesthetic and ritual hospitality practices. The importance of meals as routines, as structuring a recognizable everyday life at the hospital, has been reported previously (Johns et al., 2010; Larsen & Uhrenfeldt, 2012) and the affordance can be compared to the FAMM models Management Control System (Jönsson & Knutsson, 2009).

The field of tensions between a disruptive micro event and routine is part of The Hospitable Meal Frame as it enables the ability to enact structured meal patterns and formats to be considered but also the ability to transcend these patterns and formats. The Hospitable Meal Frame enables the potential of disruptive micro-event and their capacity to transform ordinary ward routines to be recognized and it brings in a certain degree of unpredictability into the hospital foodscape.

The last field of tensions is represented by the affordances of meals as co-creation and meals as provision. Co-creation is centred on the idea that patients are considered as active persons, similar to the idea behind co-creation in service encounters (Grönroos & Voima, 2013) and is in contrast to the affordances of meals as provision. Meals as provision is based upon the idea that persons needs to be motivated or to be acted upon in accordance to a predetermined food culture, staff appearance or by staged surroundings and atmospheres. This is represented in the existing literature's ontology based on linear causality, which is materialised in the FAMM model's static conceptualisation of meal experiences and static asymmetrical guest-host relations. Co-creation is found in the transformation processes of pop up restaurants, as presented in the Assemblage paper, where hospital rooms are transformed into meal rooms and in which patients assign new meanings to artefacts through bricolage, underlining how materiality takes part in the construction of meal experiences. Furthermore, it was materialised in nostalgia and carnivalesque events, as presented in the NRT paper. Co-creation became enacted in the patient's way of expressing identity through meals and in shifting host-guest roles despite being contested by efficiency, safety and nutritional rationales. Co-creation was also enacted in the affordance of meals as sociable. Sociability around hospital meals has been highlighted in previous literature (Council of Europe, 2003; Fødevarestyrelsen, 2009; Hartwell et al., 2013; Larsen & Uhrenfeldt, 2012; Lassen et al., 2005). However, the understanding of sociability has mainly been associated with a cultural pre-understanding of sociability as performed within the physical act of eating whereas this study finds sociability to be co-created in different times and places, e.g., around the serving event as presented in all three papers.

Co-creation therefore allows the conceptualisation of hospital meal experiences to be explored further as bound in a certain time and certain place and as more than a sensory now and here experience found in the existing hospital meal literature, such as in satisfaction studies and in the FAMM models aspects of the Product, the Room and the Meeting (Edwards & Gustafsson, 2008; Öström, Rapp, & Prim, 2008).

The aspect of co-creation is therefore an important part of The Hospitable Meal Frame. However, the affordance of co-creation is placed in the field of tension between meals as provision. Meal as provision allows the degree in which patients are able to participate and co-create hospital meals to be considered due to their mental or physical conditions. The story of “the white days”, as presented in the first chapter, represents a patients shifting ability to co-create hospital meals. The lack of ability to co-create hospital meals might be comparable with the findings of Sorensen (2010) and Holst et al. (2010) on the motivation undernourished patients to eat (Holst et al., 2010; Sorensen, 2010 p. 33). However, due to the hospitality approach of this thesis, “the white days” would instead be considered as a negotiated state that might be in a state of becoming something else, and the focus would be placed on potentialities and a possible degree of co-creation in the situation.

This Ph.D. project clearly highlights the importance of hospitality and co-creation as one of the core findings. The project points to the reconsideration of hospital meals by including hospitable and co-creational aspects and suggests that the ability to co-create could become a joint platform for considering and practising good hospital meals, this including a focus on passion for food and undernutrition. Furthermore, the idea of co-creation offers and opens up new perspectives on traditional institutional foodservice provisions and on patients’ empowerment. Hospital meal values are not only created by the foodservice- and hospital organisations, the physical surroundings or the professionals, and patients are not passive recipients of hospital foodservices. In contrast, patients themselves bring value into the hospital meal experiences. Therefore, this thesis suggests a shift in focus from foodservice provision towards empowerment, articulated through co-creation, which is enacted in-between professionals, organisations and patients but also with artefacts and atmospheres. Furthermore, the notion of hospitality provides a frame for articulating and discussing hospital meals as more than just food.

The left side of Hospitable Meal Frame represents existing knowledge based upon the static conceptualisation of hospital meals, whereas the core findings of this project such as unconditional hospitality, co-creation and disruptive micro-events are placed on the left side of the frame (see Figure 3).

5 DISCUSSION AND CONCLUSION

The findings gained from different epistemological and ontological perspectives and the connected methodological choices helped shed new light on hospital meals.

5.1 Discussing findings

This Ph.D. thesis seems leaves hospital meals to be perceived as contested and *despite*. Despite efficiency or hygiene rationales that permeate the meal processes, despite the medical surroundings and lack of sensory design, or despite asymmetrical culturally-learned host-guest relations, patients, HCPs and KPs co-created hospital meals.

This leaves one to question whether this Ph.D. thesis can be used to make any recommendations or claims about how to bring value into future hospital meals, considering the coming new Super Hospitals in Denmark. The idealistic answer to that question should in principle be *No*. However, the realistic answer would be *Yes* as hospital meals in the coming years still would be challenged by a medical scape, even though a patient-oriented hospital design is generally sought. It is also a *Yes* considering that the findings of this thesis are materialised in a hospitality thinking and co-creation. This includes the co-creation of disruptive micro-events which enables the professionals as well as the connected organisations to focus on opportunities for hospital meals that are filled with hope, laughter and to make meals alive, despite contested

surroundings and despite a discussion on the lack of economic resources towards hospital foodservice provision in general. In contrast to the FAMM model, the proposed conceptual framework of the Hospitable Meal Frame offers a more open frame which allows hospital meals to be considered from a dynamic and relational perspective, transcending static linear causality thinking and a static time and place conceptualisation. While the FAMM model is built upon a static ontology, the Hospitable Meal Frame considered a dynamic and more unpredictable interaction built upon hospitality and co-creation, this includes co-creation of disruptive micro events.

The use of Derrida's (2000) hospitality approach provided this Ph.D. thesis with a conceptual and analytical framework that allowed hospitality to be considered as an engagement through the "mutual recognition of each other's alterity". By focusing on the temporal, relational and dynamic aspects of hospitality, it enabled the transcendence of a traditional conceptualisation of culturally-learned pre-understandings of meals and social relations, including asymmetrical host-guest relations. However, as Derrida (2000) also claims, unconditional hospitality is impossible and contradictory as there had to be a sovereign host (Derrida, 2000). Therefore, the field of tension between unconditional and conditional hospitality has to be taken into account in hospital organisations, including service organisations and the professionals involved in hospital meals.

Hospital organisations, including foodservice organisations, are bound to meal and nutritional policies, strategies, regulations and rules manifested in menu choice, certain meal times etc. However, an unconditional hospitality and co-creational thinking could be applied when developing meal- and nutritional policies and strategies as it provides a possibility to rethink, question and reconsider the organisation's culturally-learned understandings or assumptions about how to create good hospital meals. It also presents the opportunity to consider new ideas and potentials. This includes strategies that enable the organisations to enhance their visibility as hosts during the transformation processes of pop up restaurants. In addition, it allows the organisations to reconsider a service design that focuses on co-creational aspects of the transformation process in terms of sensory hospital meal design, co-creational aspects of transforming patients to guests, and the co-creational aspects of involving the physical surroundings, artefacts and atmospheres manifested in performative social and domestic meal practices. Inspirations could be gained from the study by Tvedebrink et al. (2013) on hospital meal design which underlines the importance of a holistic design approach that transcends a focus on functional properties, instead focusing on aesthetic meal experience such as the social aspects of hospital meals (Tvedebrink, Fisker, & Kirkegaard, 2013). Furthermore, the policies and strategies need to be open-ended, calling for a high degree of flexibility within the organisations. In addition, this thesis advocates for establishing *meal host* functions at the wards, comprised of a person who possesses hospitality meal competencies.

The hospital and foodservice organisation might also benefit by adapting visual methods in future clinical practices. This provides an opportunity to gain insight into patients' multisensory responses towards meal experiences and motivations for eating or for not eating. Thereby, visual methods can contribute to the continuous process of developing hospital meal strategies and concepts. Furthermore, they become a reminder to consider far more than simply cognitive and rational practices. PDPE as a method may need to be strengthened and may seem too extensive in a busy hospital life, but other visual methods, such as Research-Driven Photo Elicitation whereby produced images are used as props, can be useful in the continuous process of developing hospital meals and as and methods for quality assurance.

The professionals could engage with hospitality meal competencies. Hospitality meal competencies comprise an ability to co-create unconditional hospitality and thereby to reflect and operate within the conceptual Hospitable Meal Model (HMF). This comprises an ability to operate in structured and nutritional meal routines but also to transcend and develop new meal structures that are more or less stable. These open-ended competencies demand an extensive knowledge on meals as cultural and socio-materially constructed,

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expressed through aesthetic form symbols and rituals. Furthermore, it demands openness towards patients' temporal strategies for eating or not. This includes an ability to consider the transformation processes of pop up restaurants as socio-materially co-created and through an ability to transcend one's own culturally-learned and non-articulated meal practices. Instead, hospitality meal competencies encompass the ability to co-create meals through disruptive micro-events in terms of bricolage, nostalgia, carnivalesque, and conviviality moments and thereby to promote sociability among patients, professionals or visitors. Hospitality meal competencies comprise both meal-as-objects and competencies related to meal-as-events. The ability to use visual methods and to reflect on the capability of visual methods to provide insight into patients and one's own multisensory response to hospital meals might also be part of hospitality meal competencies.

Educational institutions that educate professionals involved in hospital meals need a greater focus on hospitality meal competencies. This might enable a shift towards the co-creational aspect of meals transcending a focus on food, food quality and food as nutrition. This includes knowledge, skills and competencies related to culturally-learned hospitality with a focus on rituals and aesthetic form symbols in doings and sayings during the process of establishing the pop-up restaurants. This also includes a focus on unconditional hospitality, seeing meals as temporal, dynamic, socio-material and co-created in terms of meals as event. Within the area of meals as events, the focus should be placed on how to co-create meal experiences and how to manage and act within an open-ended planning process, presented as hospitality meal competencies. Furthermore, there is a need to articulate and discuss different epistemological and ontological approaches towards hospital meals and meal experiences. This includes the use of visual methods.

The introduction of Ellingson's (2009) crystallization approach in connection to the ethnographic research approach proved to be useful. It allowed the development of new knowledge into how meals were co-created throughout the day and it provided a focus on the socio-material constructions of meals. In addition, it provided an opportunity to present hospital meals from different epistemological perspectives. These perspectives provided a way of presenting the complexity of hospital meals, including the possibility to transcend linear causality thinking. However, the chosen multiplicity of this thesis also made it less focused to a certain extent and prevented a deepened focus, e.g., in developing, implementing and examining PDPE as a useful tool in the daily clinical quality work.

The focus on meal experiences, meal processes and events might have neglected critical perspectives on power-relations and created a lack of organisational focus. However, this project did not aim to identify structural or professional challenges and barriers such as a lack of motivation, time, resources and communication (Engelund, Lassen, & Mikkelsen, 2007; Holst, Rasmussen, & Unosson, 2009; Larsen & Uhrenfeldt, 2012). Instead, this thesis raises the question of how to bring value into hospital meal experiences, which is framed by a focus on opportunities, co-creation, and the making of *meals alive* rather than a focus on barriers.

Whether a food scientist would be the best person to conduct an ethnographic study in a hospital meal context may be questioned. However, a food-scientist background appeared to strengthen this work as it provided a recognizable identity and helped open up the field, from the perspective of both the medical management and from the HCPs and patients as it allowed a distance to the persons involved as the focus were placed on food and not on individuals. This was further supported by the choice that was made in terms of not being involved in patients' medical treatment and medical journals. These choices did, however, foreclose a possibility to focus on the medical history of specific patient groups and individuals.

The PDPE study offered an analytical frame which in principle was built upon exploring the connections between defined categories of images and words. However, this did simultaneously reduce the experienced

reality of hospital meals by creating static strategies for making sense of hospital meals. This may have made it easier to convey, but also reduced the ability to explore hospital meals as dynamic, negotiated and constructed. It could also be questioned as to whether PDPE as a method requires reflexivity and cognitive rationalization of meal practices, an aspect that patients do not think much about.

The choice of analytical frames founded on an assemblage approach and NRT thinking helped further expand Derrida's (2000) hospitality approach by allowing agency towards the materiality aspect of hospitality interactions. It provided an opportunity to frame and describe a complex and more accurate hospital meal reality, but also made it more difficult to navigate and convey these complex presentations as the question *What are good hospital meals?* cannot be answered. So while the strength in the assemblage approach and the NRT thinking is manifested in an ability to present a complex reality, it also became the weakness, especially in the assemblage approach, as it lacks a rigorous way of framing the reality. Further, the NRT has been criticized for representing a certain romanticism and partly naïve celebration of singular events as well as for over-emphasising individual and material agency and for focusing on good emotions and possibilities rather than being critical of organisational and structural challenges.

The findings of this thesis on co-creation in combination with a hospitality thinking as a way to create value to hospital meals offers new perspectives on how to empower patients. This includes a reconsideration of value creation as inherently constructed by all involved parties and actors including materiality and it offer a platform for supporting nutritional care strategies. Therefore, despite difficulties targeting seriously ill and undernourished patients, it can be argued that insights from this thesis might be useful when developing welcoming and hospitable environments that cater also for the needs of undernourished patients.

However, the findings gained from this thesis, including those related to the Hospitable Meal Frame, require further examination. This includes research on hospitality meal competencies targeting undernourished patients. This comprises competencies that focus on hospital meals as socially and culturally constructed, creating a space for social exchange, transformed into abilities to co-create disruptive micro-events. For example, an ability to co-create nostalgia, conviviality and carnivalesque moments or the ability to co-create new meal events outside structured meals. Future research on these competencies needs to focus on both sayings and bodily doings but also on choices. This is not only articulated as different menu choices but also as negotiated choice in terms of different plate expressions, different serving-tray expressions or how this might increase food consumption among undernourished patients.

A study of how the Hospitable Meal Frame transformed into *Hospitality Meal Reflection Maps* might be a first step. Hospitality Meal Reflection Maps should act as props and help professionals to enact new hospitality meal possibilities. These maps could contain ideas on how to co-create hospital meals inspired from events such as: 1) individual situations such as the celebration of good medical results or the celebration of coming guests, 2) cultural or national occasions such as a national football match or a forthcoming election, and 3) seasonal occasions such as the first spring or a rainy day etc.

Furthermore, this thesis advocates for research into how food and nutrition policies, including communication strategies, could empower foodservice and hospital organisations to become more visible and welcoming hosts, while simultaneously also creating the possibility for co-creation. This also includes research on how sensory design might promote and enhance a hospitality approach.

The findings gained from the PDPE project further revealed the need for pursuing the idea of visual knowledge contra verbal knowledge. This advocates for further studies to look at how visual methods can shed light on hospital meal experiences and it advocates for studying how PDPE as a research method can be strengthened with a focus on undernourished patients. Perhaps a Research Driven Photo-Elicitation would accommodate this quest? However, further research is needed.

Another, and not yet well explored issue, is the pre-understanding of hospital meals as related to everyday meals at home. Jane's different meal experiences presented in the first chapter reveals the need for studying this relation further as it can be questioned whether relations to home are related to everyday meals or related to "caring meals at home when ill".

Finally, this thesis suggests a need for a further examination of hospitality and the diverse way of socialising around meals and meal processes, which both transcend the conceptualisation of the proper meal but also reproduce it. A study on different social meeting places and its impact on sociability is therefore suggested.

5.2 Reflections on quality

The discussion on the scientific quality of this project takes a point of departure in Denzin & Lincoln's (2011) eight historical moments of qualitative research, where *post-experimental moments* as the sixth moment represent a paradigm where the quality criteria is expressed in terms of accountability and in which Ellingson's crystallization approach can be placed (Denzin & Lincoln, 2011 p. 3). This is further underpinned in Creswell's (2013) discussion on quality in qualitative research, where a crystallization approach is explicitly presented as "different perspective on qualitative validation" (Creswell, 2013 p. 245). Creswell (2013) takes a point of departure in Richardson's (1994) introduction to crystallization which is further developed by Ellingson (2009). Richardson (1994) introduced the concept of a crystal which seeks to transcend a conceptualisation of quality criteria in qualitative research based upon validation of findings through methodological rigor and mixed-methods (Ellingson, 2011 p. 605; Richardson, 1994 p. 934). Ellingson's (2009) crystallization approach is developed from Richardson's (1994) crystal and Ellingson (2011) presents Richardson's crystallization as a post-triangulation approach which is more than a presentation of a detailed methodology. Instead, crystallization is a "rich, open partial account of a phenomenon that problematizes its own construction, highlights researchers' vulnerabilities and positionality" (Ellingson, 2009 p. 5). Ellingson (2011) claims that post-triangulation entails different epistemological positions and representations and through their interwoven, blended, and thickened and complex interpretations, they contribute to strengthening the gained knowledge. Furthermore it enabled to represent the complexity of the phenomena studied without making claims about an objective truth. Therefore, the dendritic crystallization process, which is adapted in this thesis, strengthens the quality of the research while also presenting the researcher's vulnerability and positionality. Denzin and Lincoln (2011) highlight the notion of accountability in which the researcher has to take responsibility and be accountable. This includes a visibility of the researcher's position, attitudes, preconceptions and of how knowledge is created in this context (Haraway, 1988; Rustad, 1998 p. 123). This also entails an ethical aspect. Ellingson (2009) claim that the process of crystallization itself can be considered as ethical by being introduced to different epistemological genre automatically, the reader will be forced to reflect on different epistemological positions and to ask what counts as knowledge. Furthermore, this strengthens the transparency of the created knowledge (Ellingson, 2009 p. 15). Accountability in this project has been sought by explicitly presenting the researcher's background and aim for the project, the professional position, academic development, attitudes and pre-conceptions (see preface). Further, openness towards the research process has been sought in order to demonstrate the integrity of the researcher and subjectivity transformed into an opportunity for dialog and reflections (see chapter 3). Further, accountability has been sought through a description of the context of the field of study, including a consideration of how to represent the data (see chapter 3).

