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ALLEGORY AND ITS OTHERS*

John Law* and Vicky Singleton**

*Centre for Science Studies and Department of Sociology,
**Centre for Science Studies and Institute for Women's Studies.

Email j.law@lancaster.ac.uk

d.singleton@lancaster.ac.uk

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Many friends and colleagues have helped us to think about representation, interference, silence, complexity, fluidity and allegory. Important amongst these have been Kevin Hetherington, Annemarie Mol, Ingunn Moser, Tiago Moreira, Mimi Sheller, Bron Szerszynski, John Urry and Helen Verran. We are also most grateful to the anonymous medical and administrative staff who gave up their time to respond to our questions, and to the senior doctor who asked us to undertake the study and facilitated it at every stage.

Hospital

> Imagine a patient who presents with jaundice. This patient might be referred from the GP *[community doctor]*, or from the Accident and Emergency Unit. He might go to the hospital ward, or perhaps to the outpatient clinic. This would depend on how ill he was. They would do a blood test in order to exclude other causes of jaundice. They would probably do a liver scan, and maybe a liver biopsy. The patient would be told to abstain from alcohol, and if the patient was in the ward then he could usually be kept abstinent, though even this isn't completely certain because relatives have been known to bring in alcohol disguised as lemonade. If the patient was very ill he would stay in the ward, perhaps for a week or two. Then he would be discharged, and asked to attend the clinic. Some patients don't accept this, and don't attend the clinic, but then you are onto a loser. They would attend the clinic for six months to a year, and if they have established cirrhosis they would never be discharged. In the normal course of events, a patient would be asked to come back to the clinic six weeks after being discharged from the ward, and if they were better they would be asked to attend again in three months, and then perhaps six months.[1]

He's one of the three senior doctors specialising in gastro-enterology at Sandside District General Hospital[2]. He's talking to us, Vicky Singleton and John Law. And he's responding to a question that we've put to him about the 'trajectory of the typical patient'. The typical patient, that is, with alcoholic liver disease. Of course there is no such thing as a 'typical patient'. That's why he's imagined a patient presenting with jaundice.

Mapping Trajectories[3]

So what is going on here? Part of the answer lies in the way we've set up the study. Here's an excerpt from the description of the project that we sent to the people we wanted to interview:

> '**Pilot stage**: in the pilot stage of the research we are hoping to map how patients diagnosed with alcoholic liver disease move through the system of the hospital, and where the key decisions about care are made.'[4]

And here we are again in a somewhat longer version of the same sentiment sent to another of the senior gastro-enterology specialists – the one who made the initial approach to us and acted as gatekeeper:

> In the first stage of the research we will seek to map out the processes involved in diagnosing and treating a 'typical' patient with alcoholic liver disease – so to speak, the typical 'trajectory' of a patient within the organisation of medical care.[5]

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[1] Reconstructed from interview notes with hospital senior doctor specialising in gastro-enterology - specialist A, 8th February, 1999, page 10/2 (italics added).

[2] All names (other than a passing reference to the international Christian charity, the Salvation Army) and some details are changed in this paper in order to preserve anonymity. Please also see note 8.

[3] There is interesting and important work exploring the notion of trajectory in medicine that it would be inappropriate to expand upon here. Perhaps most notable is that of Anselm Strauss (1993) which seeks to highlight the on-going, practice-based and thereby processual nature of ordering/trajectory. See also Michel Callon and Vololona Rabeharisoa (1998) which reconfigures the notion of trajectory through consideration of the patient as a collective. Tiago Moreira (2000) furthers this work through his fascinating ethnographic study of neurosurgery. The current paper differs from this work in that its main purpose is to explore an alternative to the notion of trajectory, rather than to develop it.

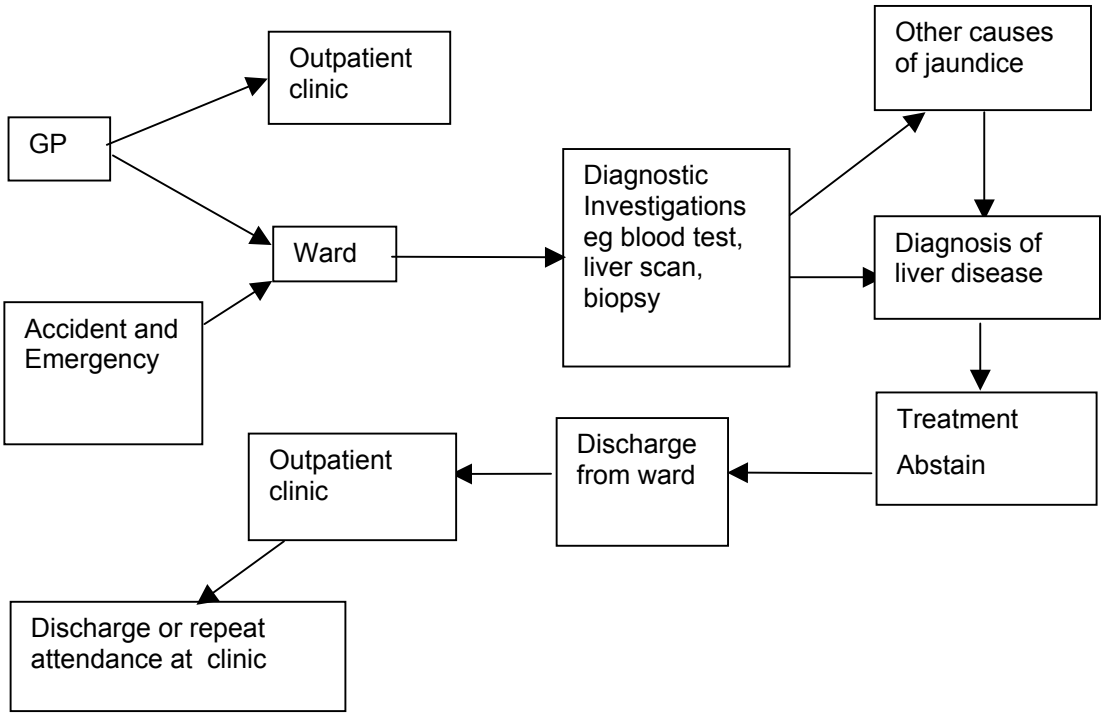
[4] Excerpt taken from letter sent to hospital gastro-enterology specialist B on 24th December, 1998.

[5] Excerpt taken from letter sent to hospital specialist doctor B on 7th October, 1998. It may seem that one assumption built into mapping the trajectory of patients with ALD is that the patient will pass from illness to wellness. However, we would argue that this is not the case.

Look at the key phrases here: 'to map out'; to 'move through the system'; the idea of a 'trajectory'; the 'organisation' of medical care' and the notion of 'key decisions'. So what is the significance of these?[6]

Notes on Mapping

A partial answer is that if we talk in this way we are living in and helping to produce a particular version of the world, one that is cartographic, indeed cartographic in a particular way. We're imagining and trying to operationalise the health-care equivalent of the AA route map. How to get from Carlisle to Bristol. Or, in the case of the hospital-based treatment of alcoholic liver disease, how to get from admission through diagnosis to treatment, discharge and continued care as an out-*[of hospital]*-patient. We're interested in charting the traffic flows and the most frequently used route. And (since we also talk about 'key decisions') as a part of this we're also interested in depicting the junctions or the options in the network of roads,



Rather the assumption is that patients with ALD rarely achieve wellness and will probably return to hospital with the same symptoms in the near future – what the medical practitioners refer to as 'the revolving door' (Please see note 31). Mapping the trajectory of the ALD patients is about tracking their movement through the hospital systems - from acute illness to a state of relative wellness that allows discharge from the hospital.

[6] As will become clear later in this paper, these are 'key' phrases because those were the phrases that were used by the senior doctor specialising in gastroenterology (specialist doctor B) when he approached us to carry out the study. In this way the phrases and the assumptions embedded within them framed this study. However, it became clear as we carried out the research that these phrases are used by the medical staff with a pinch of irony. We describe this in some detail later in the paper and also in Law and Singleton (2000).

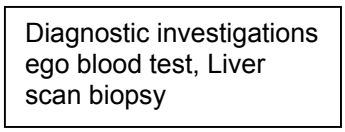
trajectories, passages[7]. The nodes. We'd like, in short, to be able to draw the 'system of health care' for alcoholic liver disease in Sandside District General Hospital[8] as a network of nodes, links, and flows. Perhaps something like the above.

And there is more to say about our experience of mapping. Like the route planner map so kindly provided at the front of many road atlases, we wanted to get a 'proper overview' of the 'main features' of the network, the system, the trajectories in question. We wanted (as they say) to 'make a context', get a sense of the 'overall character' of the trajectories of those suffering from alcoholic liver disease in the health authority area in question. We'll return to some of the difficulties about this in due course.

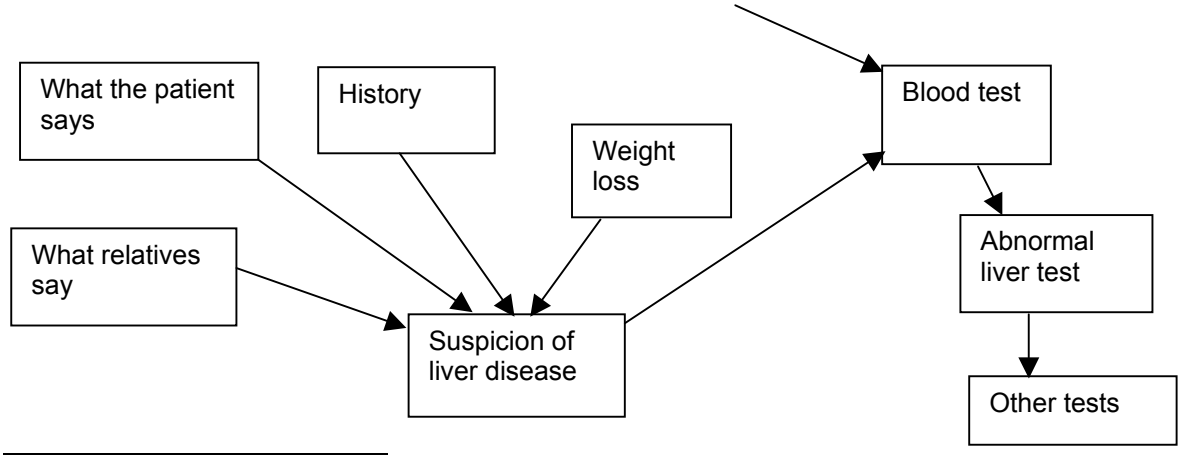
Conversely, we frequently learned 'more detail' about specific parts of the trajectory, specific locations and arrangements that lie within the larger context. Here's an empirical example:

> Vicky: Could I ask you about diagnosis. Is this done on the basis of blood tests?
>
> Specialist: The answer again is that diagnosis is quite varied and complex. It may be as the result of blood tests or an abnormal liver test, but this is combined with a history, with other tests, and what the patient and the relatives say. For instance, there may be weight loss, suspicion of liver disease, a history in which a woman says that she does not drink much – perhaps two to three glasses of wine a day. Then somebody from her family phones in, and says that she is drinking a bottle of whisky a day.[9]

In which case what took the form as a small part of the figure above:



became something more elaborate, perhaps like this (there are differences too, but perhaps we can ignore them for the moment):



[7] The term 'passages' is explored in Ingunn Moser and John Law (1999).

[8] This is the central and largest acute general hospital in the geographical area of the study. In the United Kingdom, the term District General Hospital has been replaced by the term 'Hospital National Health Service Trust'. This change, in large part, reflects national changes in health service funding policy and management. There has been a move to localised funding with geographical areas being fund holders and managing their own health care budgets in their own ways. In the area of this study there is continuing organisational changes so that currently coming into being is a large Primary Care Trust, one aspect of which is 'Sandside Hospitals National Health Service Trust' representing a collection of nine hospitals (providing both acute care and chronic day-care). We also have the community care provided outside the hospitals, including the extremely localised community clinics staffed by, for example, doctors (General Practitioners), child care practitioners and community nurses.

[9] Reconstructed from interview notes with specialist doctor A, 8th February, 1999, page 9.

So specificity or detail is added. It's like the city centre route maps that appear at the back of many road atlases. We're now being shown the more important roads in the city. But the process can continue, for alongside the main roads there are maps of side streets and the way they join on to the main roads: that is, maps of the 'same places' scaled up yet again. Look at this:

> **Blood tests**: He talks about AST and ALT. 'A ratio of 2 to 1 is suggestive of alcoholic liver disease. The Americans say that the ratio of 3 to 1 is diagnostic'. 'When I came here seven years ago they didn't do ALT.'[10]

More detail – and, though we don't want to go into it further here, even now the process of magnification is far from complete[11]. And what can be done for blood tests can also be done for any part of the smaller scale map. For instance:

> 'the **ultrasound scan** … may not affect management of alcoholic liver disease. It may not be used….' Alcoholic cirrhosis is histological. An ultrasound scan cannot diagnose it. 'We use them to look at blood flow patterns to the liver.'[12]

So, what is going on in the process of mapping?

Mapping and its assumptions

A study to map the 'trajectory of the typical patient' is a study which aims to *represent* a health-care reality.[13] Fine. But representation, as we know, is not a neutral tool. It makes assumptions about what can be known (also known as 'epistemology') and about what it is that can be known about (also known as 'ontology'). That is, mapping, as the particular version of representation that we are interested in here, carries a series of assumptions.

We have hinted at one of these ontological and epistemological assumptions above – that scale, size, is given in the order of things. We wanted to map the typical trajectory of a patient with Alcoholic Liver Disease – we wanted to scale down, to get the overview, the 'big' picture. We can also write about the detail, the specificity of various nodes in the trajectory as we scale up and these nodes are magnified.