Being based upon Ellingson's (2009) crystallization approach and the analytical frames of this thesis, which question the tendency to claim a terminology of universal generalization, the transferability of this thesis can be discussed. Transferability allows a discussion into how the project findings can be applied to other settings. However, the discussion on the transferability of this thesis still should be articulated carefully. As

such, whether findings from this project can be transferred to other hospitals, to other group of patients, or to other institutional meal settings such as elderly care centres or work places, can be discussed.

However, the findings from this project, which include a suggested conceptual meal frame, could be transferred to many other situations, most likely to other hospitals. This argument is reliant on the fact that a majority of Danish hospitals are built upon a foodservice system based on a buffet-trolley serving systems (Engelund et al., 2007). Furthermore, it relies on the assumption that medical treatment is foregrounded and that hospital meals have to fit into daily medical routines and practices. This makes the project findings in terms of working with the disruptive micro-events and to consider hospitality within the nutritional and efficiency rationale relevant. As a point of departure, the same argument could be made in relation to other hospital departments. By taking a point of departure in Kofod's (2012) paper on meals and building of communities in care homes (Kofod, 2012) and considering Nyberg's (2009) suggestion of opening up the conceptualisation of meals in work places (Nyberg, 2009 p. 45), the findings from this project and explicitly the thinking behind the suggested conceptual meal frame could be relevant to other institutions. However, the conceptual frame needs now to be applied and tested in other public and commercial meal settings.

5.3 Presenting scientific contribution

The scientific contribution of this Ph.D. is reflected in the introduction to new methods and to new analytical frameworks manifested in the findings from three different papers and in the development of the conceptual frame of Hospitable Meal Frame (HMF).

The scientific contribution from a methodological perspective is represented by Ellingson's (2009) crystallization approach and the connected ethnographic research which can be considered as a new research design related to hospital meals. Further, the introduction of visual methods, both as part of an observation strategy but also in terms of Participant Driven Photo Elicitation (PDPE), can be considered as a new research methodology introduced to the field of hospital meal studies. The ethnographic research design enabled the presentation of a hospital meal context which is intertwined into hospital everyday life. Further, by adapting visual methods, it enabled a new way of engaging within the context of hospital meals as the methods worked as a can opener to the field, justifying the research, but also enabled a focus on materiality and bodily doings.

The introduction of Participant Driven Photo Elicitation (PDPE) as a mean to explore patients' hospital meal experiences can also be considered as a new scientific contribution. The scientific contribution by applying PDPE is especially attributable as the method enables emotions and memories to be triggered. Furthermore it creates the possibility to convey abstract matters that transcend the use of verbal or written methods adapted in the existing scientific literature. It can be concluded that PDPE is a research method capable of providing insight into patient meal experiences by transcending the limitations of verbal discourses and by allowing contextual, situated and emotional responses to meal experiences. However, further attempts to strengthen PDPE as method is needed.

This Ph.D. introduces and applies two analytical methods in which the semiotic analysis is well established but the idea of using the produced images as more than just an interview tool as well as using a reflexive content analysis in combination with the semiotic analysis is new. The discussion on visual knowledge of hospital meal experiences contra verbal knowledge is an outcome of that. It can be concluded that the semiotic analysis and the reflective content analysis connected to PDPE supplemented each other. However, the reflective content analysis first became meaningful when coupled with the verbal interviews.

Findings from the PDPE study provided new insight into how patients consider hospital meals as constructed all day long while nostalgia provided an insight into how patients transcend specific time and place

experiences. Further, PDPE provided new insight into how meals can act as a proxy for a missing host, revealing the significance of a hospitality approach and how artefacts influence meal experiences. Finally, this study questioned existing visual knowledge in contrast to verbal knowledge.

The introduction of PDPE in the field of hospital meal studies represents one of three other epistemological frames adapted in this Ph.D. The other epistemological frames can also be considered as a new way of studying hospital meals as they take a point of departure in a hospitality approach, an assemblage approach and a NRT thinking.

The introduction of the notion of hospitality is not a new idea due to its etymological connection to the word hospital and due to recent use of the notion within institutional meal services. However, knowledge gained from contemporary hospitality scholars has provided an academic legitimacy and perspective into the study of hospitality in relation to hospital meals. By combining a Derridian hospitality approach with an assemblage approach and with non-representational thinking, this Ph.D. contributes by introducing two new analytical frames in which hospital meals can be studied as dynamic and socio-materially constructed. It can be concluded that the notion of hospitality inspired by Derrida can be useful as a conceptual frame for adding value to hospitals meals, both in relation to considering hospitality as the “mutual recognition of each other’s alterity”, but also as a thinking which enables hospital meals to be considered as open and co-creative and to focus on possibilities rather than static categories.

The dynamic, relational, temporal socio-material lenses adapted in this Ph.D. project provide scientific knowledge that enables the complexity of hospital meals to be considered by transcending a research approach based upon linear causality thinking which currently dominates existing scientific knowledge of hospital meals.

Findings from The Assemblage paper contributed with new perspectives and knowledge into how hospital meal processes could be presented as transformative pop-up restaurants. Additionally, it provided an insight into how patients dynamically co-created their meals, e.g., through a bricolage approach giving artefacts new meanings or through shifting host-guest roles, despite being contested by efficiency and safety rationales. It can be concluded that considering hospital meals as pop-up restaurants enables a focus in meal process which can be characterized in terms of a changing sensory scape, transformations of patients to guest and by a changing physical surroundings.

Furthermore, this Ph.D. contributes to the field of Hospitality Studies through the developed analytical frame of hospitalityscape, as presented in The NRT paper. This frame combines abstract conceptualisations of hospitality and the everyday micro-geographies that involve transactions of food and drink sought from contemporary hospitality scholars and a NRT thinking. The NRT paper contributed to new scientific knowledge by presenting hospital meals as established in socio-material disruptive micro-events, both all day long but also within structured meals. It can be concluded that an ability to consider the co-creative aspect of hospital meals by considering recognizable meal structures as aesthetic and ritual performances but also by an ability to transcend these structures in terms of disruptive micro-event, e.g., in terms of carnivalesque meals, opens up new considerations for bringing value into hospital meal experiences.

The use of social-material lenses provided an agency to materiality and further opened up a chance for the consideration of how meals become co-created, not only socially but also materially. This became highlighted through the presentation of hospital meals as a construction that transcends a conceptualisation of meals based upon a container thinking and reflected in conviviality, nostalgia and the bricolage ability. It can be concluded that sociability in relation to meals is found to be co-created and manifested in different forms, times and places and in connection to other meal processes rather than simply as an eating act.

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Further, it is suggested that the social act of eating together does not necessarily have to be bound physical. It is also suggested that the serving event should be considered as an opportunity for social interaction.

This Ph.D. project aimed to develop a new framework for understanding hospital meals. The suggested conceptual framework of Hospitable Meal Frame (HMF) is presented as a framework that enables the transcendence of the static conceptualisation of hospital meals by existing hospital meal literature. Instead, the conceptual Hospitable Meal Frame suggests an open-ended approach towards hospital meals based upon unconditional hospitality thinking, co-creation and disruptive micro-events. Furthermore, Hospitable Meal Frame should be open-ended with a focus on opportunities rather than being closed.

Therefore this thesis concludes:

The notion of hospitality allows a frame for articulating meals and meal experiences in a hospital frame. Visual methods contribute to expanding insight into meal experiences and a focus on unconditional hospitality thinking, co-creation and disruptive micro-event can create a platform for adding value to hospital meal experiences and a passion for food.

ABBREVIATIONS

CW	Cardiology Ward
FAMM	Five Meal Aspect Model
GW	Gynaecology Ward
HCP	Health Care Professional
KP	Kitchen Professional
NRT	Non Representational Theory
PDPE	Participant Driven Photo Elicitation

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APPENDIX

- o Paper 1: Justesen, L., Mikkelsen, B. E., & Gyimóthy, S. (2014). Understanding hospital meal experiences by means of participant-driven-photo-elicitation. *Appetite*, 75:4, 30-39.
- o Paper 2: Justesen, L., Gyimóthy, S., & Mikkelsen, B. E. (2014). Hospitality within hospital meals – Socio-material Assemblages. (Submitted to *Journal of Foodservice Business Research*)
- o Paper 3: Justesen, L., Gyimóthy, S., & Mikkelsen, B. E. (2014). Moment of hospitality, rethinking hospital meals through a non-representational approach, *Hospitality & Society*, 4:3, 231-248 (In press).

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Paper I: Understanding hospital meal experiences by means of Participant-Driven-Photo-Elicitation

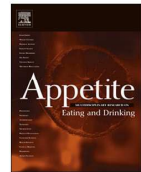
Hospitable Meals in Hospitals



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Research report

Understanding hospital meal experiences by means of participant-driven-photo-elicitation [☆]



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ARTICLE INFO

Article history:

Received 30 September 2013

Received in revised form 26 November 2013

Accepted 11 December 2013

Available online 24 December 2013

Keywords:

Participant-driven-photo-elicitation

Hospital meal experiences

Reflexive Content Analysis

Semiotic Analysis

ABSTRACT

A patients' hospital meal experiences can be complex and often difficult to capture using traditional methods. This study investigated patients' hospital meal experiences using participant-driven-photo-elicitation (PDPE). PDPE invites respondents to photograph their daily lives and combines this with interviews, which can provide deeper insight into multisensory experiences beyond verbal or written discourse. The sample consisted of eight hospitalised patients. Patients completed a photo-essay of their hospital meal experience during a single day at a Danish hospital and afterwards participated in an open-ended interview. Two inductive analytical approaches were selected to assess the patients' reflections on their hospital meal experiences. First, the interview transcripts were analysed using the Semiotic Analysis approach using qualitative data analysis software NVivo 9. Second, the 91 produced photographs and the participants' engagement with the photographs were analysed by means of a Reflexive Content Analysis. The study found that PDPE is a research method that can be used for expanding the conceptualisation of hospital meal experiences, revealing the significance of the meal context, materiality and memories beyond food *per se*.

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Introduction

Scholars within the field of Nutrition, Foodservice Research and Meal Science have noted the importance of understanding public meals, including meals served at hospitals (Cardello, Bell, & Kramer, 1996; Edwards, 2013; Gustafsson, Öström, Johansson, & Mossberg, 2006; Meiselman, 2009). This study aims to introduce and explore whether the application of the participant-driven-photo-elicitation (PDPE) research method in a hospital meal context can contribute to a richer insight and understanding of the experiences and perceptions of hospital meals. It aims to expand the conceptualisation of hospital meals by providing access to a multi-sensory response to meal experiences. As such, the method seeks to exceed traditional research methods that are confined to verbal or written expression (Harper, 2012; Pink, 2007). The necessity for novel research approaches to analyse public meal experiences is manifold. Arguably, PDPE may reveal new aspects

associated with patient satisfaction with hospital meals as well as potential roots leading to undernourishment (Johns, Hartwell, & Morgan, 2010; Rasmussen et al., 2004; Sorensen, 2011).

Background

Studies investigating patients' responses to hospital foodservice and hospital meal experiences are traditionally carried out as patient satisfaction surveys, in most cases using a questionnaire approach (Johns et al., 2010; Morgan, 2006). Satisfaction studies are, however, criticised for taking a service provision and management perspective, which emphasizes the rational aspects of service quality, therefore reducing the hospital meal experience to a few functional properties (Johns et al., 2010; Morgan, 2006). Other studies have adopted semi-qualitative methods such as the Profile Accumulation Technique (PAT), where informants write their assessment of a meal experience in free text key words (Johns et al., 2010). Hospital meal experiences have also been studied using semi-structured interviews, focus group interviews as well as observations (Dickinson, Welch, & Ager, 2008; Hartwell, Edwards, & Symonds, 2006; Holm & Smidt, 2000; Larsen & Uhrenfeldt, 2012; Watters, Sorensen, Fiala, & Wismer, 2003).

The unambiguous focus on written and verbal responses to hospital meal experiences favours patients with the ability to express them verbally. Also, the focus on rational and cognitive responses

* Acknowledgments: We would like to thank Holbæk Hospital, and patients who participated in the photo-elicitation exercise. Also thanks to Dr. Enni Mertenan, Principal Lecturer, JAMK University of Applied Sciences for proof-reading. The authors declare no conflict of interest.

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leaves out emotional and non-reflexive responses to the meal experience and relates hospital meal experiences to the “real world” rather than to an “imagined world” (Pink, 2009). As such, the perception of quality and hospital meal experiences can only be expressed relative to what is already available. In innovation efforts, the general challenge is to be able to imagine “desired futures – how things *could* be”. As a result of this critique, there is growing interest in visual methods that can complement traditional written and verbal methods (Harper, 2002; Pink, 2009).

PDPE as a research method

PDPE is a visual research method in which participants are provided with a camera, are asked to provide a number of photographs in relation to a specific phenomenon and are subsequently interviewed based on the photographs produced (Harper, 2012; Pink, 2007). PDPE attempts to create access to multi-sensory experiences by capturing the surrounding context and facilitating the possibility to convey abstract issues and to reflect and comprehend as memories and emotions are triggered (Harper, 2002; Pink, 2007). In this way, PDPE enables a “richer” communication between the interviewer and informant, exceeding limitations of verbal and written discourses. Pink (2007) points to a reflexive approach in which it is the participants’ intentions and engagement with the act of photographing that becomes a representation of their creation of meaning towards the hospital meal experience. By adopting a reflexivity approach, the researcher creates the opportunity to acknowledge the participants’ first hand intentions and meanings given to the photographs. This is in contrast to the interview, where the photographs are renegotiated (Harper, 2012; Pink, 2007).

According to Harper (2012) PDPE has become a widely acknowledged and employed method within the area of sociology and has been adapted within food and health research. However, while PDPE as a research approach is well described, an explicit PDPE methodology has not yet been extensively described (Power, 2003). According to Rose (2007), interview and analysis methods related to PDPE should be governed by research questions. As shown in Table 1, semi-structured interviews and inductive analyses methods seem to be the most frequently used in food and health research using PDPE. Table 1 also shows that food and health research employing PDPE uses photographs as an interviewing tool to facilitate verbal exchanges but the reflexive way of adapting PDPE has not been reported. However, arguments for choice in relation to the interview method, selection of participants, days of photographing and how to use photographs in the

interview, either vary or simply lack extensive description. The lack of consensus about appropriate approaches and the non-reflexive argument for using different methods connected to PDPE makes it difficult to evaluate and consider PDPE as a stringent and developed method. The PDPE methods in the aforementioned studies are therefore difficult to transfer to other studies.

Few studies apply PDPE in relation to patients’ experiences while hospitalized (Harper, 2012; Radley & Taylor, 2003). Radley and Taylor (2003) used PDPE in a study of patients’ recovery, which differs from the aforementioned studies as the PDPE approach used by Radley and Taylor (2003) was inspired by Pink’s way of thinking of reflexive PDPE (Pink, 2007). In Radley and Taylor (2003) study, photographs were produced in collaboration with the researcher and the subsequent analysis was based on the knowledge gained in the collaboration process, as well as from the interviews. Unfortunately, the analyses methods are not extensively described (Radley & Taylor, 2003).

Materials and methods

The study was carried out in a gynaecology and cardiology ward of a Danish Public Hospital in the eastern part of Denmark during the spring and fall of 2012. The hospital selected for the study produced 350 meals, six times a day using a 3-week menu cycle and had an allocated budget of £11.15/patient/day. The foodservice system was based upon a cook-serve and bulk trolley system and lunch and dinner were served in the wards by kitchen professionals (KPs), whereas breakfast was served by service assistants. At breakfast, there was a choice of bread, milk and fruit juice, porridge and different cereals. The hot meal of the day was served at lunch-time and was comprised of a first course of soup or salad, a choice of two different main courses and a dessert. In the evening, a selection of open sandwiches, soup and hot dishes was served.

Participants

Eight patients were enrolled in the study. Patient selection criteria included patients who had a limited appetite and the ability to handle a camera. Patients who participated in the study were required to have been hospitalised for more than two days but less than four days and were discharged one to three days after their participation. Exclusion criteria included unwillingness to participate, medical reasons or poor physical health. The selection of patients was done in cooperation with healthcare professionals. Every effort was made to obtain a balanced distribution in relation to age and gender (see Table 2).