A second assumption presupposed in the talk of mapping, and particularly audible in the talk of scaling, is *realism*. In other words, it's being assumed that these maps might represent something real. A real set of processes which are (to labour the point) actually there. Which is a way of saying at least three things.

First that whatever is being mapped is indeed there. That it exists prior to the mapping, as independent of and outside of the mapping. Call this the ontological assumption of *'out-thereness'*.

Second, that whatever is being mapped has a definite form. That it has attributes, relatively stable attributes, that may be represented in the map. Think of this, then, as the assumption of *singularity*. That we are in the process of creating, whether adequately or not, a map which depicts 'the' real world – which means that there is indeed a single, real world available to be depicted. Again, then, we are in the realm of ontology.

And third? This is the possibility of error which removes us from ontology into the classic domain of epistemology. The issue is easily stated: we might simply be getting our representation of the 'typical trajectory of the patient' wrong. Perhaps we are being told lies. Perhaps we are asking prejudiced questions. Perhaps we are asking the wrong people.

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[10] From interview notes with hospital specialist doctor F, 10th March, 1999, page 22.

[11] See, for instance, pages 19 and 32 to 34 in Sherlock (1989),

[12] From interview notes with hospital specialist doctor F, 10th March, 1999, page 22.

[13] We are aware that there is an important issue here about whose version of health care reality is represented in such a study. For the record, we spoke to a variety of health care practitioners in the course of the study. The crucial point is that the focus of the current paper is to trouble the notion of mapping rather than to explore and interrogate the production of different health care realities.

Perhaps the people we are asking have a particular interest in depicting reality one way rather than another. Perhaps they have forgotten 'the detail'. Perhaps they don't think that we will be 'interested' in certain phenomena. The possibilities are endless – and indeed fill libraries of books on the philosophy, history and sociology of science. This third point, then, we might think of as the assumption of *possible error*.

There are a lot of complexities here. Scale, singularity, out-thereness and the possibility of error, all these taken together tend to produce a more or less stable self-bracing representation-and-the-reality-it-represents. To take one example: contradictory stories or maps don't raise doubts about singularity because their differences may be attributed to error. Or perhaps to different perspectives. Like the a route map of the UK, which is a great tool if you want to drive from one place to another across the country but not nearly so good – close to useless in fact – if you want to study geomorphology, or go for a walk in hill country. Error in its various forms and differences in (pragmatic) perspective – these are epistemological tools which work to protect ontological singularity[14].

Which brings us back, to be sure, to the reason we were asking the questions in the first place. Why the attempt to map at all?

Spaces - Compartments

Here's the formal response:

> '**Aims**: the project is a study of multi-disciplinary judgements of medical effectiveness in the context of complex decisions about diagnosis, care and treatment. Our concern is thus with how complex medical judgements are made. It will focus on aspects of alcoholic liver disease.'[15]

So in this work we were concerned with complexity, and in particular with complex 'multi-disciplinary judgements'. We were interested in how such judgements are achieved as a part of creating the patient trajectory. Now here's specialist doctor B:

> '[I'm concerned with] the multidisciplinary aspects of managing complex medical conditions. The communication aspects, how people communicate, how teams work together, how they determine the treatment for patients.'[16]

Perhaps unsurprisingly, the way in which he talks is similar to our own. Unsurprising because he was our gatekeeper, the person who asked us to carry out this study and with whom we established its terms of reference.[17] More thoughts from specialist doctor B:

> 'There are differences in training between different doctors and different groups. So one of the questions is, how far do members of the team other than doctors understand the *essentials* of what we are trying to achieve.'[18]

> 'And another problem has to do with the differences between specialists and generalists. … At the medical level, it is clear enough that X is treated by X-ologists, but who decides what is X and what is Y? …. And then, in addition, nurses are becoming specialists – there are cardiology nurse specialists and so on … those who work on liver failure generally know more about that … which is okay, but the work of nursing is not rigidly compartmentalised in this way.'[19]

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[14] And in terms of which it is possible to understand much of the history, philosophy and sociology of science. The issue is explored at great length in Law (2003).

[15] Further excerpt from the letter sent to specialist doctor B on 12th December, 1998.

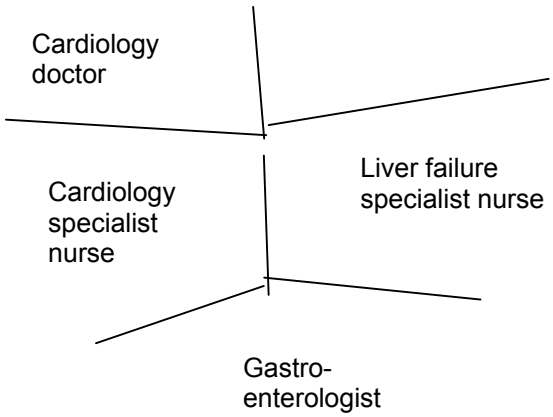
[16] Reconstructed from interview notes with specialist doctor B, 10th December, 1998, page 5.

[17] Please see note 6.

[18] Reconstructed from interview notes with specialist doctor B, 10th December, 1998, page 5.

[19] Reconstructed from interview notes with specialist doctor B, 10th December, 1998, pages 5-6.

A lot is going on here. But we have chosen these citations because we are interested in the repetition of certain forms of imagery: the persistence of different *groups*; different *disciplines*; *specialists*; the idea of the specialist 'X-ologist'; and then (for us the give-away) 'nursing *is not rigidly compartmentalised* in that way'. Put on one side the fact that we have a doctor talking about nurses (which clearly raises its own problems). Attend instead to the spatiality of the imagery. Our contention is that we're dealing here with a *language of compartments* – and the communication between different compartments. All of which can also be understood as a further form of cartographic representation: the map of an area with its boundaries:



This is a language, a set of preoccupations, and a representational style that is going to recur:

> John: Where do patients with alcoholic liver disease go in the hospital?
>
> Sister A: They don't necessarily come to ward X (or ward Y if they are men). Ideally, they would do so. But the beds may be full, in which case they will go to another ward, and be under another specialist doctor. It turns out, that at least in principle, the same patient may have 12 different specialist doctors on 12 different visits to the hospital. If a serious problem arises on another ward the senior doctor there may seek advice of one of the gastro-enterology specialist doctors. She mentions that patients with alcoholic liver disease may end up on the medical wards, numbers A, B, C, and D. On occasions they may end up in E, F, and G, as well as X or Y. Indeed, if there is no space on medical wards, they might end up on surgical wards too![20]

This Ward Sister is telling us about trajectories – but at the same time organisational and architectural divisions (and the communications between them). It's like a map of a country which highlights the regions and their boundaries, in addition to the roads, which as a result suddenly become less prominent, even though they may still be there. So it's taking us into and highlighting 'the hospital'. And then a list of different wards as long as your arm. As well as the trajectories.

And we can fly with our respondents up and out of the hospital and look down to discover other seemingly larger areas, different distinctive compartments.[21] Here's Ward Sister C again:

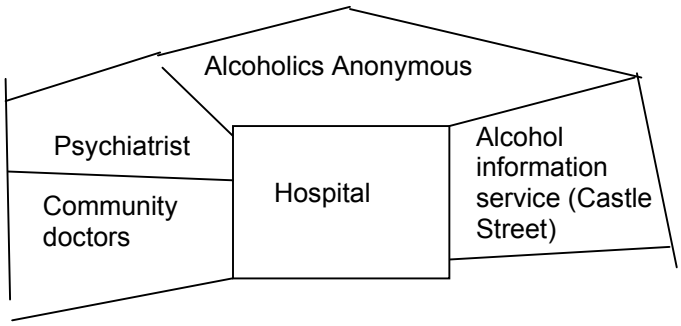
> 'we have a social worker who may offer financial advice. Not very many patients get to see the psychiatrist. But we give them information about Alcoholics Anonymous, and also about the Alcoholic Information Service, which offers counselling and

[20] Reconstructed from interview notes with ward Sister C, 10th March, 1999, page 17.

[21] Like the flows and links of trajectories, mapping compartments also involves judgements – and presuppositions – about scale. Here we are concerned with the imagery rather than with the performance of scale.

> support one-to-one. Many patients prefer that to the group sessions of Alcoholics Anonymous.'[22]

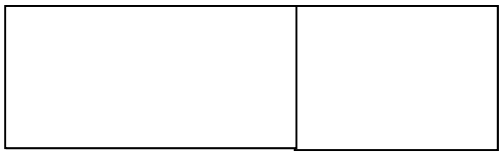
Reading this, then, as compartments rather than pathways, we discover new organisational areas. We might depict them in this way (adding in at the same time the local community doctors who will appear in the next-but-one citation below):



And again:

> There is talk about the differences between the Community Trust and the Sandside Acute Hospital Trust. It appears that the Community Trust is much more decentered in the way in which it has made decisions, and implemented guidelines. In the Acute Trust decisions 'fly down from London'.[23]

The Community Trust that this doctor refers to includes, for example, localised health care services such as community doctors (General Practitioners) while the Acute Trust, includes Sandside Hospital.[24]



By now we are far 'above' the hospital wards (or for that matter the pathways between the wards). The hospital, which (presumably) 'contains' the wards is itself (presumably) contained within the Acute Hospital Trust. We have moved to the compartmentalisation of 'large scale' health-care structures, and then, at the same time, into what we might think of as 'cultures': one culture in the community and another in the acute trust. Or (to revisit specialist doctor B above) one amongst X-ologists and (presumably) another amongst Y-ologists.

Interferences

So the official purpose of the research is to study multi-disciplinary judgements of effectiveness. But this language, and a great deal of the talk about the organisation of health-care for those with alcoholic liver disease in Sandside, turns out to reflect not only a model of representation which depicts trajectories and pathways, the nodes and the lines of a network, but a complementary model of depiction to do with compartments: that is, to do with regions and with boundaries between the regions. So we have two cartographic visions, but the

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[22] Reconstructed from interview notes with Sister C, 10th March, 1999, page 16.

[23] Reconstructed from interview notes with specialist doctor D and NHS researcher E, 5th February, 1999, page 8.

[24] Since the time of the study there have been national and local changes in the funding and organisation of health care services. These are currently continuing in the area covered by this study. Please see note 8.

quotes below suggest that *the two are interfering with one another*[25]. They come from two workers at Castle Street, a community based alcohol information centre.

> 'What happens in Sandside is that sometimes patients are referred from the hospital to Castle Street. Then they may be given wrong expectations about what can be achieved, and they get lost to the system. In the hospital it depends on who they see. The psychiatric liaison nurses … are very experienced, but junior Consultants *[specialist doctors]* do not have that experience. Wrong expectations are built up, when patients think they can come straight to Castle Street, and do not realise that it is by appointment only.
>
> We have meetings between General Practitioners *[community doctors]*, staff working on accident and emergency, and psychiatrists at Sandside, and ourselves, to discuss what to do with people. It is important for the hospital to understand that Castle Street has no crisis facilities. In any case, an assessment demands that the client be relatively sober. Links with GPs *[community doctors]* are a bit variable. Some don't refer to Castle Street at all.[26]

Here, then, the compartments – Sandside hospital, Castle Street Information Centre, community doctors – are interfering with the trajectories.[27] The generally agreed result is that the passages – the parts of the trajectories that move across the boundaries – often don't work as well as they might. Like the roads that petered out in the minefields along the old Iron Curtain, there are trajectories which lead nowhere. Or back into 'the community' where, for instance, those who have been dried out in the wards tend to take up drinking again. All of which – the difficulty in moving down passages from one compartment in the health care system to the next – was something which we endlessly encountered. Here is a community doctor speaking:

> These patients cannot be referred to the Psychiatric services at the hospital because the hospital will not treat patients with drug or alcohol related problems. They have a strict exclusion policy and alcohol problems will not be admitted. Patients are referred to Castle Street but are firstly assessed by a Psychiatric Nurse at the surgery.
>
> Patients may go on to detox or may be seen by the alcohol counsellor who is related to Castle Street and comes to the surgery. The counsellor offers support while drinking and encourages patients to rethink whether they may be able to stop drinking.
>
> Vicky adds in her notes: This all seems to be rather problematic. The Psychiatric unit will not take patients, Castle Street will only see patients when they are not drinking and drunk and only during office hours. Where are patients to go?[28]

Some of the passages between the compartments, and hence some of the trajectories, 'kinda work'.[29] There is *some* traffic across the boundaries. There are, indeed, sets of partial connections – and these vary in quality and character[30]. But the passages don't necessarily

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[25] The term 'interference' is used by Donna Haraway(1992). See also her (1997) and John Law's (2000).

[26] From interview notes with the staff at Castle Street Centre, Sandside, 10th June, 1999, page 39/7. Italics added.

[27] In the present study we came across fewer complaints about trajectories interfering with compartments. Though this happens often enough, sometimes in the form of complaints about the movements of money (fraud or money-laundering), and sometimes as worries about following proper administrative procedures. For discussion of the latter, posed in an alternative idiom, see John Law (1994).

[28] From interview notes with community doctor F, 11th June, 1999, page 54/2.

[29] The reference is to (and from) a paper by Ed Constant. See (1999).

[30] The term partial connection is drawn from Donna Haraway, and developed by Marilyn Strathern in her (1991).

work – which returns us to the concerns of the specialist gastro-enterology doctor who led us into the study[31]

Here are some of the presenting symptoms of the interference between compartments and trajectories:

- Some border crossing points – passages – *didn't seem to be open*.
- Some *narrowed themselves down* and choked off what was taken to be inappropriate traffic from at least one of the compartments. (More data: for reasons that made perfect sense in terms of the priorities of that service it was, for instance, pretty difficult to get help from the psychiatric service[32]).
- There was what the participants called '*miscommunication*' between different compartments about the nature of trajectories – different understandings or interpretations of appropriate traffic.
- There was what one might (misleadingly) think of as '*simple ignorance*' of events in, and passages to, other compartments.