Table 1
Food and health studies using PDPE – a review of the literature, adapted from: Cannuscio, Weiss and Asch (2010), Husby, Heitmann and O’Doherty Jensen (2009), Johansson et al. (2009), Johnson, Sharkey, Dean, Alex McIntosh and Kubena (2011), Lachal et al. (2012), Maley, Warren and Devine (2010).

	Lachal et al. (2012)	Johnson et al. (2011)	Maley et al. (2010)	Cannuscio et al. (2010)	Husby, Heitmann, and O’Doherty Jensen (2009)	Johansson et al. (2009)
Subject	Obese adolescents	Mothers food identity	Eating and Exercise in community	Urban Foodways	Meals and snack children	Children’s foodscapes
Participants	7	12	8	32	24	59
Photographs	No limits	Min. 15	No limits	Max. 27	No limits	12–14
Days	?	7	?	7	?	?
Method interview	Semi-structured	Semi-structured,	Semi-structured	Open ended	Semi structured	Group discussion
The use of photographs	Researcher choose 1 photo	Participants choose 6 photographs	Participants choose 1–2 photographs	Participants choose 1 photographs	All photographs	All photographs
Method Analysis	Interpretative Phenomenological Analysis	Grounded theory	Constant comparative method	Theme coding	Template analysis	Theme coding
Analysis based on	Interview text	Interview text	Interview text	Interview text	Interview text	Interview text

Table 2
Participants' characteristics (due to confidentiality names have been changed).

	Gender	Age	Ward	Occupation
Jette	Female	32	Gynaecological ward	Secretary
Johanne	Female	63	Gynaecological ward	Farmer's wife
Rie	Female	45	Gynaecological ward	Health professional
Erika	Female	19	Cardiovascular ward	Unemployed
Jesper	Male	NA	Cardiovascular ward	Retired butcher
Frederick	Male	73	Cardiovascular ward	Retired postman
Tomas	Male	81	Cardiovascular ward	Retired sailor
Rasmus	Male	71	Cardiovascular ward	Retired chiroprapist

The Danish code of conduct of research within Health and Social Sciences, based upon the Helsinki Declaration, was followed. The informants were notified about the project, their rights to confidentiality and anonymity orally as well as in writing. They were also informed that recorded interviews would not be published, that participation was completely voluntary and that they may revoke their signed consent and withdraw from the study at any time.

Procedure

Patients were provided with a digital camera and invited to photograph any food and meal events, whether in the physical or non-physical form, during one day. Patients were told that the purpose of the study was to capture the characteristics of a good hospital meal experience. No limitation on the number of photographs that participants could take was set but the participants were not allowed to photograph other persons. Field notes on how patients approached the act of photographing was made and used in the subsequent analysis. Altogether, 91 photographs were produced.

The follow-up interviews took place the next day in the patients' rooms. The photographs were uploaded on a computer and presented to the participant in the order in which they were produced. The participants were invited to speak about the photographs and based on the study's aim an inductive interview method was applied. The dialogue was initially based on the participants' comments followed by questions such as "What do you mean by...?" or "Can you elaborate on this experience?". The interviews lasted between 15 and 30 min and were subsequently transcribed. Quotations were further translated from Danish to English.

Subsequent analysis was based on inductive approaches reflected in two different analysis strategies and inspired by Harper (2012), Pink (2007) and Rose (2007). The first analysis strategy was based on the interview text manifested as a Semiotic Analysis (SA) and the other strategy on photographs and observation notes from patients' engagement with the photographs and manifested in a Reflexive Content Analysis (RCA). The choice of two different analysis strategies contributed to strengthening the credibility of the research. By providing an extensive description of the analysis processes, it also strengthens the reliability as well as the development of a stringent research method connected to food and health research.

SA of patient interviews was inspired by Barthes' systems of signification, which provides the possibility to explore signs and symbols of significance for experiences (Echtner, 1999). SA was comprised of a denotative part that represented a first order analysis and a connotative part, representing a second order analysis. In the first step of the denotative analysis, word categories were identified from the transcribed interviews by reading the interviews several times and using the Word Frequency Function in the data program NVivo 9. In the second part of the denotative analysis, relationships between categories were examined through a cluster analysis conducted in NVivo 9, and meanings were gained from a syntagmatic and a paradigmatic analysis. In the syntagmatic analysis, the researcher identified apparent relations between words and phrases. An example could be the combination of words like *inviting* and *meal-tray*. In the following paradigmatic analysis, new combinations of words or phrases were joined in order to gain new meanings but in the same context. An example would be *boring* and *meal-tray*. The next step of SA was the connotative and second order analysis in which patterns of word relations and underlying meanings were investigated. In the second step of the connotative analysis, the underlying significance was further extracted, interpreted and related to existent foodservice and food sociology literature.

RCA enables the examination of patients' different intentions and meanings in relation to hospital meals through their engagement with the act of photographing and the photographs themselves. The analysis was combined from Pink's (2007) reflexive way of exploring patients' engagement within the act of photographing and Rose's (2007) reflexive critical visual interpretations that allow Content Analysis to be brought into a reflexive frame (Rose, 2007). Field notes on patients' engagement with the camera at the ward as well as during the interviews and the 91 photographs were uploaded in NVivo 9. The first step consisted of a Content Analysis in which the 91 photographs were investigated and codes were identified in terms of motives, time of production, place of production and photographic perspective. In the second step, patients' engagement with the photographs and the photographing act were interpreted from observations notes. In the last step, named cross validation, results from the first step were related to the second step and relations between the patients' engagement with photographs, the photographing act and elements from the Content Analysis were examined. This was done through a cluster analysis in which the patients different intentions and meanings of hospital meals were interpreted.

Results and discussion

Findings from SA

Denotative analyse part 1 consisted of an identification of main word categories and subcategories. Six main categories and 19 subcategories were identified, as shown in Table 3.

The subcategory of "Culinary" differed from the subcategory of "Sensory" in that it was related to personal judgements whereas the 'Sensory' subcategory represented words related to sensory

Table 3
Denotative analyse part I: identified six main word categories and 19 subcategories.

Meal quality	Autonomy	Meal relations	Meal format	Meal situations	Eating
Culinary quality	Attitudes	Other places	Lunch	Serving food	Where to eat
Sensory properties	Actions	Personal relations	Dinner	Conviviality	How to eat
Choice		Hospital stay	In-between meals		With whom to eat
Safety properties			Breakfast		
Healthy properties					

Table 4
Denotative analysis part II. Six dimensions revealed from cluster analysis in NVivo 9.

Dimensions	Word Subcategories	Phrases	Words
The material dimension	Breakfast	"We could get"	Bread, milk, soup, sandwiches, yoghurt, patients room, bed
	Dinner	"I took"	
The culinary dimension	Where to eat	"I had supper at"	Tasty, good, inviting, welcoming, appealing, sad terrible, boring
	Attitudes	"It was"	
	Culinary	"I think"	
	Lunch		
The serving dimension	Sensory		Buffet, trolley, uniforms, home
	Serving	"Inviting attitudes"	
	How to eat	"Nice with safety practices"	
	Whom to eat	"Nicely arranged"	
The co-diners dimension	With other places		Coffee, neighbour, talking
	How to eat	"Ability to eat together"	
The choices dimension	Serving	"if you want"	Cherries, chocolate, coffee, water, lemonade, fruit, nuts
	Hospital stay	"Prefer to eat alone"	
	Personal relations	"Use to queue"	
	Choices	"A lot to choose"	
	In-between meals	"not much to choose"	
The safety and healthy dimension	Drinks	"you can bring"	Clean, safety, buffet trolley, dustbin, whole grains
	Actions	"Good for digestions"	
	Safety health	"Give energy"	
		"Balanced diet"	

properties. The Autonomy category was further divided into "Attitudes" and "Actions" as words were related to what patients either stated or did. Meal relations consisted of the subcategory "other places", representing words of places outside the hospital. The category of eating strategies was divided into three subcategories: "Where to eat", and "How to eat", which related to patients' articulations of the meal event and location for the event, and "With whom to eat", which consisted of words related to social relations within the meal event.

Denotative analysis part II consisted of a search for associations between words from each subcategory. This was examined through cluster analysis in NVivo 9. Word relations revealed six dimensions, as presented in Table 4.

The material dimensions was related to the subcategories 'Where to eat', 'Dinner' and 'Breakfast'. At the syntagmatic level, this signified that dinner, breakfast and the physical eating location were articulated in the same way. It also implied the description of a physical room of available breakfast and dinner meal components and that breakfast was eaten in patients' rooms. Johanne expressed the signification of the physical location when eating lunch by stating:

"It was nice to be able to sit in a chair while eating- it tastes differently. I would have loved to eat where there was more light and clear view than here".

The significance of the physical eating location for the meal experience has previously been highlighted through the concept of "Servicescape" and later through the introduction of the Five Aspect Meal Model (Bitner, 1992; Gustafsson, 2004; Gustafsson et al., 2006). The importance of the meal environment in healthcare settings has also been highlighted as a means to improve health (Edwards & Hartwell, 2004; Holm & Smidt, 2000; Larsen & Uhrenfeldt, 2012; Rapp, 2008). Even though several studies recognize that qualities such as the atmosphere and ambience are important, the focus has mainly been on the immediate environment, such as furniture and plates, whereas experiences of the broader surrounding hospital space still need to be extensively studied (Olsen & Fisker, 2011). Johanne's way of articulating the physical location into a broader experience of a situation is a good example.

The culinary dimension was connected by "Attitudes" and "Culinary" and were related to "Lunch" and "Sensory". At the

syntagmatic level, this signified how patients articulated their experience of lunch through personal judgements of the culinary quality or sensory descriptions. Few patients had the same competence of articulating sensory properties as Jesper, who stated:

"...there are colours; there are mashed potatoes that have colour as it should – easy and mellow ... there are three four different cut raw vegetables – cabbage, apples and everything, but there was too much lemon in ... but it is delicious".

The significance of culinary and sensory qualities in the meal experience has been reported in many studies and qualities, including tenderness, temperature and overcooked vegetables, have been highlighted (Fallon, Curr, Hannan-Jones, & Bauer, 2008; Messina, Fenucci, Vencia, Niccolini, Quercioli, & Nante, 2009; Porter & Cant, 2009). The way of describing culinary quality using terms such as normative and hospitality might be attributed to a lack of ability to express sensory properties but it may also signify that patients experienced meals as "a total whole". This not only includes sensory properties, but also the more contextual and aesthetic part of the meal.

The serving dimension consisted of relations between the subcategories of "How to eat", "Who to eat with" and "Other places". On the syntagmatic level, this signified how patients related the provision of food with the eating event and with social interactions and it signified that patients within the eating event were also related to other places. Johanne connected the buffet trolley with the provision of food and the meal event by stating:

"And I think they [kitchen staff] do a super job and they have a lovely appearance, those who stand by the buffet trolley You feel like a desire for eating when they put on a nice face in contrast to an angry mask; – otherwise you think that it does not matter at all".

Johanne's articulation of the kitchen staffs' way of serving meals through appearance, gestures and artefacts emphasizes that serving styles, the way things are done and how they are done influences the hospital meal experience.

The co-diners dimensions consisted of relations between the subcategories "Social interactions", "How to eat", "Serving", "Personal relations" and "Hospital stay". Through phrases like "better ability to eat together", "if you want to" and "eat alone", it signified

that patients often did eat alone. However, social activity also took place around the buffet trolley, expressed by Rasmus as:

“It is not nice to be in the range of someone with a walker, with a wheelchair and someone with a drip stand. It’s a nice bunch to look at ...so we’re doing a bit of fun with each other and talk about how miserable the food is and what it looks like”.

The above quote signified informal social interactions around the buffet trolley, which was both verbal and gestural. It also underlines that patients were related to each other and that they created a patient community. The importance of social interaction in connection to hospital meals have been underlined in previous studies. Here, the importance of healthcare professionals and of service staff interactions with patients in relation to nutritional therapy have been underlined (Holst, Rasmussen, & Laursen, 2011). This study showed that fellow patients were also related to each other as Cloakroom communities (Bauman, 2000). The metaphor of cloakroom communities emerges from the theatre world in which the audience dresses for the occasion, leaving their coat in the cloak room in order to become a theatre audience who know how to behave and in which relations to other members are sketchy. In hospitals, patients also dress for the occasion, they know how to behave as patients and relations to other patients also remain sketchy (Bauman, 2000). They become “co-diners” in a secluded practice.

The choices dimension consisted of the subcategories of “Choice” and “In-between meals”, which were then connected to “Drinks”. On the syntagmatic level, this signified that patients articulated the ability to choose food in-between meals. Jette stated:

“Just for a little snack if you feel like ...to bring you own thing with you (chocolate and nuts) – I think that is ok”.

The significance of being able to choose has been underlined in several studies and signifies the patient’s ability to be recognised as an individual as well as being in control of the alien situation of being hospitalized (Fødevarestyrelsen, 2009; Holm & Kristensen, 2012; Høyrup, 2012).

The safety and health dimension consisted of the subcategory “Actions”, connected to “Safety” and “Health” and signified how patients, through actions, choose food or meal components from a health and food safety perspective. The connection of “Actions” to the subcategory of “Safety” also related to artefacts which Rasmus articulated as:

“I’m comfortable with people not serving themselves [by the buffet trolley] because they otherwise touch the food”.

“Actions” were also connected to “Health” in terms of choice towards healthy food components. Specific food items were chosen from a nutritional perspective, which Rie articulated as:

“If it was being normal life – I would never have taken creamed sauce – I do it only because I know I need the energy”.

The significance of being able to choose healthy food as well as knowing that food safety practices are taken seriously is a way for patients to seek recovery (Holm & Kristensen, 2012; Høyrup, 2012).

Connotative analysis part I revealed four new dimensions as shown in Table 5.

The imagined dimension was related to home and other places out of the hospital. Memories and previous experiences were used to travel backwards but also forward in time, which Jesper articulated as:

Table 5

Connotative analysis part I. Four identified dimensions representing underlying meanings of hospital meal experiences together with related phrases and words.

Dimensions	Words/phrases
The imagined dimension	“It was just like home” “Being soldier again” “While reading recipes”
The convivial dimension	Conviviality, reading, eating, magazines, coffee, flowers, paintings
The artefact dimension	Glasses, plate, buffet trolley, water jug, flowers, magazines
Dimension of expressions cue	“ I do not belong here” “for elderly people” “Too old for brawn bread”

“Yesterday when I got the open sandwiches with eggs and anchovy... I got my mind on a great Wienersnitzel...yes with fried potatoes”.

Therefore, hospital meals became significant for the creation of an imagined space that was related to home and other places out of the hospital. Johns et al. (2010) also found that hospital meals were parallel to normal life and life at home. This study expanded the relational character to home by showing how artefacts and the ability to use an imagined space acted as mediators to relate the hospital meal to normal life and home as well as to other places. Furthermore, this study showed how patients constructed meal experiences through situations of conviviality during the whole day. Hence, these findings suggest that hospital meal experiences are conceptualised in a whole day perspective and not just through isolated meal events at the hospital.

The convivial dimension was articulated by Jette as:

“It was because it was really convivial to be in the bed drinking and watching TV, it was just like home”.

Jette’s articulation of conviviality was related to actions of drinking and watching and also to home. The ability to create situations of conviviality and to form relations to home became significant for a free space to act as well as for seeking pleasure. The creation of a free space has been described in Goffman’s Asylum (Goffman, 1967).

The artefact dimension consisted of artefacts and in particular the buffet trolley. The buffet trolley was connected with safety practices and became a sign of both safe and secure food. Other artefacts became important to how hospital meals gained different meanings. This was underlined in Jettes’ comment:

“Such a thing did not make me want to drink water ... because it was such a white plastic thing”.

Jette’s comment on the water jug was related to both serving practices and aesthetic considerations and her experience of being recognised as an individual.

The dimension of expressions cue consisted of a way to choose or to express patients’ own identity or frustrations for being hospitalised. Similar to other studies, this study revealed how hospital meals were used as expression tools and a place for frustrations and complaints (Hartwell et al., 2006; Holm & Kristensen, 2012; Johns et al., 2010; Larsen & Uhrenfeldt, 2012).

Connotative analysis part II was the last analysis step, comprised of an identification of how a patient adapted different strategies in order to make sense of hospital meals. The identification was based upon previous findings from the Denotative and Connotative analysis. Seven concepts of hospital meal strategies emerged, as outlined in Table 6.

“Meals as nostalgia” was the strategy in which patients created an imagined space for daydreaming and nostalgic memories by traveling forwards and backwards in time. Nostalgic thoughts of being a soldier became well-known and provided a secure place.

Table 6
Seven concepts of patients' strategies for eating meals interpreted from denotative and connotative analysis.