All of which made the lives of patients complex, difficult. And it also made the job of cartography as route map frustrating too. For instance, starting as we did with our happy notion of 'trajectories' in the Sandside District General Hospital, it was only after quite a number of interviews that we even became aware of the existence of Castle Street Alcohol Information Centre.

What to make of all this?

First, we cannot say we were not warned. We were endlessly told that there *is* no 'typical patient' And, indeed, we were warned about the difficulties of mapping itself. Here are John's notes about one of the first interviews of the study, an interview with specialist doctor D and NHS Researcher E:

> [They are telling us that] our metaphor of mapping is too simple. I feel we should have seen this. We will need multiple maps, with multiple points of entry. Then we will have the job of seeing how these multiple maps partially connect with one another. Perhaps the metaphor of a 'map' is a bad one?[33]

Multiple maps with multiple points of entry.

Second, we have a decision to make about the consequences of the interferences between trajectories and compartments. And that decision has ontological as well as epistemological implications.

- First, it can be treated as a cartographic or *epistemological problem*. This suggests that there *is* the possibility of an overall map. We just need to sort out our perspective – and try a little harder.

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[31] For he and most of the other people involved knew that the passages and the trajectories didn't really work, if only because they were frustrated at the way in which patients who had been dried out in the Sandside District General Hospital reappeared in Accident and Emergency within a few weeks or months (some trajectories, like this 'revolving door', seemed to circulate freely, a point to which we will return below). And also the ontological and epistemological problems of representing the treatment of alcoholic liver disease within the Sandside area.

[32] Which should not be taken as a complaint about the psychiatry department, which had been directed, in conformity with national policy, to focus its resources on patients with serious psychiatric problems.

[33] Reconstructed from interview notes with specialist doctor D and NHS researcher E, 5th February, 1999, page 8/1.

- Second, it can be treated as a *managerial problem*. This suggests that a route map should be possible. It's a matter of co-ordinating realities across compartments. This possibility is closely related to the first.
- Third, the interference can be treated as producing – or being indexed by this *displacement and slippage*, seemingly purposeless ebb and flow. Which suggests that the latter becomes a phenomenon worth thinking about – and representing – in its own right, even if this means it doesn't conform to the cartographic conventions.
- Or fourth, it can be imagined as a set of elements, structures, arrangements, which *could never fit together as a whole, and which could never be mapped together as a whole*. In which case we are left with Lenin's question: what is to be done?

We'll review each of these in turn, combining the first two

Managing Epistemology

It is, to say it quickly, possible to treat the whole difficulty as a technical problem: that things might be pulled together into some kind of coherence whether cartographically (Vicky and John, or those who run the system need to try harder) or managerially (those who run the system need to impose a kind of uniformity). Perhaps the two run together in this citation, where the specialist doctor-gatekeeper is talking about information, in part with a senior nursing officer:

> Information should, says the specialist doctor, be easily available in the hospital. But in practice, despite the new manager of information systems … information is difficult to get. In principle it should be possible to get information about, say, the proportion of people discharged in which alcohol is mentioned on the discharge summary. Because the information on the discharge summary is coded up. But in practice this is not easy. Access is difficult. … As a senior specialist doctor I should be able to get information, they should give me information if I ask for it. But well, they are constantly being pushed by tighter 'management' squeezes, and there aren't enough staff or time.' … And then they talk about the practical difficulties of getting data, because there are difficulties with getting the coding right, with date sequencing, and the codes themselves are opaque.[34]

This reveals an ontological commitment to singularity and the realism of 'out-thereness', combined with the epistemological frustration that comes from perceived representational failure. If only we get the instruments right we can see reality. And (hovering not very far in the background) if only we get the management right we can make a decent set of trajectories for patients – a sentiment from which it is obviously difficult to dissent. But what happens if we shift from this understanding of trajectory? What happens if we attend, instead, to displacement and slippage?

Slippage, Ebb, Flow

> John asks Nursing Officer G if they have success stories. 'Yes,' she says, 'sometimes'. Then she talks about the symptoms which are very diverse: confusion, haematosis, malnutrition, DTs. These are people who may be homeless because they have been spending all their money on alcohol. Their families may also be aggressive. Indeed members of the family may be worse than the patient. The patients are socially diverse, including businessmen and middle class women left at home. People with alcoholic liver disease are all ages and from all social classes. The treatment depends on the stage they are at, and also their attitude to alcohol. They *have* to come off the booze, and this is impossible if they deny that they have a problem.[35]

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[34] Reconstructed from interview notes with specialist doctor B and Nursing Officer G, 10th December, 1998, page 6/3.

[35] Reconstructed from interview notes with Nursing Officer G, 10th December, 1998, page 2/2.

This describes what one might think of as the *diffuse* character of alcoholic liver disease and its correlates. Presenting symptoms, patient backgrounds, patient attitudes, families and outcomes, all are variable. Here is a specialist doctor:

> Patients present with a range of different symptoms including liver disease, jaundice, other liver complications, bleeding from the stomach, diarrhoea (which may be the result of drinking fifteen pints a day, even though they don't realise this) pancreatic disease, fits and epilepsy. In addition to these physical problems, there are also socio-economic problems which include lost jobs, overdoses, and family conflicts.[36]

Note that: physical *and* socio-economic problems. And, if they are different, what one might think of as personal problems too:

> When we are managing patients with alcoholic liver disease, we address the initial problem. But we also look for precipitating factors. We look for anything that is treatable. For instance, many alcoholics start drinking because of depression. If we think they are depressed, we will send them to the psychiatrist. So we try to look at their mood after withdrawal.[37]

In practice the patient diagnosed with alcoholic liver disease is slippery, variable, elusive, and difficult. Almost everyone involved says things about such patients which can be interpreted in this way. We know that there is no such thing as the *typical* patient trajectory – but *individual* patients too are difficult and elusive. Nursing Officer G says:

> Proper counselling is needed, but in fact there is not much psychiatric treatment available, so there is a waiting list, and while they are waiting they are more likely to go on a binge, and be readmitted. … The nurses also get to know many of the patients quite well because they keep on coming back. But the kind of attachments which grow up between nurses and patients with some other diseases don't happen .. so much, and this is because the patients are difficult, self abusive, and need to (but often don't) recognise that they have a problem. Indeed … the majority are difficult, aggressive because they are withdrawing from alcohol on the ward; which means that they can be very disruptive of ward routine.[38]

Not everyone agrees that staff never get attached to patients – as we'll see from a citation below. But the basic point – that many of the patients slip through the net recurs. 'Slip' through the net.