Denotative analysis	Connotative analysis I	Connotative analysis II
	The imagined dimension	➔ Meals as nostalgia,
	The convivial dimension	➔ Meals as conviviality
The material dimension	➔ The artefact dimension	➔ Meal quality through artefacts
The choice dimension	➔ Dimension of expressions cue	➔ Meals as expression cue
The safety and healthy dimension	➔	➔ Meals as proxy for recovery
The serving dimension	➔	➔ Food as proxy for hosts
The culinary dimension	➔	➔
The co-diners dimension	➔	➔ Meals as sociability

This allowed an escape from the current and maybe alien situation and became a strategy for achieving security and avoiding alienation, as such maintaining an identity too. "Meals as nostalgia" also became a place for pleasure which was reflected in the patients' ability to transform hospital meals into something pleasant. The daydreaming ability also revealed that hospital meals were created all day long and not only during main, structured meals.

"Meal quality through artefacts" was related to patients' engagement with artefacts. Artefacts contributed to create pleasant meals. These artefacts were often related to home and family and became a representation of security and of being recognised as an individual. Artefacts were also connected to "cleanliness" and became a sign for patients' experiences of security and the experiences of being cared for, seeking recovery and maintaining identity. As the buffet trolley was related to statements like "industrial food", it also became a signifier for meals as an alienation.

"Food as proxy for hosts" was created as patients articulated culinary quality and serving practices through human characteristics and through hospitality language as representation for an invisible host. The invisible host became a signification for a search for personal relations in meals, a search for being recognised as an individual and, as such, for maintaining identity. As food was often related to the home, it also became a signifier for security in contradiction to the alien situation at the hospital.

"Meals as conviviality" were created as good hospital meals and were articulated verbally as situations of conviviality as well as situations related to home. Conviviality situations became a space where it was possible to escape from the uncertainty associated with being hospitalized and allowed the patients to connect to the well-known home. As such, conviviality became a signification of security, of being recognised as an individual and of maintaining an identity. Further, conviviality became a place for enjoyment in order to achieve pleasure.

"Meals as sociability" represented the patients' different strategies for social engagements with meals. Social interactions took place around the serving area, where some patients interacted informally as cloakroom communities and where some patients avoided social interactions while eating. This became a representation of patients' intentions to distance themselves from the current situation and, as such, to avoid alienation and instead retain identity. In the eating event where patients' adopted different social eating strategies, the meal became a signification for performing

identity, creating pleasure, and to distance one of being hospitalised.

"Meals as expression cues" became a space where food and meals were used to express something beyond the actual meal experience. This became evident through the deselection of hospital meals due to age, profession or the situation of being hospitalised. As such, meals became a space for complaints and frustration and a signifier for alienation and the maintenance of identity.

"Meals as proxy for recovery" was related to patients' acceptance of the circumstance of being hospitalised and also of the fact that meals are functionally constructed. This was reflected in meal choice, which was made based on the patient's nutritional perspective, the acceptance of the medical surroundings and the focus of safety practices as necessary parts of the hospital meal experience. As such, hospital meals became a signifier of security as well as recovery.

These concepts became strategies used to make sense of hospital meals and for achieving higher goals such as seeking recognition, security and avoiding alienation. Further goals were to achieve pleasure, recovery and performing identity, as outlined in Fig. 1. The findings support existing knowledge of hospital meal experiences by underlining the importance of extrinsic factors and significance of emotional aspects in terms of seeking pleasure, recognition, security and identity as well as avoiding alienation (Hartwell et al., 2006; Holm & Kristensen, 2012; Johns et al., 2010). However, strategies including the use of meals for nostalgia, meals as a proxy for hosts, meals as conviviality and meal quality through artefacts have not previously been reported.

Findings from RCA

The three analysis step within the RCA analysis will be presented in the following order: *Content Analysis, interpretations and cross validation.*

Content Analysis. The 91 photographs were examined in term of motives, place, time and photographic perspectives and divided into 14 sub-groups, as outlined in Table 7.

The photographs were produced in patients' bedrooms, around patients' beds and their bed tables. Few photographs were produced around the small dinner tables in the patients' bedrooms. Photographs were also produced at the ward corridor. The motives consisted of meal room motives, such as meal trays and meal

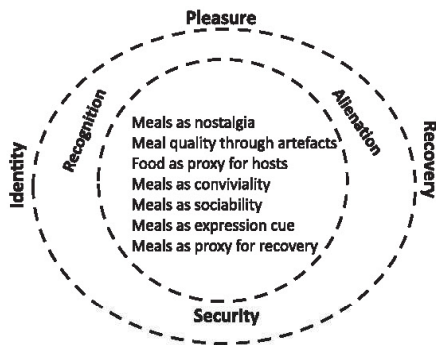


Fig. 1. Making sense of hospital meals. The inner circle represents different meal strategies that patients adopted in order to achieve recognition, security and avoiding alienation, which in turn, became strategies for achieving pleasure, recovery and performing identity. The dotted lines represent the interconnected between the goals and strategies.

Table 7
Content Analysis. 91 Photographs divided into motives, place of production, time and photographic perspective.

Motives	Place	Time	Photographic perspective
Non food	Bed	Breakfast	Close up
Food	Ward	Lunch	Normal
Meal components	Bedside	Dinner	
Meal room	Room	In-between	

components as part of a meal. Food items which were not meal components and 14 non-food artefacts were also framed. The majority of the photographs were produced in-between meals and during lunch while dinner and breakfast were the least produced motives. In-between meals were reflected in images shot in the morning, afternoon and evening.

The Content Analysis showed that hospital meal experiences were reflected all day long and not only during main meals. Although most photographs were produced around the patients' beds, photographs from the ward corridor showed that hospital meals experiences were also related to the wards and the serving event around the buffet trolley. The 14 non-food motives also showed that hospital meal experiences were not necessarily experienced as food or meals but that artefacts contributed to meal experiences as well.

Interpretations. Observations notes showed that the patients engaged rather differently with the camera and instinctively used different photographic tools to support different meal approaches. Three different approaches were identified: "The Reflexive Approach", "The Documentary Approach" and "The Performance Approach".

"The Documentary Approach" was characterised by a documentation of the physical presence of food without the need to express an engagement within the photographs. When patients were handed the camera they waited to produce photographs until food or meals became physically present. In the interviews, focus was related to a description of the content.

"The Reflexive Approach" was characterised by an engagement with photographs that transcended the physical documentation. Instead, this approach represented an engagement that focused on personal reflections and present experiences during the daily life at the wards. When patients received the camera, they started to reflect hospital meal experiences at once. During the interviews, it was became apparent that patients knew exactly why they had

shot the photographs and they clearly expressed their experiences connected to the photographs.

"The performance approach" was the most expressive way of engaging with the camera and was characterised by an approach in which the act of photography became a representation for attitudes towards hospital meals or frustrations of the current situation rather than a description or reflection of their present food experiences. This became evident through patients engagement with their first image shot immediately after the camera was handed to them. These images framed non-food elements and were meant to represent patients' understanding or attitudes of good hospital meal experiences in general. In the interviews, patients' knew why they had shot the photo, but they could not necessarily identify the motive.

The different approaches signified how patients had different intentions and provided different meanings towards hospital meals. Patients who performed "The Performance" and "The Reflexive" approach were the most expressive and emotionally involved in hospital meals and for them hospital meals seemed to be of great importance. However, they differed in the sense that patients performing "The Reflexive Approach" were focused on the actual meal experiences, whereas patients performing "The Performance Approach" had a preconceived approach towards hospital meals.

Cross validation. Relations between elements in the Content Analysis and the three patients' approaches were studied through a cluster analysis, conducted in NVivo 9. Three clusters expressed as three new concepts on how patients made sense of hospital meals were identified and presented in the following paragraphs as "Meals as visual knowledge", "Meals as conviviality and artefacts" and "Meals as a proxy for hospital stay" (Table 8).

"Meals as visual knowledge" was characterised by patients adopting the "Documentary Approach". It was connected to photographs of meal trays placed on bedside tables or tables in patients' rooms and shot with a normal perspective, just before eating and often around breakfast time. The connection to breakfast, meal room motives and tables in patients room photographs is presented in the pictures below (Fig. 2A).

Tomas's first comment on photo 2A was:

"So this is breakfast – yes it may be – yogurt and bread yes – and jam and coffee"

The descriptive character and the enumeration of available food items underlined the documentary approach where the focus is on meal components and not on the entire situation, like the entire meal room consisted of tables, medicine, hospital folders and another meal tray for a fellow patient.

Thomas' photo of his evening meal (Fig. 2B) was also framed while standing in front of the table in his room. To this photo, he stated:

"It's evening dinner – It's a piece of ham and some salad, and then there are some cauliflower with shrimp and tomatoes with dressing – otherwise it was very good".

The motives related to the "Documentary Approach" were consistent with the material dimensions described in the SA. However, the contrast in motives and the initial sayings related to the photographs might further suggest that some patients are not able to verbalize their meal experiences in a broader context. Pink (2007) introduce this as visual knowledge in contrast to verbal knowledge.

"Meals as conviviality and artefacts" was characterised by patients adopting "The Reflexive Approach" and were connected to photographs produced all day long and with food or non-food

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Table 8

Cross validation. Interpretation of cluster analysis conducted in NVivo 9. Relations between patients' engagement with photographs and categories from the content analysis.

Content analysis		Patients engagements with photographs		Cross validation clusters
Meal room, room normal perspectives breakfast bedside	+	The documentary approach	→	Meals as visual knowledge
In-between meals food non-food bed	+	The reflexive approach	→	Meals as conviviality and artefacts
Close up perspectives lunch ward meal components dinner	+	The performance approach	→	Meals as proxy for hospital stay



Fig. 2. 2A left: breakfast in patient's room. 2B right: evening meal in patients' room.



Fig. 3. 3A left: table at the entrance to the ward corridor. The photo shows potted Flaming Katy, and a fruit bowl with apples, banana and paper napkin placed on a round Table 3B right: a motive of a window view produced in the afternoon.



Fig. 4. 4A left: a close up photo of a plate with lasagne as a part of the evening meal. 4B right: part of a breakfast meal tray placed on Rie's bed table.

motives. Frederick's comment to the photo below was as follows (Fig. 3A):

"I like that – that looks convivial"

Frederick was expressing the importance of artefacts and the contextual environment related to hospital meal experiences as well as stressing the aspects of conviviality. A situation of conviviality was also expressed in the photo below. Jette's comment to this photo (Fig. 3B) was:

"it was really convivial to sit and eat while the sun was shining... it was a good feeling"

The motives related to "The Reflexive Approach" were consistent with the aspect of artefacts and conviviality found in the SA. The photo of the flowers and the fruit bowl may further expand the host and hospitality aspect mentioned in SA. By including the materiality aspect in the shape of the a nicely arranged paper napkin and the potted Flaming Katy, it signified that meals became a proxy for an invisible host.

“Meals as a proxy for hospital stay” was characterised by the way patients used hospital meals as a way to express their experiences of being hospitalized. They were connected to “The Performance Approach” and to photographs shot at the ward and often during lunch. “The Performance Approach” was also connected to pictures of meal components using the photographic tool of close up motives so as to underline the importance of their statements. Erika had the following comment to the photo below (Fig. 4A):

“It is the most disgusting lasagne I have ever tasted there were some vegetables – and you could not taste the meat and – the béchamel tasted just plastic. It was really disgusting – I did not eat anything. Then my friend came with a burger, so I could get something to eat. The burger was good and it was just what I fancied”

By using close up perspectives and highly expressive words, Erika showed her dissatisfaction with the culinary quality of the food and expressed her thoughts about what hospital meals should look like. By letting her friend buy a well-known burger, which became a relation to her well-known life at home, her expression might also represent her frustration of being alienated at the hospital.

Rie also used close-up perspectives and highly expressive words connected to the photo below (Fig. 4B). Rie made the following comment on this photo:

“I think it looks boring. It is the service they provide here. I think it’s beneath contempt.”

Rie is dissatisfied with the food and expressed her idea about what hospital food should look like. She refers to the service in general and as such to her dissatisfaction with the hospital stay. The meal became a surrogate for her whole hospital experience, underlining the aspect of hospital meals as expressions cue presented in SA.

SA read together with RCA

Altogether, findings from RCA supported findings from the SA as concepts related to conviviality, artefacts and as meals expressions cue were identified in both analysis, as outlined in Fig. 5.

RCA differed from the SA by being able to show how patients approached hospital meals differently, some being more reflexive or expressive than others. Most importantly, it questioned the existence of visual knowledge. This means that there might be some knowledge on hospital meal experiences which some patients are not able to express verbally. SA differed from RCA by further expanding knowledge about how patients adopted other meal

strategies. Strategies related to recovery and social aspects have been reported in existent literature but whether strategies related to nostalgia and food as a proxy for host has not yet explicitly been reported.

PDPE adapted in a hospital meal context

By handing over a camera and inviting patients to frame their hospital meal experiences, it became possible to access multi-sensory responses to hospital meal experiences. This became manifested in the patients’ engagement within the process of producing photographs, but also in the process in which photographs worked as interviewing tools, triggering patients’ memories and emotions. This, among others, resulted in the creation of an imagined dimension. Photographs also helped patients explain and convey abstract matter as conviviality, welcoming meals and meal practices and highlighting the importance of situational and contextual elements. Patients that stood out most regarding hospital food were in particular Rasmus, Frederick and Jesper. Rasmus’s way of being expressive in both photographs and in speech, conveying his general view on hospital meals without really sensing the actual experience, was in clear contrast to Frederick’s way of capturing and reflecting “small things” such as flowers and tables that affected him in the situation despite being hospitalized and in pain. Jesper was somehow in-between as he had an ability to experiences the sensory quality and at the same time use his memories and imagination of other meal experiences. However, together they reveal the necessity to conceptualize hospital meals in a much broader context than isolated meal events.

Compared to methods like PAT and other traditional verbal or written research methods, PDPE provides a richer interview communication, which questions the use of traditional verbal research methods.

PDPE’s limitation as a research method is its lack of stringency which means PDPE as a method needs to be considered and described depending on the different research question and conditions. A limitation of PDPE for studying hospital meal experiences is related to restrictions on photography in hospitals, which often do not allow the photographing of other persons and photography being reduced to only one day. This might have downplayed findings related to social aspects of hospital meal experiences, or may have reduced the possibility to visualise other aspects or situations of hospital meal experiences during the patients’ process of recovery. Also, the nature of framing actual experiences and context might further emphasise these aspects and naturally downplay others.

The decision to include all of the photographs in the interview provided an insight into how food and meals were experienced and negotiated during daily life at the hospital. On the other hand, it prevented the pursuing of substantive depth for particularly important images, as patients often became tired during the interviews.

Furthermore, the ability of PDPE as a research method to elucidate meals connected to under-nutrition could be questioned since PDPE requires patients being able to handle a camera, an action that might not be possible for undernourished patients. However, although PDPE methods might have difficulties targeting seriously ill and undernourished patients, this study showed that PDPE revealed a much broader understanding of how patients generally used and approached hospital meals. Using PDPE should therefore concentrate on patients that are not seriously ill or undernourished but insights form interaction with such patients might be useful when aiming at developing welcoming and hospitable environments that caters also for the needs of undernourished patients in the future. Probably the ability to create an imagined meal situation, the ability to focus on conviviality and hospitality or on the

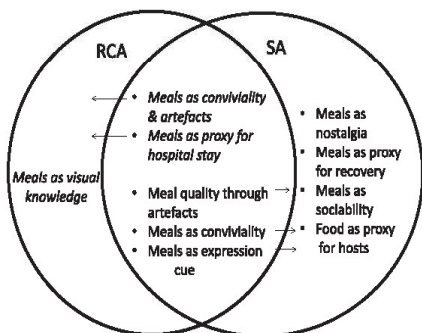


Fig. 5. RCA and SA shared findings related to conviviality and artefacts aspects as well as meals as expressions cue. RCA revealed the aspect of hospital meals as non-verbal and SA revealed the aspect of nostalgia, recovery, sociability and proxy for host.

aspects of relations to artefacts might address undernourished patients desire for eating. However, further research is needed.

Life at hospitals is busy and concerned with completing necessary “need-to” routine tasks and methods for quality assurance using PDPE and other innovative methods tends to risk being regarded as “nice-to” tasks. Therefore, further development and work is needed if PDPE as a method should be transferred into a practical professional tool that can be used on a routine basis in hospital and other similar type of Foodservice Organisations.

Conclusion

PDPE as a research methodology contributes to a richer insight and understanding of hospital meals by triggering memories and emotions and exceeds traditional research methods that are confined to verbal expressions. The findings of this study imply a need for further research in how materiality and practices become part of hospital meal experiences and how these findings can address the aspect of under-nutrition at hospitals. The study also suggests introducing the notion of hospitality as part of hospital meal practices.

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Paper II: Hospitality within hospital meals – Socio-material Assemblages

Hospitable Meals in Hospitals

Hospitality within hospital meals – Socio-material Assemblages

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Submitted to Journal of Foodservice Business Research

ABSTRACT

Hospital meals and their role in nutritional care have been studied primarily from a life and natural science perspective. This article takes a different approach and explores the idea of hospitality inspired by Derrida's work on the ontology of hospitality. By drawing on ethnographic fieldwork in a Danish hospital, hospitality practices were studied using a socio-material assemblage approach. The study showed that rethinking the meal event could change the wards into temporary *pop-up-restaurants*, transcending the hospital context and providing a scene for shifting host-guest interactions and creating temporary meal communities. However, asymmetrical host-guest relations bound to health and efficiency rationales typical for public meal production-systems contested the hospitality space. Findings indicate that hospitality thinking can be a valuable guiding principle to enable staff and management involved in hospital food service and in nutritional care to work more systematically with the environment for improved hospital meal experiences in the future.

Keywords: Hospital meals, Hospitality, Meal practices, Socio-material assemblage.

1. Introduction

The notion of hospitality has recently been introduced in a conceptual framework applied in hospital foodservice practices and in research aiming to improve the hospital meal experience (Beermann, Mortensen, Skadhauge, Rasmussen, & Holst, 2011; Hepple, Kipps, & Thomson, 1990; Høytrup, 2011; Lund, 2012). Such improvements have formed part of strategies that seek to counteract the fact that 30-40 per cent of hospitalized patients are at risk of becoming undernourished (Kondrup, 2001; Rasmussen et al., 2004). However, the introduction of hospitality within hospital foodservice practices has only been subject to scientific debate and inquiry to a limited extent. So far, the conceptualization and development of a conceptual hospitality framework has been based upon culturally determined hospitality practices. These practices have merged from an operationalized way of thinking about hospitality, originating from the hotel and restaurant world, as attributes aiming to make people feel at ease (Beermann & Holst, 2010; Hepple et al., 1990). Therefore, a paradigm shift representing a new ontology of hospitality might contribute to addressing and expanding existing knowledge related to hospital meal experiences as well as to addressing undernutrition. This new hospitality ontology is based upon the French philosopher Derrida's conceptualisation of hospitality as ethical and unconditional in terms of welcoming anyone and as seeing hospitality as infinite, absolute and open and as an act of engagement through mutual recognition of each other's alterity (Derrida, 2000; Dikeç, 2002). Derrida states further that hospitality is temporal in the sense that it is not something that is present all of the time. Dikeç (2002) extends Derrida's conceptualisation of

hospitality as an ideology by including free will and the mutual aspect of hospitality, seen as the dynamic and shifting roles between hosts and guests in a constant process of engagements and negotiations that allow host and guest relations to be constituted by each other and thus relational (Derrida, 2000; Dikeç, 2002). The new hospitality ontology is also supported by the so-called new 'service-dominant' logic (Vargo & Lusch, 2004), which proposes that values are co-created and emerge from interactions or dialogue between service providers and in this case, patients. The idea of value co-creation is based on the dyadic notion that providers and patients are each other's constitutive conditions. Furthermore, this new hospitality ontology underpins a request from hospitality scholars to address and explore hospitality as both socially and materially constructed (Lynch, Germann Molz, McIntosh, Lugosi, & Lashley, 2011).

This article explores how hospitality can be co-created in a hospital food environment and how it emerges from socio-material interactions. The article takes as a point of departure the following research questions:

How is hospitality within hospital meals established and constituted in social and material practices? How might Derrida's hospitality approach and hospitality as materially constructed contribute to new insights and opportunities to add value to hospital meal experiences?

2. Methods

2.1. Analytical frame; hospitality as socio-material assemblage

The idea of a socio-material assemblage originates from cultural geography as way of exploring how a phenomena comes into being through dynamic social and material relations and processes. Further, a socio-material assemblage approach explores how these relations and processes are assembled, held together and changed and thereby transformation everyday life practices (Adey, 2012; Anderson, Kearnes, McFarlane, & Swanton, 2012; Marcus & Saka, 2006). A socio-material hospitality meal assemblage allow as such a focus on how the hospitality space is brought about and mutually constituted through dynamic social and material relations in the hospital meal setting. Therefore, it allows a focus on how entities such as food service organisations, actors such as patients, and practices such as meal routines, procedures and artefacts like the buffet trolley transform and temporally co-create the hospitality space.

2.2 Ethnographic study at a Danish hospital

An ethnographic study was carried out in the gynaecology ward (GW) and cardiology ward (CW) of a Danish hospital. The hospital operated a cook-serve foodservice system with bulk trolley serving in which kitchen professionals (KP)s are responsible for serving lunch and dinner from a buffet trolley at the wards. Patients at the GW were mainly cancer patients or patients hospitalized for surgery. Some of them were screened as at risk for undernutrition.

The fieldwork was based on and inspired by Pink's (2012) conceptualisation of situational ethnography which focus on studying practices articulated as 'doings' and 'sayings', (Pink, 2009; Pink, 2012). The terms 'doings' and 'sayings' are drawn from Schatzki's (2001) definition of practices as: "A practice is a set of doings and sayings organized by a pool of understandings, a set of rules and a teleo-affective structure" (Schatzki 2001:53). This was further analytically operationalized by Warde (2005) as three components representing *understandings*, *procedures* and *engagements*. Here, understandings represent a focus on "what to do", "how to do", "knowledge" and practical knowledge, in terms of knowing "how to do". Instructions represent a focus on principles and rules of "how to do" and engagements allow a focus on an emotional and normative relations to understanding of "what" and "how to do" (Warde, 2005).

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The data collection was based on a four-component strategy using unstructured as well as structured participant observations and semi-structured interviews. The different fieldwork approaches and their connection to this study's research question and analytical work are presented in Table 1.

Table 1: Presentation of three fieldworks approaches related to the research question and analytical work.

Fieldwork approaches	Conceptual linkage to research question:	Conceptual linkage to analytical work:
	Establish hospitality in social and material practices	Identifying hospitality co-creation through practices.
	Exploring hospitality practices in doings and sayings	Identifying arrangements of practices as socio-material assemblages
Participant observations unstructured	Allows exploration into how hospital meal practices come into being in terms of understanding, procedures and engagements. 200 Photographs Field notes and diary	Allows identifying intensities of socio-material activities involved in co-creating hospitality. Basis for planning of semi-structured interviews and structured observations. Messy Maps
Participant observations structured	Allows exploration into how hospital meal practices come into being in terms of understanding, procedures and engagements connected to structured meals with a special focus on routines, artefacts, procedures and bodily movements. Field notes and diary 200 Photographs and 14 videos	Allows identifying socio-material activities involved in enacting hospitality connected to structured meals. Hospitality practices coded
Semi-structured interviews	Allows exploring peoples experiences and practical concerns of how hospital meal practices come into being in terms of understanding, procedures and engagements, centred on structured meals. 22 interviews, 8 interviews based upon Participant Driven Photo Elicitation	Enables the identification of peoples experiences of how hospital meals and hospitality becomes co-created. Described, transcribed and coded Quotations were translated by the researcher.

The first two components entailed structured and un-structured observations through 6 months of observations. The unstructured part of the observation strategy was based upon being present at the ward during the day, evening and night, observing and photographing routines, atmospheres and procedures of daily life at the wards. Observations were documented in field notes, in personal diaries and in photographs. The following structured observations became structured through a specific focus towards meal practices exploring the 'doings' and 'sayings' connected to the serving event. This was documented in field notes, diaries, photographs and videos.

The third component included 22 semi-structured interviews with patients and health care professionals (HCP)s focusing on their concerns and experiences of hospital meal routines, in terms of doings and sayings. Further, 8 patient interviews based on the principle of Participant Driven Photo Elicitation were conducted (Justesen, Mikkelsen, & Gyimóthy, 2014).

The Danish code of conduct of research within Health and Social Sciences, based upon the Helsinki Declaration, was followed.

2.3. Identifying hospitality as socio-material assemblages

The analysis strategy was based upon a three-fold strategy. The first part was based upon the unstructured data collection process with the aim of identifying the intensities of meal practices. Inspired by Clarke's (2005) Situational Analysis, messy and relational maps were produced (Clarke, 2005) and these maps revealed that many relations were connected to the buffet trolley and to the act of serving. Therefore, the subsequent structured part of the fieldwork was centred on the serving act and the serving event by the buffet trolley.

The second part of the analysis strategy aimed to identify socio-material practices connected to the serving event. All video actions were described and interviews were transcribed and coded based upon practices in terms of understandings, procedures and engagements. Finally, in the following interpretation process, intensities of socio-material practices and their transformations were identified and grouped as socio-material assemblages.

3. Findings and discussions

The top-three socio-material assemblages identified are presented in the following three paragraphs.

3.1 Transformation of a hospital room into a temporary hospitality space

This socio-material assemblage represents the transformation of a hospital room into a temporary space of hospitality which is marked by patients being transformed to guests, the emergence of intensified 'sensespaces' and dining room transformations.

The hospital and foodservice organisations as well as the HCPs contributed to this by transforming patients to guests through oral and written communication such as welcome brochures with information on meal structures and menu plans. A patient comment on these menu plans was:

"It's actually nice to know- what kind of food is served, then you could get prepared."

Another patient expressed her experiences of being transformed to a guest:

"They come into my room and say: now it's time for food. Would you have something to eat? I say: What is on the menu? So they say: There are three dishes - this and this and that - and then I find out which of the three dishes I would like to have."

The process of transforming patients to guests was also articulated by a HCP as:

"Before meals are served you could start presenting today's menu in order to create expectations... and as nurses we know how patients' experienced yesterday's meals you could take that into account and discuss what they want for today."

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The first quotation demonstrates how a patient took part in the transformation process whereas the second quotation demonstrates how a HCP, by saying '*there are,*' disclaimed an active host role. The quoted HCP negotiated the coming meal by taking a point of departure in the patient herself. These three citations reveal how patients temporally came to find themselves in new host–guest relations. However, these relations are characterised as being asymmetrical guest-host relations in which foodservices and hospital organisations have sovereign authority by defining the conditions of how, where and when hospital meals were to be served. Hospitality in terms of welcoming the guest became expressed as information of food availability and despite a HCP's ability to negotiate a coming meal, the hospitality space became a less welcoming space in which it was difficult to identify a meal host.

The transformation process was further marked by the emergence of intensified 'sensescapes', described as sensory perceptions and manifested in sensory experiences of sounds, scents, light and atmospheres. An 89 year-old patient expressed her sensory experience of meals:

"The sound at the ward changed tremendously – I hear a very specific buzz and a totally different sound than usually and then new sound appears and disappears and then it gets complete quiet again."

Sounds, scents and atmospheres were also expressed by a HCP as:

"There is much resonance here (GW). When you come into a restaurant there is a sound of knives and forks – yes sounds does matter.... and atmosphere – and patients value if they can hear noise as they think it's nice that there is life at the ward and that someone is enjoying themselves Good scents are scents that tell you what to eat but also tell you that something are going on ... however heavy scents - if you have little nausea and pain - it must be taken into account."

A cancer patient also reflected on scents:

"Once there was a scents of cinnamon buns from the ward corridor, and even though I had poor appetite, I had to taste them."

Further, a daughter helping her elderly mother with breakfast expressed her view on scents:

"It's the smell of cabbage that you normally get from the buffet trolley - we lose our appetite."

These quotations showed a web of sensory cues and perceptions that can be referred to as an intensive 'sensescape'. Understanding this scape is an important part of transforming the hospital room into a hospitality space. Nonetheless, this space became contested as some of the patients not only gained but also lost their appetite. The smell of cinnamon buns created enjoyment and a desire for eating whereas smells such as cabbage or the physical condition of the patient such as nausea and pain contested the hospitality space by reducing the desire for eating. The sensory change was also articulated through the sounds and atmosphere in which patients had the ability to hear and feel the transformation process. The 'sensescapes' transformations took part during the hospital socio-material meal assemblage, affecting patients' appetite as well as visitors and HCPs' perception of meal experiences. However, even though HCPs appeared to be aware of the importance of sensory elements, it was not used as part of a designed strategy in the transformation process to a hospitality space. The connection of 'sensescapes' to emotional reactions further revealed that hospitality spaces are pre-cognitively constructed.

The last element in the transformation of a hospital room to a hospitality space was manifested as a physical transformation. In the quotations below, two HCPs describe how they attempted to transform the hospital room into a meal room:

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“It is important to be present and to have time to arrange the tray and make sure the bed tables are cleared upit takes two seconds, you can do it without bothering the patient just so that is nice and clean.”

“I tell patients’ 5-10 minutes in advance that the buffet trolley will soon be ready and that they can prepare themselves for the meal – also I make sure to open up windows, to encourage patients to get dressed and to move from the bed to a table in order to create a eating situation.”

These quotations show routines in which HCPs act as visible hosts, transforming a hospital room into a temporary hospitality space that invites patients to co-create the meal, emphasising the importance of ‘being present’ and having time to prepare and negotiate the meal event with patients. However, although patients were invited to participate in this process by “preparing themselves”, host and guest relations became asymmetrical as HCPs culturally learned and prior understanding of how hospitality spaces could be designed to create positive hospital meal experiences that promote patients to eat were the starting point for the negotiations.

Nonetheless, a possibility for patients to transform the physical room was also valued, as expressed by a patient:

“It was a big thing and it was nice to be able to come up and sit in the chair - it tastes different. Well this is more delicious when you can sit up rather than in bed - it's nicer.”

Patients themselves also took the initiative to transform the hospital room into a hospitality space. This is visualised in the figure below where two fellow patients at the CW transformed a table into a dinner table as part of what the patients call their “café”.



Fig 1. The café: The photo shows the outcome of two patients transforming a table into a dining table with table cloths and flowers.

One of the two patients commented:

“My fellow patient and I - we say that we have made our own little cafe by grabbing a small table and dragging a few chairs and so we pretend it as our café.”

The previous two quotations demonstrate how the hospital room physically changed into a hospitality space. Changing the physical surroundings by clearing bed tables, venting, helping patients to get dressed or assisting them to a dinner table meant that HCPs could create a hospitality space separate from the medical treatment. However, the physical transformation process was not always negotiated with patients. Instead, non-articulated, socio-cultural conventions carried out as traditions, rituals and habits in terms of where to

sit, how to clear tables and how to dress dictated the understanding of good hospital meals and left the hospitality space to be contested as asymmetrical. Further, the creation of the hospitality space was contested as HCPs often had to compromise in the transformation process as medicine packs, urine bottles and vomit bags were necessary parts of the physical surroundings. Patients themselves were also involved in this transformation process, as demonstrated in the creation of the “café”, supporting the transformation of the hospital room into a hospitality space. The creation of the temporary café worked as a *bricolage* in which two patients transformed artefacts such as cloths or napkins, bringing new meaning to a hospital meal room. The term *bricolage* is inspired by Strauss’s notion of *bricolage*, in which seemingly incomprehensible elements may create a new coherent system of meanings (Strauss, 1966, in Fuglsang & Sørensen, 2011).

3.2 Transforming the buffet trolley into a hospitality actant and ordering device

The transformation process from a hospital room to a hospitality space was intensified around the buffet trolley in which HCPs, KPs, meal components and the buffet trolley co-created different rationales. These rationales supported or contested hospitality intentions as guest empowerment, mutual recognition and free will. These rationales represented safety rationales, efficiency rationales, and nutritional rationales.

Guest empowerments could become contested by food safety rationales. Due to foodservice regulations, patients were not allowed to touch the food or the buffet trolley. Sometimes patients tried to help themselves with drinks from the drink trolley located beside the buffet trolley but they were stopped by either KPs or HCPs. KP could reply to patients as:

“You are not allowed to do that – I will have to do it.”

One patient commented on this event:

“I thought: Why do I have to wait? It was not a part of the buffet trolley and beside you normally helps yourself with lemonade and stuff anyway.”

Another patient who had the same experiences made this comment:

“I just wanted to help.”

Food safety regulations were followed due to food safety reasons but were also a way of presenting clean and safety practices to everyone around the buffet trolley. A patient noted this:

“They are very careful about patients not getting too close [to the buffet trolley]. I like that - because I think it's disgusting if someone coughs and breathes or pokes their head over the buffet trolley.”

An embodied way of performing food safety practices was also noticed as:

”I think it's very nice the way foods are served and that others do not mess around with the food.”

Serving practices around the buffet trolley are illustrated in figure 2. This shows how patients and HCPs queue in front of the buffet trolley, leaving KPs to serve and arrange plates and drinks. Patients were only allowed to receive the arranged plate and carry it away with the serving tray.



Fig 2. Serving event around a buffet trolley. The photo shows how a food safety rationale was manifested in patients prohibition to touch anything but the serving tray. At the front of the drink trolley are glasses and cutlery and a yellow sign saying “Do not touch”.

The quotations above represented situations in which food safety regulations, established to avoid contaminations, contested the hospitality space by disempowering the patients in preventing them from helping themselves or being permitted to touch food or pour themselves drinks. As a result, the hospitality ideology of acknowledging the individual manifested as “the guest always has the right” was questioned. In addition, the queuing aspect in which the guest had to take into account the other guests following an ordering line also contested the individual aspect of hospitality space and the possibility of transforming patients to guests.

Conversely, the quotations also showed that some patients valued these food safety practices as food safety rationales became a demonstration of security by protecting a guest from other guests. A patient’s intention to help a KP could also be interpreted as an attempt to co-create a hospitality space and reciprocity as patients often acted as a temporary host at their ‘home ward’. However, as the above quotation demonstrates, these attempts were not allowed and such episodes became as such a contested hospitality space.