Tidal Objects and Subjects

So patients, symptoms, causes and results are all diffuse. As, too, or so we found, is the *disease itself*. It is not only that definitions of the disease tend to vary from one location to another, though they do.[39] In addition, it turned out that alcoholic liver disease was a category that only made sense in particular locations, and not in all. Yes, it was relevant as a possible cause of hepatitis. Yes, it was potentially relevant to the process of drying out. But in other aspects of nursing the origins of that hepatitis weren't relevant. And in most locations in community health care alcoholic liver disease was only one aspect – not indeed a necessary aspect – of alcohol dependence whose correlates extended, as the above citations suggest, into family, lifestyle, occupation, life-events and depression. So the compartment of alcoholic liver disease was variable, and *it went on varying* as we talked to the professionals involved. So that we were just as likely to find ourselves talking of alcohol dependence, alcoholism, or indeed alcohol abuse as we were of alcoholic liver disease 'itself':

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[36] Reconstructed from interview notes with specialist doctor A, 8th February, 1999, page 9/1.

[37] Reconstructed from interview notes with community specialist doctor I, 19th March, 1999, page 28/1.

[38] Reconstructed from interview notes with Nursing Officer G, 10th December, 1998, page 2/2.

[39] We have discussed this in John Law and Vicky Singleton (2000).

> At least 20% of acute medical admissions are in some way related to alcohol.[40]
>
> 75% of night admissions are alcohol-related in diverse ways. This is an approximation.[41]

Two senior hospital doctors speaking, one in Gastro-enterology and the second in Accident and Emergency. And the 'object' is no longer alcoholic liver disease.

Perhaps we were guilty of poor scholarship, of poor map-making. Perhaps we simply had difficulty in mapping the walls of the compartment, the boundaries of an object that is in reality relatively stable. But perhaps there is simply something diffuse about the object itself, the compartment of alcoholic liver disease, alcoholism, alcohol abuse. Perhaps it simply slips, slides, and displaces itself. Perhaps its boundaries move about from one location to another, and do not stay still. Perhaps they ebb and flow. But if this is the case, then something similar goes on, too, for the patients, clients, citizens who experience this condition (or set of conditions). Consider this:

> John asks whether they fear that patients who they've discharged will come back in again. Does it affect their attitude to the patient? Ward sister H says that a lot of patients do come back in, but that the girls *[the nursing and ancillary staff]* build up relations with them, and often this is good. They will know how a patient is going to be, how he is. People are not as judgmental as you hear they are. If patients treat staff well, then you get along OK.[42]

Here the ward sister is talking about one part of a well-recognised cycle which many of the health professionals refer to as the 'revolving door'. And many are not as forgiving as ward Sister H about that cycle. Here is specialist doctor F:

> We spend weeks getting them right, and we discharge them, and they go out and start drinking again, and it is back to square one. It is soul-destroying to get them back again.[43]

So the story is that patients are dried out on the ward, discharged, told to report to the out-patient clinic, either do or don't, but in any case, in the majority of cases take up drinking again – and in due course return with acute symptoms and are re-admitted, only to be dried out again. Which suggests that here we have discovered (it wasn't difficult) another trajectory – though patients might leak out of this trajectory too.[44] But also we have learned that there is something wrong with that trajectory. It isn't the kind of trajectory that specialist doctor B (or indeed any of the other professionals) were happy about. It is a trajectory that causes trouble. But exactly *why* does it cause trouble?

The quick answer is that it is frustrating since there is no sense of progress. This also means that it is expensive for the health care system since beds are occupied again and again by the same people: this is also implied in several of the above citations. At the same time it also implies a gradual deterioration in the condition of the patient. As time passes patients don't get better. Instead they get worse.

> *[The ward sister]* … talks about the way in which they come back in, and the way in which they are worse than they were before. 'We think, she's not going to get out this time.'[45]

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[40] Reconstructed from interview notes with specialist doctor A, 8th February, 1999, page 9/1.

[41] Reconstructed from interview notes with specialist doctor J, 11h June, 1999, page 49/3.

[42] Reconstructed from interview notes with ward sister H, 3rd March, 1999, page 13/1.

[43] From interview notes with specialist doctor F, 10th March, 1999, page 22.

[44] 'If patients are mistreated, then they become difficult to manage. They come to Accident and Emergency, but then if they get difficult there they are likely to end up in police cells, and fall through the net.' From interview notes with ward sister K, 19th March, 1999, page 26/2.

[45] Reconstructed from interview notes with ward sister L, 3rd March, 1999, page 19/4

All of this makes sense so far as it goes. But there is something about the *shape* of these frustrations that is important too. It is that, like the disease category, within this loop *the patient is also so variable*. He or she is drinking or not. Back and forth. He or she is responsible, or not. Back and forth. And he or she is properly supported – or not. Again back and forth. For us this implies that the metaphor of trajectory or loop, though it isn't exactly wrong, doesn't quite catch the logic of what is going on. We have offered a clue to the metaphor we want to use above. Our suggestion is that we are dealing with something more like the *tide*. Back and forth, patients, alcohol-related conditions come and go, changing shape and changing character. There is an endless flow, ebb and wash instead of the more purposive displacement of trajectory implied in a 'proper cartography'. Though, to be sure, it depends on the way you look at it.

Failed Trajectories/Failed Representation

Most of the professionals see slippage, frustration, deterioration, an endless downward loop. This is a slippage that can sometimes be fixed in place in a way that breaks the loop and turns it into a more progressive trajectory. Our data suggests that fixing comes in two great forms: on the one hand fixing from *within* the patient. Gastro-enterologist A:

> It is crucial to get patients to abstain from drinking. But the results aren't brilliant. About 40 per cent will abstain, but one in two of those will relapse within a year. If someone with cirrhosis says can he have an occasional pint, then I say no. It is essential to get the patient to take responsibility, and I need to be quite firm about it. If they don't take responsibility, then you won't get anywhere.[46]

The other is fixing from *outside*:

> John asks if there is anything she *[the ward sister]* would like to see changed, improved. 'I would like to see more support for alcoholics. The fact that there is no psychiatric support makes me mad. Social work support is limited. If they can't re-house them, can't move them, then they are likely to be going back to the situation which made them drink in the first place. That's distressing. If they want to get out it would be much easier it if they could have proper support.'[47]

But if many professionals see a deteriorating loop, a repetitive downward trajectory in which patients oscillate between abstinence and drinking, it isn't clear that the world is experienced that way by those who have been diagnosed with alcoholic liver disease.[48] Data from the Castle Street centre cited below reveals one version of this: the cycle is necessary before clients will take responsibility: come to the necessary 'internal' fix. But here is another, as told by a community doctor in a poor housing estate far from the centre of Sandside town:

> *[It]* is not an issue to *[talk with patients]* about the physical consequences of alcohol. I cannot talk about such things to many of the clients – this might provoke a violent response. It just is not relevant to them. Long term issues are not considered. Many people have accepted that will never work again and do not aspire to a fancy car and different housing.[49]

She also described how a warning issued by one of the specialist doctors at the hospital: 'You will be dead very soon unless you give up drinking', which was intended to shock the patient into abstinence, instead led to the inquiry: 'So how many months have I got left, Doctor?'

What are we saying here? The answer is we're suggesting that there are certain realities – indeed certain categories – which escape the techniques of cartography both as a network of trajectories and as a set of compartments. These are realities which are either

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[46] Reconstructed from interview notes with specialist doctor A, 8th February, 1999, page 9/1.