Efficacy rationales were framed by the 30 minutes that KPs had to prepare meals and to serve 20-30 patients during each meal event. As visualised in figure 3, the efficiency rationale was manifested in serving trays in layers and by stacking plates.

Expressions and signs of efficiency rationales were reflected in patients and HCPs relations to the buffet trolley. One patient articulated this:

“I know that it can’t be different but I think it [buffet trolley] is just like an industrial kitchen – it is not nice at all.”

A HCP expressed his relations to the buffet trolley as such:

“It is just like feeding equipment.”

The above quotations and the images in figure 3 highlight how the buffet trolley, co-created by an efficiency rationale, contested the hospitality ideology by leaving out possibilities for individual serving practices and for mutual recognition of the individual. As such, the buffet trolley became an alienating device, leaving hospital meals as only fuel for the body.

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Fig 3. Serving event. The photo shows how an efficacy rationale was manifested in serving trays placed layer by layer with cutlery and paper napkins.

Efficiency rationales were also carried out through practices related to control and accuracy, made evident by ladles placed in the same corner of each GN container, as visualised in figure 4A. Further, plating practices became part of an accuracy efficiency rationale as meal components were separately placed on the plate and in which drips or food stains were avoided, as visualised in figure 4B.



Fig 4. 4A. left. Buffet trolley ready for serving. Ladles are all placed leaning against the right side of the stainless GN container. 4A right. A plate in which meal components were plated separately. The photos show how accuracy practices became part of an efficiency rationale by regimented ladles and separately plated meal components.

The plating practice connected to the buffet trolley was expressed by a patient as:

“Of course you do not have to use 10 minutes to put a carrot in a nice way - but the cafeteria way where food are splashed on the plate and it is not possible to see what is what – just like they want to hide something - that I do not like. They don’t do it here and it makes a nice experience to be served with a gentle hand.”

This quotation shows that the buffet trolley was also related to a culinary rationale. The embodied movements of plating to avoid plate drips, placing meal components separately and the gentle act of placing the plates on the serving tray was a way in which KPs could exchange honour and share generosity. This demonstrated altruism appreciated as “not in the cafeteria way” or the “gentle hand” acknowledging and empowering the individual patient, which underlines Derrida’s understanding of receiving the guest by openness (Still, 2010).

Free will as a part of a hospitality ideology was sometimes overruled by procedures rooted in nutritional rationales. Most patients at the CW were subscribed to a *normal diet* which limited menu choice and could

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cause problems if dishes that represented the more energy-dense *hospital diet* were more popular than the 'normal diet' menu. On one occasion, a patient subscribed to the normal diet preferred the dish representing the hospital diet and said as such:

“But I am hospitalized, shouldn't I have a hospital diet then?”

At the GW, patients were also nutritionally screened but the nutritional practices were different as the patients' choice became valued more than a subscribed diet. This was expressed by a HCP as:

“Never the less, whether it is patients with low appetite or not we have to take into account what patients prefer.”

Even though patients' choice was valued, nutritional negotiation of patients with low appetites was also practiced in order to enhance eating but also to “give patients a day off”, expressed by a HCP as:

“Sometimes it can be too much – so every time the door goes patients say "Oh no, now you're asking again whether I should have protein drink or another enriched drink" ...and it is too much for themthen we sometimes agree on taking a day off.”

The first quotation demonstrates how patients' free will and the hospitality ideology became contested by nutritional practices in which patients were subjected to a prescribed diet that limited their own choice and in which hospitality became manifested as a duty for the guest to meet their nutritional recommendations. However, the other two quotations show how patients, as guests, were invited to participate in their own nutritional treatment by negotiating menus and by listening to their needs, as such recognising and empowering the individual guest. This was also highlighted when patients were given a “nutritional day off”.

3.3 Transformations of shifting host-guest roles around the buffet trolley

Within the temporal transformation process around the buffet trolley, host-guest relations were negotiated into shifting host-guest roles, in co-creation of meal events, and in a negotiation of a meal community. In these transformation processes, the buffet trolley, plates and cutlery and the meal components co-created possibilities for a hospitality space.

HCPs, KPs and patients co-created shifting host-guest roles. KPs enacted as guests while entering the medical wards in order to serve lunch or dinner. However, they co-created rather differently. Some KPs went down the ward corridor as invisible persons without announcing their attendance whilst others searched for eye contact with HCPs while saying 'Hi'. When entering the buffet trolley a KP might say:

“Here comes the host.”

Just as HCPs sometimes co-created as hosts, KPs at the ward corridor often became guests while standing in front of the buffet trolley ordering meals for bedridden patients. This is shown in the following exchange in which a HCP standing in front of the buffet trolley negotiated with a KP:

HCP: “No pork and no beef.”

KP: “Is it for religious reasons?”

HCP 6: “No.”

KP 3: “How about soup, salad, mashed potatoes and dessert.”

HCP 6: “That will do.”

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This episode shows how the buffet trolley became a device that made it possible to co-create different host-guest roles. Behind the buffet trolley, the KP enacted as a host, acknowledging the guest in front of the buffet trolley by negotiating different meal components. At the same time, the HCP had the opportunity to co-create as a guest, acknowledging the KP's knowledge and recommendations whilst standing in front of the buffet trolley. Patients also co-created shifting guest-host roles. While standing in front of the buffet trolley, they acted as hosts but by helping other patients carrying serving trays, by offering chocolate to HCPs and by offering coffee from the coffee trolley for other fellow patients or for visitors, they became hosts temporarily. A patient expressed this as:

“It is nice that you are able to offer a cup of coffee for visitors, just like at home.”

The above quotations show how the buffet trolley, coffee trolley, serving trays and cups of coffee enabled HCPs, KPs and patients to act shifting host-guest roles. Within this host-guest shift, the coffee trolley became an important artefact for feeling welcome and triggered an imaginary hospitality space similar to that of being welcomed at home. Co-creating shifting host-guest roles is in line with Derrida's conceptualisation of hospitality as dynamic and temporal, opening up new hospitality spaces of mutual recognition and empowerment.

Another hospitality space became negotiated between KPs and patients involving artefacts in the co-creation of meal events. The event in which artefacts such as chairs, tables and napkins participated in creating a hospitality space e.g. the creation of the “café” is an example of that. Further, even though patients were not allowed to touch meal components, they used other possibilities to co-create hospital meals in front of the buffet trolley by negotiating the different meal components and by rearranging the plates and cutlery at the serving tray. Cutlery and plates became, in a way, hosts for patients co-creating hospital meals and empowered patients to create possibilities for a hospitality space.

Finally, a hospitality space was also created when meal components acted as hosts in the creation of a meal community. This is shown in the following serving sequence in which a dish of Goulash became reduced to a stew within four servings sequences around the buffet trolley:

KP: “Who is first? We have a Goulash with rice.”

Patient 1: “Me – sounds good.”

Second serving:

KP: “So it is your turn - what would you like?”

Patient 2: “I would like this.” – (pointing at the GN container with Goulash).

KP: “This stew? Or Goulash as it is called - I have to say it properly.”

Third serving:

KP: “What would you like?”

Patient 3: “I would also like the stew.”

Fourth serving:

KP: “What would you like?”

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HCP: “A stew and a chocolate pudding.”

This serving sequence reveals how a KP acted as a host by asking “who is first?” . The episode could represent a contested hospitality space as the KP as host turns to all four waiting patients and not to the nearest individual patient, disempowering the individual. Further, the transformation of Goulash to a stew could be interpreted as representation for mass customized hospitality encounters, despite the good intentions. In contrast, the episode created a hospitality space as the KP, by turning to all four patients, invited them to co-create a meal community around the dish of Goulash and they accepted to participate. The transformation process created an insider event and a temporary meal community among patients, empowering them in a temporary hospitality space.

3.4 Hospital meals as pop up restaurants

The socio-material assemblages identified above are part of an overall hospital meal experiences in which hospitality become co-created through social and material practices. Altogether, they created temporary ‘pop up restaurants’, which can be characterised as semi-scripted and semi-organised hospitality spaces which enable as well as contest hospitality interactions. The three socio-material assemblages are visualised in figure 5.

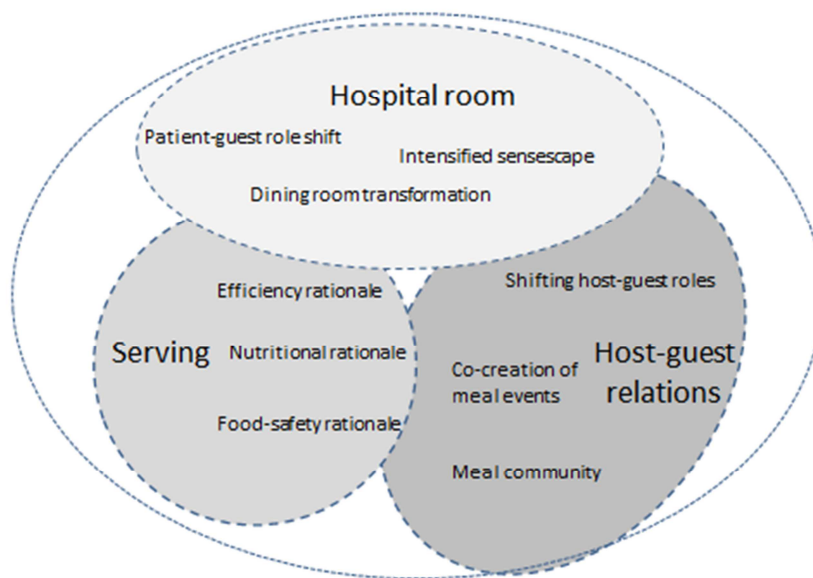


Fig 5. Hospitality within Hospital Meals Assemblages. The figure shows how the hospital meal assemblage could be constructed by three assemblages in which possibility for a hospitality space could be enacted or contested. The three assemblages represent the transformation of the hospital room, conflicting feeding rationales within the serving event as well as different host-guest relations. The dotted line represents the dynamic, temporal and overlapping character of the assemblages visualizing that despite the structural design of this article, the three assemblages’ part of each other. The “Hospital room” assemblage represents transformations of a hospital room to a hospitality space considering transformations of patients, the physical room and sensory character. The assemblage connected to the serving event represented three rationales related to nutrition, food safety and efficiency and the assemblage connected to host-guest relations represents events in which blurred host-guest roles and co-creation of hospital meals were enacted.

The character of ‘pop up restaurants’ underlines Derrida’s conceptualisation of hospitality as temporal and instant. This leaves hospital meals in transition, disrupting and changing the original hospital room into a new temporal structure in which artefacts such as tables and napkins co-created a hospitality space, enabling different host-guest roles.

However, these pop up restaurants often became a contested hospitality space, conditioned and framed by social control, nutritional and efficiency rationales. Attempts to create a hospitality space through mutually acknowledging and empowering the individual was often compromised by invisible hosts, fixed and asymmetrical host-guest relations, and by rationales connected to food safety, efficiency and nutrition. Further, the hospitality space in which culinary and social relations were co-created was compromised by a hospital room not primarily designed for eating events.

Hospitality became fundamentally co-created in incidental situations or by specially engaged or committed HCPs or KPs. However, hospitality in Derrida's terms became possible in fleeting moments where artefacts, HCPs, KPs or patients co-created hospital meals. Such co-creations may be described as 'bricolage' in which different artefacts and activities contributed to the temporary transformation to a hospitality space.

4. Conclusion and implications

The ethnographical exploration of hospitality revealed that by taking a socio-material assemblage approach, new versions of food reality at the ward could be created through the interaction between a guest and the host and that the outline of a new hospitality approach could be seen. Derrida's notion of hospitality provides a valuable framework that could be used to rethink how food at hospital should be. Results demonstrated that co-creation could lead to events that transformed hospital wards into 'pop up restaurants'. These assemblages are collectively co-created by KPs, HCPs, empowered patients or incidental artefacts revealing blurred and shifting host-guest roles and the co-creation of temporary meal communities and welcoming meals. However, host-guest relations unfolding within this temporary stage are contested by asymmetry and rationales, typical of mass customized public meal production systems. True, genuine and unconditional hospitality framing hospital meals might as a first impression be considered an illusion. Nevertheless, the findings of this article demonstrate that hospitality is still a virtue and a goal to strive for. The findings suggest that it is possible to co-create a hospital space in which patients experience mutual recognition through the opportunity to become both a host and a guest. Further, our findings indicate that strategically enabling and integrating hospitality in those hospital meal practices may contribute to improved hospital meal experiences in the future. In addition, they also present a possible strategy for addressing undernutrition at hospitals.

4.1 Implication for practitioners

When acknowledging the significance of temporary hospitality spaces in patients' meal experiences, practitioners should focus on creating welcoming hospital settings in which patients are empowered to co-create meals imitating social and domestic practices while downplaying the disempowering element of food safety, efficiency and nutritional rationales. Instead, they should focus on hospital meals as culinary and socially constructed and also acknowledge shifting host-guest roles.

Such initiatives can be facilitated through revised hospital and foodservice policies that transcend nutritional and functional service properties. This includes communications strategies that seek to make it possible for foodservice and hospital meal organisations to become more visible as hosts and design strategies that open up spatial settings, empowering patients to actively contribute to meal room transformations in terms of creating a meal community, shifting host-guest roles and an ability to take part in one's own nutritional treatment. Inspiration could be gained from recent research on hospital meal design (Tvedebrink, Fisker, & Kirkegaard, 2013) or the established restaurant industry, which has been at the forefront of implementing insight from physical and sensory design in previous years (Zomerdijk & Voss, 2010).

Further, this calls for hospital meal competencies among professionals. These competencies could be characterised by an ability to represent the hospital and foodservice organisation as hosts while at the same time being able to negotiate and to co-create hospital meals, creating a hospitality space based upon patients' immediate approach towards the hospital meal experience.

4.2 Implications for further research

However, further research is required. This comprises research on how new hospitality food policies, communication strategies and new hospital room designs could empower foodservice and hospital organisations to become more visible and welcoming hosts, whilst at the same time creating the possibility for patients to participate in the process of transforming the hospital meal room and to shift blurring host-guest roles.

Further, this call for research on hospital meal competencies among professionals that focus on hospital meals as social and as culturally constructed, creating a space for social exchange rather than a conditional space for social control, is also needed. Finally, these research aspects need to be addressed and correlated with new research on undernutrition.

Acknowledgments: We would like to thank Holbæk Hospital, Koncern Service Køkken, staff and patients. Also thanks to Dr. Enni Mertanen, Principal Lecturer, JAMK University of Applied Sciences for comments. The authors declare no conflict of interest.

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Paper III: Moment of Hospitality – Rethinking Hospital meals through a Non Representational Approach

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Moments of hospitality: Rethinking hospital meals through a non-representational approach

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Abstract

Hospital meals have increasingly become part of the political and scientific agenda of the welfare discussions in Denmark and other European countries. This article employs non-representational theory to analyse hospitalityscapes in order to explore opportunities for adding value to the hospital meal experience. By drawing on research carried out in two Danish hospital wards, this article explores how hospitalityscapes are socio-materially constructed. The research strategy was based on performative participant observations, visual ethnography and semi-structured interviews. The empirical data reveal how the daily atmosphere could be changed by social activities such as a dancing nurse, or through artefacts such as meatballs or napkins in disruptive micro-events, creating a possibility for different hospitalityscapes manifested in cultural, humorous or social performances. The article suggests that a focus on disruptive micro-events might create opportunities for hospitalityscapes and add value to future hospital meal experiences.

Keywords

hospital meals
hospitalityscapes
non-representational theory
hospital meal experiences
micro-events
atmospheres

Introduction

The notion of hospitality has recently been reintroduced as a conceptual framework applied in research, aiming at improving the hospital meal experience and, ultimately, to counteract malnutrition during hospitalization (Beermann and Holst 2010; Rasmussen et al. 2004). However, the reintroduction of hospitality within the research discipline of the science dealing with meal and food service has only been the subject of abstract scientific debates and enquiry to a limited extent. So far, the application of the hospitality approach in hospitals has been inspired by a Kantian thinking of hospitality as conditional and asymmetrical, reflected in patients being considered as guests and health care professionals (HCP) as hosts (Beermann and Holst 2010; Hartwell et al. 2013). This perspective considers meal experiences and host–guest relations as static exemplified in the host’s ability to stage a defined ‘at home environment’, ‘appropriate atmosphere’ and meal experiences by scripting a physical interior or staff appearance (Edwards and Gustafsson 2008; Hartwell et al. 2013).

Criticism of this normative and static perspective of hospitality includes that it fails to consider the possibility that hospitality, including host–guest relations, might be more dynamically constructed and that materiality in itself might create agency and contribute to different experiences of atmospheres and hospitality meal experiences. This calls for a shift in the ontological approach and lead us to a more dynamic approach towards materiality and social interactions with a focus on enactments. With the term ‘enactment’ we put emphasis on activities where both persons and material elements are involved, bringing new temporal structures and possibilities into existence (Weick 1988).

This shift in the ontological approach might be met by drawing on Derrida’s approach towards hospitality that allows hospitality to be studied as dynamic, relational and temporal (Derrida 2000; Dikeç 2002; Still

2010). However, as Derrida's hospitality approach is mainly based upon interpersonal relations in general, it restricts the possibility to consider the possible agency of the material world and, as a result, its application in the context of hospital food service. The way napkins are folded and breakfast plates are arranged are examples of material agency. This perspective might be facilitated by including contemporary knowledge gained from the interdisciplinary research area of hospitality studies as well as employing Non-Representational Theory (NRT) as a theoretical frame. In line with this, and in seeking new ontological perspectives on hospital meal experiences, this article aims to explore how hospitality becomes enacted within hospital meals and to discuss how this perspective might bring new possibilities into hospital food service.

Introduction to NRT

NRT leads to a focus on materiality, pre-cognition, affects, atmospheres and events, allowing a dynamic approach towards materiality and social interactions. NRT is a way of thinking within human geography, developed largely through the work of Thrift and Dewsbury (Cadman 2009). NRT is founded on a post-structuralist paradigm and is distinct from social-constructivist theories by considering that not only human interactions take part in constructing reality through cultural representations and shared meanings. Instead, NRT claims an ontology assigning agency to both humans and non-humans, giving the same agency to materials such as napkins or meatballs as co-creators of hospitality. Further, NRT considers precognitive actions that cannot necessarily be interpreted as intentional or cultural representation, structured by symbols and meanings (Anderson and Harrison 2010; Thrift 2007). In a hospital meal context, it could be exemplified by the embodied way of handling the knife and fork before eating or simply the way we walk. Anderson (in Anderson and Harrison 2010) argues that the focus on precognitive actions in NRT thinking must be conceived via embodied and environmental properties and therefore on practices. Thrift (2007) emphasizes this by quoting Deleuze and Guattari: 'we know nothing of a body until we know what it can do'. A 'body' in a Deleuzian world represents both human and non-human elements, and the focus on what bodies can do leads to an NRT approach that is relationally materially constructed. For example, the practice of pouring a glass of water can be considered a drinking action, but can also be related to a medical treatment or a previous experience at work.

NRT also draws attention to 'bodies' as affects and atmospheres (Anderson and Harrison 2010). Affect is defined by Thrift (2007) as a 'set of flows moving through the bodies of humans and other beings' that, in NRT thinking, are composed of pre-personal intensities explained as non-conscious experiences that differ from emotions and feelings. Affect is as such manifested as every form of communication whereby facial expressions, tone of voice and postures are perceptible. In contrast, emotion addresses inter-subjective expressions of intensities as anger or joy (Edensor 2012). As such a patient's facial expression of pain can affect me and maybe lead to an emotional state of compassion.

Affects and emotions can be considered as embedded into each other and inherent in the notion of atmosphere (Anderson and Harrison 2010). According to Böhme (2002: 5), atmosphere can be characterized by 'a certain mental or emotive tone permeating a particular environment but also the atmosphere spreading spatially around me in which I participate with my mood' (Böhme 2002).

This means that the phenomenon of atmosphere is placed as an intermediate between the subject and the object so that it is not only possible to experience atmosphere in terms of one's own emotional state, but also to approach atmosphere from a side in which atmosphere has been staged (Böhme 2013, 2002). Creating an atmosphere of conviviality by laying dinner tables with candles, tablecloths and napkins is an example of a staged atmosphere. However, independent of the cultural-relative character, atmosphere can also be experienced as a surprise or an occasion that brings in a more dynamic approach and allows atmosphere to be co-produced and not just staged or considered as culturally or socially constructed, or with a need for a semiotic read (Böhme 2013; Edensor 2012).

The focus on atmospheres leads to the attention on events. An event in NRT thinking provides a focus of 'potentialities of being, doing and thinking what events may bring forth' and a possibility 'to explore contingency and the relations between ordering and change' (Anderson and Harrison 2010). According to Whitehead (1920), an event can be understood as a complex of passing events that differ continually and at the same time are related to other ever-changing events, which principally have no beginning or end (Whitehead 1920). In a Deleuzo-Guattarian way of thinking, these ever-changing events become manifested as bodies in a constant flow of becomings. However, Anderson and Harrison (2010) argue that events must be seen in breaks or changes that happen within these ever-changing events, suggesting that it is during these breaks that the possibility of thinking differently is created and that these breaks can be found by focusing on how practices repeat and reproduce themselves. A person suddenly dancing down the ward corridor or a new way of arranging breakfast trays might become such breaks or changes in the everyday events.

Expanding a social-constructivist hospitality approach with non-representational approach

Derrida's hospitality approach is characterized as 'unconditional hospitality' developed on the basis of Kant's 'universal law of hospitality' (Derrida 2000; Lynch et al. 2011). Where Kant's hospitality approach lies on the condition of juridical law of hospitality, reciprocity, duties and obligations, Derrida introduces 'pure' hospitality as ethical and unconditional, implying to welcome anyone unconditionally whoever the stranger may be (Bell 2007a; Derrida 2000; Lynch et al. 2011). Dikeç (2002) elaborates on Derrida's hospitality approach by taking a point of departure in Derrida's four statements of hospitality expressed as 'we do not know hospitality', 'hospitality is not present being', 'hospitality as not yet' and 'hospitality as self-contradictory' (Dikeç 2002). As such Derrida (2000) claims hospitality to be an experience beyond objective knowledge as we do not know beforehand how to meet a stranger with hospitality, and therefore we do not know hospitality. Further, Derrida claims hospitality to be temporal, as the experience of receiving or giving hospitality can only last an instant and is therefore not a present being (Derrida 2000; Dikeç 2002). The statement of hospitality as 'not yet' refers to the need for opening up the notion of hospitality and to transcend the traditional way of understanding hospitality as conditionally reflected in duties and obligations, and therefore we do not know hospitality 'yet'. The last of Derrida's statements refers to the self-contradictory nature of hospitality as a host who, in order to be able to receive a stranger, must have sovereignty of his house, which in principle makes purely unconditional hospitality impossible (Derrida 2000; Dikeç 2002). Based upon these statements, Dikeç (2002) elaborates on hospitality as an act of engagement through mutual recognition of each other's alterity. By this Dikeç (2002) wants to exceed the conventional and stable understanding of host-guest relations by opening up boundaries, thereby changing the closed conceptualization of host and guest as being distinct and stable categories into a more open conceptualization where host and guest are constitutive of each other, entailing hospitality to be conceptualized as dynamic, temporal and relational, and the host-guest relations as blurred (Dikeç 2002).

The above presentation of Derrida's hospitality approach shows a focus on interpersonal relations that must be understood as a response to Kant's juridical hospitality approach. Therefore, it might be helpful to expand Derrida's hospitality approach by including contemporary knowledge gained from the interdisciplinary research area of hospitality studies, as it allows elaborating on a hospitality approach.

Lashley (2000) builds up a theoretical framework for the study of hospitality and introduces hospitality as activities in which social, domestic and commercial domains are shown to be independent but also interwoven with each other (Lashley 2000). As such Lashley (2000) allows considering how HCPs transfer culturally learnt norms and other social practices such as host performances between the domestic and commercial hospital domains. Telfer (2000) adds to the work on hospitality and she suggests that a good host is not just skilful and attentive but also hospitable, and she explains that becoming hospitable comes from a genuine desire to care for and please others (Telfer 2000).

The discussion on the blurred and relational character of host-guest relations has been presented in O'Mahony's (2007) description of how Irish immigrant guests become enrolled in the hospitality sector as

hosts (O'Mahony 2007) as well as in Bell's (2007b) description of train hosts' and passengers' interchangeable host–guest roles (Bell 2007b). The relational aspect of host–guest relations is also presented in Lugosi's (2008) attention to guest–guest relations in which people may be both hosts and guests simultaneously (Lugosi 2008).

Di Domenico and Lynch (2007) introduce Commercial Home Enterprises as performative settings in which artefacts and symbols are 'staged' and used in the interpretation of hospitality space (Di Domenico and Lynch 2007). In their conclusion, they stress that the home setting is not statically staged but an active participant in the host–guest process (Di Domenico and Lynch 2007).

The temporal, emotional and unpredictable aspects of hospitality are presented by Lugosi (2008). Lugosi (2008) introduces 'communitisque moments' as a concept to explain 'anti-structure experiences' in terms of a liminal space of symbolic detachment from societal norms built out of short-lived emotional bonds (Lugosi 2008). Lugosi (2008) distinguishes 'communitisque moments' characterized as 'meta-hospitality' from more rational manifestations of hospitality transactions derived from social and political purposes (Lugosi 2008).

Also, Sheringham and Daruwalla (2007) introduce an 'anti-structural' space of hospitality by considering hospitality as a 'carnavalesque' social construction with reference to the Russian philosopher Bakhtin (Sheringham and Daruwalla 2007). Here a 'carnavalesque' social construction signified the idea of a caricature of the life that opposes hierarchy and authority. It is a free space for laughter where conventional norms are abandoned (Bakhtin 1984, cited in Sheringham and Daruwalla 2007).

An NRT approach can be comparable with both Derrida's philosophical approach to unconditional hospitality and contemporary hospitality scholars by considering hospitality as situated and negotiated, which also allows for considering host–guest relations as dynamic and blurred (Bell 2007b; Di Domenico and Lynch 2007; Lugosi 2008; O'Mahony 2007; Sheringham and Daruwalla 2007). However, an NRT approach would go further by claiming the ontology of hospitality to be situated and negotiated not only by humans but also by non-human actants. This expands Derrida's focus on interpersonal relations and provides new facets of hospitality interactions and host–guest relations as shown by Di Domenico and Lynch (2007). Further, NRT is distinct from Lugosi's (2008) 'communitisque moments' and Sheringham and Daruwalla's (2007) 'carnavalesque approach', as NRT claims an ontology that is distinct from the idea of structure versus anti-structure. Instead, an NRT approach focuses on differences and dynamic intensities of events and atmospheres. The embodied and affective aspects gained from an NRT approach but also from Lugosi's (2008) 'communitisque moments' have further been presented in Rakić and Chambers' (2012) study on consumption of tourist places in which they argue that places are consumed and constructed in simultaneous processes that involve embodied, multisensory, cognitive and affective processes (Rakić and Chambers 2012).

The tension between NRT and a hospitality approach lies in the discussion of essence in terms of the existence of an 'is' rather than viewing everything as 'in becoming'. Whereas an NRT approach would be purely relational and emergent, a hospitality approach based upon Derrida would focus on the existence of 'the stranger'. Therefore, a hospitality approach seems to be less emergent than an NRT approach reflected in the existence of a host and a guest, despite the relational character. Bringing NRT into a hospitality frame, allowing hospitality to be considered as relational, situated and negotiated by both human and non-human actants calls for a hybrid analytical framework that provides an opportunity to explore atmospheres, events, affects and embodied practices of hospitality.

Hospitalityscape as an analytical frame

In order to develop an analytical frame that enables us to connect an NRT with a hospitality approach, we apply the idea of 'scapes'. We define a 'hospitalityscape' as:

Continually and temporally created in concrete events where different elements assemble, 'in which' some become temporal hosts and others become temporal guests acknowledging each other's alterity.

In this definition, 'continually' refers to the emphasis on the flow of everyday practices, whereas 'temporally' refers to the unstable character of hospitality that allows us to consider it as changeable and open. The aspect of 'concrete events' refers to an NRT emphasis on events that break with the everyday flow. Further, the 'different elements assemble' refers to the anti-structural NRT approach, which, from a hospitality perspective, allows considering the material aspects of hospitality, diversity of performances and embodied precognitive practices. Further, the aspect of 'different elements assemble' allows considering affective and emotional elements as 'carnavalesque' performances as suggested by Sheringham and Daruwalla (2007) or 'communitas moments' as introduced by Lugosi (2008). The last element of hospitalityscapes involves the blurred and dynamic aspect of host-guest relations introduced by Derrida. This allows a focus on the dynamic aspect of hospitality, and on the multiple spatial, material and representational practices that constitute it. As a result, our idea of a hospitalityscape understands the hospital setting not only as a place that is constructed by material, affective and social interactions, but also as open and changeable rather than closed, allowing a focus on hospitality possibilities.

A similar conceptual frame has recently been introduced by Lugosi (2014). In a multi-sited ethnographic study of a ritualized hospitality event [The Church], Lugosi (2014) introduces the notion of inducement, referring to the continual mobilization and configuration of organizational and customer resources, subcultural values, representational acts and embodied performances in order to co-create hedonic experiences (Lugosi 2014). The notion of inducement as a collaborative production/consumption of hospitality experience is a powerful analytical tool that enables simultaneously to consider representational, material and performative hospitality practices, rather than isolated features or dimensions. However, the conceptual frame of inducement is distinct from hospitalityscapes because the former focuses on the identification and classification of various practices of inducement, rather than on the conceptualization of inducement processes themselves, whereas the latter, by including the notion of events, also seeks to conceptualize hospitalityscapes.

Conducting research based upon a non-representational approach

An established research methodology related to NRT has not yet been introduced. However, a performative research approach has been suggested (Dewsbury 2010; Lorimer 2005). A performative research approach can be seen as a search for the immediate, embodied, present moments, with a focus on agency and events that disrupt everyday practices, but which downplays individual meaning and values (Dewsbury 2010). Dewsbury (2010) suggests a metaphorical 'studio' in which the researcher conceives the research process as an experiment. Here, the researcher attempts to 'sense the now' by adapting an unstructured observation strategy (Dewsbury 2010). A performative research approach has been applied by Vannini (2012), who explored mobility and the 'sense of place' by conducting ethnographic montages in which interviews and participant observations were condensed into small stories (Vannini 2012). Further, Morton (2005) explored the 'sense of now' at an Irish music event through unstructured observations focusing on the actual event. Morton (2005) used observant participation in terms of talking, sensing, listening and feeling, connected to audio recording, spoken diaries, photographs and videos (Morton 2005).

Studying hospitalityscapes within hospital meals

Inspired by Lorimer's (2005) and Dewsbury's (2010) suggestions of a performative research approach as well as Vannini's (2012) and Morton's (2005) methodological approaches, the first author of this article conducted an ethnographic study in a gynaecology ward (GW) and a cardiology ward (CW) of a Danish public hospital during the spring and fall of 2012. The food service system at the hospital was based upon

cook-serve and bulk trolley systems in which kitchen professionals (KP) served lunch and dinner. The data collection for this article was gained from the first three months at the GW and unfolded as a strategy based upon performative participant observations, visual ethnography and semi-structured interviews by the first author.

The participant observation strategy became performative as an ‘experimental studio’ was constructed with inspiration from Dewsbury (2010), allowing the researcher to engage with the ward day, evening and night, searching for the immediate, embodied and present moments, and inspired by sociological impressionism (Lynch 2005), the researcher’s own experiential feelings from the observations were captured, leaving out any planned or structured focus on meals or hospitality. A temporary working place at the end of the ward corridor was established and, similar to the ward secretary, the researcher became part of the daily working routine at the ward, visiting patients and helping whenever needed. Being on the ward corridor enabled the researcher to interact with patients, HCPs and visitors, and her own engagement capturing the experiential feelings of being at the ward was followed by a reflexive process while writing field notes. Here she tried to describe and reflect on her personal experiences in terms of what happened, how she got emotional touch and how it affected her relative to her expectations.

The second component was based upon visual ethnography as part of the performative participant observation strategy. Inspired by Pink’s (2007) reflexive visual approach, the researcher used digital photography, photographing embodied performances at the ward (Pink 2007). In total, more than 200 photographs were taken. The process of photographing helped describing everyday activities and opened up for reflections during the subsequent field note writing.

The third component was based on 22 semi-structured interviews with HCPs as well as patients. The interviews sought to obtain an understanding of everyday practices and experiences of hospital meals by asking questions like: ‘describe what happens during lunch time’ or ‘what do you do during lunch?’

The analytical strategy consisted of an identification of everyday practices and atmospheres followed by an identification of how these practices repeated and reproduced themselves. This was done by reading field notes, reviewing photographs and reading transcribed interviews followed by a process of identifying themes containing descriptions of everyday practices, and how they affected the researcher or other informants. First an everyday atmosphere was identified, and then a search for themes containing disruptive micro-events (breaks) that differed from everyday practices and that created different insensitive atmospheres was carried out. The identification of these events was based upon a search for themes that did not meet the researcher’s own or the informants’ expectations. Finally, hospitalitiescapes were identified in these unexpected events. The identification was based upon analysing socio-material hospitality enactments in terms of different performances, embodied movements, material agency and different host–guest relations.

Emerging hospitalitiescapes – Everyday atmospheres at the ward

The everyday atmosphere at the ward was identified as ‘accommodating silence’. Here the notion of ‘silence’ does not refer to anechoic silence but was more akin monastic, contemplative silence. The atmosphere of ‘accommodating silence’ was characterized by the HCPs’ silent but determined way of walking whilst welcoming patients with a smile. This gave a clear impression of the ward as a place assigned to nurse-caring and professional health work. The ‘accommodating silence’ was also characterized by other patients’ embodied movements at the ward. This was reflected not only in patients’ way of dwelling with a cup of coffee filling the ward corridor with a smell of morning coffee, chatting or reading magazines, but also in the relaxed activity around the coffee-trolley that was placed in the middle of the ward corridor. Here patients and visitors could help themselves to coffee, fruit and snacks. Also fresh cut flowers placed at the secretary’s desk and artwork on the walls gave an impression of an accommodating and welcoming ward.