[47] Reconstructed from interview notes with ward sister H, 3rd March, 1999, page 14/2.

[48] Our data suggest the importance of a future study about the experiences of those diagnosed with alcoholic liver disease in Sandside. Such a study was not possible within the remit of the current research.

[49] From interview notes with community doctor Dr F, 11th June, 1999, page 55/3.

misrepresented by those techniques or more or less invisible to them. In particular, we're suggesting that the fluidities of displacement and slippage are not well modelled as failing trajectories – either representationally or managerially.[50] Instead they would be better imagined as flows, tidal ebbs and flows, which come and go, though perhaps without the regularities implied in the tidal tables. But if this is right, then this has ontological as well as epistemological consequences. For it is not simply that we might think of mapping differently, though this is certainly a possibility. It is also that within the existing conventions of representation these subjects and objects – patients, disease conditions – look as if they are changing in character. They don't look as if they are the same at different times. They look and feel slippery. Or fragmented.

But the ontological hypothesis which follows if we take fluidity seriously is that these slippery, multiple, undefined subjects and objects – patients, diseases – are, in fact, *perfectly definite*. That is, some times, in certain realities, 'things' such as Alcoholic Liver Disease which lack any definite structure or stability, do have perfectly definite boundaries and perfectly definite structures. 'Things' are stable and well shaped. 'Things' are coherent and constant[51].

If this is right, then it implies that the elusiveness of subjects and objects, such as a patient and alcoholic liver disease, is not produced by them. It is produced, instead, in the way in which the patient or the alcoholic liver disease interfere with the epistemologies and ontologies that constitute the notions of trajectory and compartment. It is, in short, a representational failure (which is at the same time the imposition of an inappropriate ontological presupposition) which makes them so fuzzy. So difficult. So elusive. So inconstant[52]. Tidal objects can be well-formed. But they just don't fit the predominant methods of cartography.

Imagining

And then again, perhaps there are other possibilities, other ways of treating this lack of fit.

If the ontologies and the epistemologies of trajectory and compartment – if the representational technologies and their presuppositions – produce the *fuzziness* of tidal objects by failing to know and treat them as definite, then perhaps there are other ways of knowing, and not knowing too. Other epistemologies and ontologies. We stumble towards one of these. Indeed, it is implicit in the metaphor of interference, interference between versions of what can be known and the corresponding versions of what there is. Let us say it in as many words, before we go any further. *Imagine that the real is a set of elements, structures,*

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[50] Or even as alternative trajectories – as previously stated the purpose of this paper is to imagine alternatives to the notion of trajectory rather than discovering alternative trajectories.

[51] Here, then, we work in the opposite direction to an argument we made, using the same empirical case, in an earlier paper (see John Law and Vicky Singleton (2000)). There we wanted to say that alcoholic liver disease is not an object because it is enacted in different ways in different locations – and because it displaced itself, in the way we have noted here, into different objects such as alcohol abuse. We do not necessarily recant the earlier argument: but the fluidity, the process of ebb and flow, that we have developed here, makes it possible to say that *in certain realities* 'it' is indeed an object after all.

[52] This is very difficult to say in the standard representational languages available to us, because the temptation, all the time, is to talk in terms of change, displacement, fuzziness, slipperiness, or other similar terms. Fluids become, then, some kind of other to compartments or to well-ordered trajectories, exceeding them. This issue and the general character of fluidity as a spatial form, are discussed in Annemarie Mol and John Law (1994), Marianne de Laet and Annemarie Mol (2000) and John Law and Annemarie Mol (2001). Vicky Singleton has tackled similar issues using the related vocabulary of ambivalence. See Singleton and Michael (1993) and Singleton (1996; Singleton 1998).

arrangements, which does not fit together and cannot be mapped as a whole. But imagine that it is all there anyway.[53]

There are theoretical and empirical studies which explore this possibility[54]. But let's take it empirically by returning to our materials.

Here are some of those elements. Some of the compartments: the Sandside Acute Hospital Trust; the Sandside Community Health Trust. The Portway Community Health Trust (which runs the community alcohol and drug abuse service in Sandside even though Portway is more than twenty miles from Sandside); the District Health Authority; and the Castle Street Centre for alcohol information.[55]

Since that is where we're going to end up, let's focus on some of the things told us by the staff at the Castle Street Centre:

> 'Fresh Start' at Beach Road … offers counselling and day facilities. It helps people to settle into the community, finds work for clients, and provides advocacy. … there are very good centres in Edinburgh, Leicester, and Leeds. There is the 'Lighthouse Centre' in Castle Hill which dries people out. And then there is 'Prospect House' in Sandside.[56]

This starts the list of the other compartments with which they are in touch. Then they talk too about:

> the Salvation Army, with its homeless project. Working Together which is a centre for young people. And Linkup which offers counselling for young people.[57]

A long list – and there are others too. But the world of compartmentalisation stretches off in other directions too. For instance, Castle Street itself, how is it financed? The answer is:

> from a variety of sources: Sandside Borough Council; Sandside District Council *[both local government administrative units]*; the AH *[a charity based in Nottingham]*; the Portway Community Health Trust; the District Health Authority.[58]

Which means, the Castle Street staff also note, that the community psychiatric nurses are financed by (and responsible to) one authority, and the counsellors to another – one result being that their terms of service are different, and indeed, their contracts run out at quite different times. Compartments *within* Castle Street.

These, then, are accounts that are all about *compartments* – though they also have something to do with trajectories. But the staff are full of stories that tell more explicitly about trajectories. We've already cited this:

> What happens in Sandside is that sometimes patients are referred from the hospital to Castle Street. Then they may be given wrong expectations about what can be achieved, and they get lost to the system.[59]

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[53] In contrast to the consultant that we quoted right at the beginning of this chapter, perhaps here we are talking of the atypical – or perhaps, and more likely, what we are describing escapes the space between typicality and atypicality.

[54] See in particular the important line of work on medical materials by empirical philosopher Annemarie Mol. See, *inter alia*, Mol (1998; 2002; and Berg 1994).

[55] We are aware that these categories are no longer used. Please see note 8.

[56] From interview notes with the staff at Castle Street Centre, Sandside, 10th June, 1999, page 38/6.

[57] From interview notes with the staff at Castle Street Centre, Sandside, 10th June, 1999, page 39/7.

[58] From interview notes with the staff at Castle Street Centre, Sandside, 10th June, 1999, page 38/6.

[59] From interview notes with the staff at Castle Street Centre, Sandside, 10th June, 1999, page 39/7.