The ‘silence’ was characterized by the buzzing sound from the freezer placed at the end of the ward, the whirring venting system, the occasional sounds from patients’ call devices, the sound of rolling beds and stainless steel trollies, and the occasional laughter from the HCPs’ coffee room. The ‘silence’ aspect was not

only represented by sounds but was also a 'medical sensescape', which filled the ward with a distinct hygienic and medical feeling: the white- and light blue-coloured walls, a neutral medical smell, the cleanliness and tidiness of the patients' room and at the wards where trolleys with blood pressure measurement devices were placed side by side at one end of the ward corridor and chairs and tables placed at the other end. The 'medical sensescape' was also represented by the HCPs' white and buttoned uniforms, and sometimes also by patients in white hospital dresses leaning forward with a facial expression showing pain. These sensorial and embodied elements together created the daily atmosphere, familiarity and 'heartbeat of the ward' and were part of the ever-changing events described by Whitehead (1920). The experience of 'medical silence' has previously been described by Rice (2003) who emphasizes that sounds are vital for patients' possibility to orientate themselves in a social, material and spatial sense, as other sensory modalities get deprived in a hospital context (Rice 2003).

This atmosphere of 'accommodating silence', however, could suddenly change. The next paragraphs present two events, the first described as the 'joyful atmosphere' in which the 'accommodating' part predominated, and the second described as the 'compassionate silence' representing the more 'medical silence' of the everyday atmospheres.

One of the most surprising events took place one afternoon just before an HCP (for the purpose of this article named 'Nanna') was about to finish her day as she was off to attend a date that she was excited about.

I was sitting at my table reading when Nanna walks out of the HCPs' office. Suddenly and as a surprise, she starts singing, dancing, and spinning down the ward corridor. In that moment the atmosphere changed into one of joyful energy. Her embodied light movement and her way of filling out the ward corridor changed the ward's 'soundscape' by downplaying the buzzing sound from the freezer and the venting system as well as downplaying the institutional light-blue stripes at the ward walls. Instead, the ward 'soundscape' became filled with human activity as HCPs were laughing and their voices rose cheerfully while they went into patients' rooms with lighter and faster steps, asking them if they would like coffee or if they needed any help. Furthermore, patients not condemned to beds popped out from their rooms and attended the coffee-trolley or the sitting area whilst chattering.

Another visible event occurred another morning and changed the everyday atmosphere of 'accommodating silence' into an atmosphere of 'compassionate silence':

As I attended the ward, I immediately sensed that something was wrong. The ward seemed emptier than usual, with no patients dwelling with a cup of coffee in the sitting area, no occasional laughter or the familiar sound from the freezer and the venting system. The HCPs walked slowly and silently into patients' rooms and everyone seemed to whisper. At the corridor just outside room number 7, I could see a HCP talking with a low voice to a man whilst two children, approximately four and seven years old, were watching the conversation with silence. I went into the HCP's office and realized that the man in the corridor was a husband with two children and that their mother had been re-hospitalized during the night. I was told that her condition was 'not good at all'. The ward seemed particularly empty and the buffet-trolley, which had become a meeting place for patients, was transformed to a lonely and clinical coffee device trolley as no patients entered the ward corridor for coffee or drinks.

Although this event was a surprise to the researcher, the HCPs knew that this could occasionally happen. An HCP reflected on what she called 'the silent days'.

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Yes – it gets quiet. We do not talk about it, but we can just sense that it is one of these days. It is one of these days when patients take their serving trays with them into their rooms and shut their doors. (HCP 1)

The other and more joyful event described above was also expressed in general terms by an HCP.

I think it is nice that you can hear something. That there is life and someone is enjoying themselves. (HCP 2)

These atmospheres of mental and emotive tones described as joyful and compassionate permeated the hospital ward and became events that broke with the everyday 'accommodating silence'. In line with Rice (2003), the sensory perception of the ward was in particular attributed to the change in sounds. Singing and talking cheerfully became part of the 'joyful atmosphere', whereas whispering sounds became a part of the 'compassionate silence' atmosphere. The two events that created two different atmospheres led to the emergence of new hospitalitiescapes. In the joyful event, the sudden dance was recognized by the other HCPs as they entered the ward corridor with recognizing smiles, creating a hospitalitiescape of recognition in line with Derrida's hospitality approach, and it opened up boundaries for a new understanding of professional performances as the dance event broke the everyday monotony and became a 'carnavalesque' space as presented by Sheringham and Daruwalla (2007). Also, Derrida's understanding of hospitality as temporal and relational in terms of 'not knowing hospitality – yet' was displayed as the dancing in that particular moment became 'the yet – of knowing hospitality'. Moreover, the joyful event opened up opportunities for social activities and promoted new host–guest relations. This became evident as patients came out of their rooms and gathered around the coffee-trolley enacting simultaneously host and guest by helping each other with coffee and snacks in line with Lugosi's (2008) attention to guest–guest relations and how people may be both hosts and guests simultaneously. Also Lugosi's (2008) presentation of hospitality as 'communitésque moments' can be applied in this event by the spontaneous chattering in the guest–guest relations and by the HCPs' open laughter and embodied way of moving, transcending a scripted serving hospitality approach that was not only assigned to political and social hospitality purposes and in which medical treatment became downplayed for a moment.

When the joyful event became a representation of a hospitalitiescape with focus on joyful social guest–guest relations, the 'compassionate silence' changed into a hospitalitiescape characterized by isolated compassionate host–guest relations between HCPs and patients and by a grieving community preparing to say goodbye to a family member. Further, it was characterized by culturally learnt rituals and an understanding of how to enact sorrow and grief. This was transformed and expressed in a collective host performance in search of recognizing and acknowledging the family in room 7. The impossibility of hospitality expressed by Derrida is evident here as culturally learned rituals and the understanding of grief and sorrow permeated the hospitalitiescape in search of acknowledging the family in room 7, but it downsized hospitality to a mutual recognition of other patients as guest and stranger. However, the isolated compassionate host–guest relations might conversely enable opening up boundaries for enacting hospital meals as caring and as more than part of a medical treatment and a hospital stay. The caring aspect of hospitality is also reflected in Telfer's (2000) suggestion of hospitable behaviours as motivated by genuine need to care for and please others, which is also reflected in the close connection of the words hospitality and hospital (Selwyn 2000; Telfer 2000).

Emerging hospitalitiescapes – disruptive micro-events

The atmosphere of 'accommodating silence' was sometimes transformed into temporary local atmospheres of tension and intensities by different socio-material performances. The following paragraphs present three disruptive micro-events where home-made meatballs, yellow napkins and cornflakes enacted different

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temporary hospitalityscapes that opened up boundaries for experiencing hospital meals as relations to home, as ritualized and aesthetic performances, and as joy and laughter whilst temporarily downplaying the medical and nutritional aspects of meals.

The first micro-event took place in front of the buffet-trolley at lunchtime:

One day the atmosphere around the buffet-trolley seemed discouraged as an elderly woman seemed to be in a state of pain. When the KP asked what she would like for lunch, the elderly woman remained silent. Suddenly, the KP broke out with a clear voice and a smile and said: ‘It is home-made meatballs. We have made them ourselves this morning – they are good – why don’t you try?’ The rather large meatballs appeared hot but still crunchy and round without being completely round. The situation changed within a second, filling the room with energy and tension. Other queuing patients reacted by turning to each other and with amazed expressions commented on the meatballs. The elderly woman changed her painful appearance and smiled. Suddenly everyone was discussing meatballs. Even an HCP turned around and rushed to a patient’s room to inform her that the meatballs were home-made, and two queuing patients went on talking while walking away with their serving trays together.

In this disruptive micro-event with home-made meatballs, the KP and the meatballs enacted hosting due to the meatballs’ homely appearance and the KP’s sudden embodied and emotional host performance. This created a hospitalityscape that opened up boundaries for relations towards a traditional Danish food culture and to home as something well-known and secure. Further, it shows how commercial and domestic hospitality is intertwined with each other as suggested by Lashely (2000). In addition, it showed a hospitalityscape marked by blurred host–guest relations giving the meatball and HCP host agency, stressing the relational character of hospitality as presented by O’Mahony (2007) and Lugosi (2008). The emotional and unexpected outbreak performed by the KP and the subsequent guest–guest interactions became a serving event that transcended hospitality as a political or social purpose into a hospitalityscape of ‘meta-hospitality’ (Lugosi 2008).

The next socio-material micro-event describes how a yellow napkin and breakfast at springtime created a local intensified atmosphere.

I arrived earlier than usual to the GW and went into Jane’s room. She smiled and nodded towards her breakfast tray in which a yellow napkin was folded across the serving tray, transforming the serving tray into a breakfast table and the napkin into a table cloth. In that moment, the sun went into the room and it was as if the sun was targeting the glass with orange juice, and the yellow napkin filled the room with light and warm atmosphere. Jane changed her dialect to a local dialect while praising her breakfast and stating how much she felt like eating and that she had nearly eaten the whole meal. Like Jane, the warm and light atmosphere touched me. (see figure 1)



Figure 1: Serving tray representing Jane’s breakfast at springtime.

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In this ‘breakfast at spring’ event, the yellow napkin as well as the sudden sunlight gained host agency by enacting a hospitalityscape, which made it possible to relate breakfast to ritualized, symbolic and aesthetic hospitality performances. As the event contrasted, the everyday breakfast trays that normally had a white napkin folded beside the plate, the event itself became a hospitalityscape meant to acknowledge the patient as an individual. Further, the transformation of a napkin into a table cloth and the ritualized way of placing the tablecloth across the table in order to create an aesthetic expression, as well as the choice of the yellow colour with the symbolic meaning of spring, opened up a gateway to either a domestic or a commercial restaurant hospitalityscape, thereby temporally detaching the patient from a focus on hospitalization, nutrition and the necessity of eating. As Jane articulated the event as a way of motivating her to eat, it is debatable whether this event could be characterized as rational service transactions with a functional goal. The sudden and unexpected sunlight changed the event into an emotional hospitalityscape filled with the symbolic meaning of spring. Here the event could correlate with Lugosi’s (2008) descriptions of ‘meta-hospitality’.

The last socio-material micro-event involved among other things cornflakes:

That day I just went into the GW for a short visit as I was going to conduct a focus group interview with KPs in the kitchen later this morning. As usual, I went into Jane’s room. She appeared delighted and proudly displayed two breakfast images while saying: ‘And of course, I had to taste them and I almost ate the entire hair’. She then laughed. Cornflakes, raisins and banana were transformed into a clown-like-face on the first plate, and cheese, marmalade, orange, chocolate and pineapples were transformed into a smiling Dracula-like face on the other plate. (see Figures 2a and 2b)



Figure 2a (left): Breakfast transformed to a clown head. **Figure 2b (right):** Breakfast transformed to a Dracula head.

This ‘cornflakes breakfast’ event created other hospitalityscapes that transcended cultural norms and rituals of how to present breakfast as the cornflakes were not traditionally arranged on a plate. Instead, the cornflakes were arranged as a clown head. The cornflakes and the clown head became a temporal host enacting a hospitalityscape, which opened up possibilities for humorous and imagined elements and ‘carnavalesque’ as introduced by Sheringham and Daruwalla (2007), and the cornflakes clown head became a host symbolizing the idea of a caricature of the hospital stay opposing hierarchy and authority. As such the hospitalityscape created a possibility to distract attention from an alien and seriously hospitalized situation and form hospital meals as either part of mechanical service transactions or nutritional strategies interwoven into cultural norms of how to eat. Like the napkin in the ‘breakfast at spring’ event, the cornflakes and the clown head gained agency and as such became active participants in the creation of a hospitalityscape, as

similarly emphasized by Di Domenico and Lynch's (2007) description of a home setting, which was not statically staged but an active participant in the host–guest process.

Discussion: Possibilities for hospitalityscapes within hospital meals

This article shows that hospitalityscapes are emergent socio-material constructions. It shows how different elements like artefacts, moments, unexpected events, embodied movements and expressions together participated through their relations to each other in creating different ward atmospheres or more local disruptive micro-events that enabled different hospitalityscapes. For instance, the sudden dance event, the change of soundscape at the wards, and the introduction of home-made meatballs created possibilities for shifting host–guest roles and sociability between patients. Sociability as a means of increasing hospital meal experiences and food intake among undernourished patients has been emphasized in several hospital studies (Edwards and Hartwell 2004; Hartwell et al. 2013; Holm and Smidt 2000; Johns et al. 2010; Larsen and Uhrenfeldt 2012). However, these studies explore sociability in relation to structured eating events such as lunch and dinner, whereas this article also considers the possibility of sociability within the serving event and in other unexpected events outside structured meal times. Nevertheless, as the event of the 'compassionate silence' indicated, there are moments where the possibility for hospitalityscapes as sociability are downplayed and changed into more focused social relations between HCPs and patients. This is represented by the two different breakfast events that created other possibilities for hospitalityscapes in terms of either opening up boundaries for hospital meals as culturally, ritually and aesthetically constructed, or, on the contrary, opening up boundaries for hospital meals to become 'carnavalesque' in terms of transcending the meals as part of mechanical service transactions or nutritional strategies interwoven into cultural norms of how to eat. The notion of the 'carnavalesque' and laughter in connection with hospital meals have not yet been extensively studied, although several studies found that hospital meals may be used as a means to express dissatisfaction or frustration of being hospitalized (Holm and Smidt 2000; Johns et al. 2010), or as a means to create nostalgic memoirs (Justesen et al. 2014). This potential for transferring homely environments in terms of relating hospital meals to home, manifested in cultural well-known menus, has also been stressed in other studies (Holm and Smidt 2000; Johns et al. 2010).

Introducing an NRT approach enables a focus on hospitalityscapes in different atmospheres and disrupted micro-events. Here, daily practices and unexpected events take place on the basis of initiatives by HCPs to tell stories or dance or by yellow napkins and springtime, which lead to new potentialities for creating hospitalityscapes. The focus on unexpected events is in line with Derrida's (2000) hospitality approach as 'we do not know hospitality – yet' and as such becomes a significant element in a hospitalityscape. It brings in a certain degree of unpredictability, which challenges hospital organizations' comprehensive and necessary use of quality management systems in terms of standards, rules and procedures that are also transferred to hospital meal provision in terms of food-safety regulations, nutritional screenings and monitoring procedures.

Practical implications

This leads to a discussion on how hospital and food service organizations can enhance hospitalityscapes within a hospital meal frame, and how they can balance between structured clinical produces and providing a hospitalityscape, allowing hospitality to become the unknown and unexpected. A focus on the importance of recognizing the potential of the disruptive micro-events and their capacity to transform the ordinary ward atmosphere, as well as allowing both HCPs and patients to individually enact different hospitalityscapes might enable that balance. Lugosi's (2014) notion of inducement where hospitality experiences can be conceptualized through spartial, material, performative and representational practices is potentially relevant for hospital organizations as well. Combined with this study's focus on intensive atmospheres and disruptive micro-events, the inducement framework may contribute to improvements in co-created hospital meal experiences. This calls for the development of hospitality meal competencies among professionals.

Hospitality meal competencies could include the ability to enact disruptive micro-events that might enable a relation to cultural, ritual or aesthetic meal experiences, to sociability or to ‘carnavalesque’ experiences, which can again shift attention from thinking of hospital meals as simply being either part of mechanical service transactions or nutritional strategies.

Focusing on a hospitalityscape within disruptive micro-events might enable meal experiences that do not necessarily require the allocation of economic resources. By this, we are not trying to disregard or override the importance of allocating economic resources to hospital food service provision, considering the significance of hospital meals for patients’ well-being and process of recovering (Kondrup 2001), nor do we seek to downplay the importance of hospital architecture and meal design. On the contrary, we advocate for flexibility within food service systems and call for hospital meal architecture that enables hospitalityscapes to become enacted as unexpected events as well as enable possibilities for sociability and ‘communitasque moments’, cultural, ritual and aesthetic meal performances and to open up hospital meals as ‘carnavalesque’ experiences. The lack of design as an overlooked element in a hospital meal context has recently been discussed by Tvedebrink et al. (2013). They stress the importance of a holistic design approach, emphasizing the contextual, ritual and social meanings rooted in architecture as a means to create aesthetic meal experiences in hospitals (Tvedebrink et al. 2013).

In line with an NRT approach, this article can be criticized for representing a certain romanticism and partly naïve celebration of singular events, for over-emphasizing individual and material agency, and for focusing on good emotions and possibilities rather than being critical of organizational and structural challenges. Certainly, there are organizational and structural challenges within food service organizations that need to be addressed (Engelund et al. 2007). However, the combination of Derrida’s hospitality approach and NRT has opened up a new way of thinking by emphasizing that disruptive micro-events might create opportunities that transcend the static hospitality approach presented in the introduction to this article. More importantly, these approaches might add value to hospital meal experiences and help address problems of undernutrition in hospitals in the future.

Acknowledgments

We would like to thank Holbæk Hospital, Koncern Service Køkken, staff and patients. Also, we thank Dr Enni Mertanen, Principal Lecturer, JAMK University of Applied Sciences. The authors declare no conflict of interest.

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