And this too:

> Links with community doctors are a bit variable. Some don't refer to Castle Street at all. Counsellors will only see people whose refer themselves.[60]

But here is a new trajectory story:

> sixty per cent of the clients are self-referrals, and the majority of the rest come from community doctors. A few are referred by the hospital, or from the probation service.[61]

And another:

> Certain clients end up in the Centre by mistake. Those with anorexia bulimia for instance. These are referred elsewhere.[62]

And another to do with the area that is covered which is:

> … very wide. This can be difficult and costly, but (spending money on bus fares) is also … an expression of motivation *[on the part of the client]*.[63]

And another which this time points to the paucity of resources:

> There is a three-week waiting-list to see the community psychiatric nurse. And a five week waiting list to see the counsellor.[64]

And yet another, which is also about resources:

> If we had better premises we could have groups on the ground floor, and give each of the eight counsellors their own room. We would have room for more volunteers to work and run groups, and it might be possible to have a drop in centre.[65]

That is enough. But it makes the point that we could tell stories – these little excerpts would be some of the elements – that would map the world from the point of view of Castle Street: treat it as a set of compartments interfering with a set of trajectories, or indeed vice versa (because, for instance, the compartmentalised approach to finance inhibits some of the possible trajectories, appears to choke them off). In addition, though we won't do it here, we could perhaps rework our data quite differently, in order to make Castle Street ebb and flow – for it does seem remarkably variable in the stories of others if not its own. But let's try something very different instead.

InDirection

Think, then, about the story that follows. No. Don't so much think, as *feel* the story. Try to *visualise* it. Try to *smell* it. Try to *be* there. Suspend your disbelief and read between the lines. Try to see what is *not* being said in addition to what is.

> Finding the door is difficult enough. In a terrace, between two cheap store-fronts in a run-down part of Sandside. The kind of street only three blocks from the big store that

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[60] From interview notes with the staff at Castle Street Centre, Sandside, 10th June, 1999, page 39/7.

[61] From interview notes with the staff at Castle Street Centre, Sandside, 10th June, 1999, page 33/1

[62] From interview notes with the staff at Castle Street Centre, Sandside, 10th June, 1999, page 34/2

[63] From interview notes with the staff at Castle Street Centre, Sandside, 10th June, 1999, page 34/2.

[64] From interview notes with the staff at Castle Street Centre, Sandside, 10th June, 1999, page 35/3.

[65] From interview notes with the staff at Castle Street Centre, Sandside, 10th June, 1999, page 38/6.

doesn't make it. That doesn't make it at all. That smells of poverty. That speaks of hopelessness.

It is a nondescript door. Unwelcoming. A tiny spy glass. An inconspicuous notice. Nothing very obvious. Nothing very appealing. We are ringing the door-bell. Is anyone listening? Has anyone heard? Dimly we hear the sound of footsteps. We sense that we are being looked at through the spy glass. Checking us out. And then the door opens. And we're being welcomed through the door by a middle-aged women. To find that there isn't a proper lobby. Instead, we're facing a flight of stairs. Carpeted, cheaply. Yes, shoddily.

So we've been admitted. We are, yes, Vicky Singleton and John Law from Lancaster University. And now, we're being led up a flight of stairs. And the building is starting to make an impression. An impression of make-do. Of scarce resources. Of inadequacy. For we're being told people have to come up all those flights of stairs. Some of them can hardly walk through drink. And some can hardly walk, full stop. Up this long flight of stairs. For we're in the kind of Victorian building where the rooms on the ground floor are twelve feet high. Big fancy three-story houses. Built at a time of optimism. At a time of some kind of prosperity. Which, however, has now drained away.

So the clients need to negotiate these stairs, turn around the half landing, up a further short flight, and then they are on the first floor. Next to the room that is the general office, library, meeting room, leaflet dispensary, the place with the filing cabinets, the tables, the chairs. People are milling about. At the moment no clients, but a researcher who is smoking. Several social workers, the manager, community psychiatric nurses coming and going.

The leaflets and the papers are spilling over everything. Brown cardboard boxes. Half drunk mugs of coffee. New mugs of coffee for us. Clearing a bit of space. Not too much. There isn't too much space. Files and pamphlets are pushed to one side. Two more chairs. And the numbers in the room keep on changing as clients arrive, or people go out on call, or the phone rings. One client hasn't turned up. Relief at this. The pressure is so great. And then there's another with alcohol on his breath. A bad sign.

The staff are so keen to talk. Keen to tell us about their work. Keen to talk about its frustrations and its complexities.

How to *tell* this?

Appreciating

The fact is, it cannot be *told*. Or if it is told then it loses something. Or, no, the telling of it is the telling of something else. *Which is the stuff of allegory*.

Imagine it, then, this way. There is a building – or a story about a building – which is an allegory. An allegory for? An allegory for *that which cannot be told*. That which cannot be held together. That which cannot be represented within any of the traditions of cartography, compartmental, trajectorial, or for that matter tidal. It is that which evades the epistemologies which tell that it can all be drawn together and placed on a surface, seen by a single eye, represented by traces on a sheet of paper. That which resists the ontological assumptions which sustain, and are sustained by, those representational traditions. The notion that there is indeed an out-thereness that is singular. The idea that this out-thereness has an intrinsic size. The idea that whatever is out there is homogeneous – or that it occupies a homogeneous sort of out-thereness which is reducible, perspectively or otherwise, to a representation at some scale or another, that is able to handle it satisfactorily at least in principle. That can picture it. For, by contrast, allegory is about what cannot – or has not – been told. Or drawn. Or mapped. It is about excess. It is about *figure* as opposed to *discours*. It is about alterity. It is about motility. It is about the presence of absence, or the absence of presence.[66]

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[66] For discussion of allegory see Kevin Hetherington and John Law (1998). On the distinction between *figure* and *discours* see Jean-François Lyotard (1985). On absence/presence see

Now this. The Castle Street building tells a story. No. It does not *tell* a story. Or it tells a story about something else. *But the story, one of the stories, that it does not tell is about interferences*. It reports about, witnesses, resonates with (we lack the metaphors), the interferences between different compartments – which interferences will resist the attentions of the cartographer. It evokes, too, the interferences between different trajectories – which exert similar intractabilities from the point of view of the mapmaker. And then, yes, it calls forth the interferences between the compartments and the trajectories of the kind we have discussed above – interferences which have always posed the trickiest problems of representation. And have led to the fuzziness and seeming indeterminacy of the fluid, of the tidal, the sense that things go in and out of focus, ebb and flow, that they are not under control. That they cannot be pinned down.

So the Castle Street building does not *tell* a story about ontological heterogeneity. Instead it *appreciates*, it *witnesses*, it *enacts*, it *evokes* and it *condenses* the lumpiness of a non-homogeneous reality: not so much the interagency squabbles (though those can be read there too); not so much the fact that different locations have different versions of trajectory (for this can be understood perspectivally). Instead it summons up the irreducibility of different and only partially connected realities. And it witnesses these allegorically, in the enactments of its materials. In the chaos of leaflets, chairs, contracts, rooms, clients, agendas, files, doors and stairs. In the different speeches. In the realities that these index: realities that cannot be brought to presence. In the conjoining of that which is present and that which is other. In the juxtaposition of realities that are necessarily Other to each other. It witnesses these Othernesses, these presences which are also absences, in the condensation of elements – the incredible but *working* condensation of elements which makes it up. It witnesses the irreducible as allegory, as absent presence, if we can but learn to sense it.[67]

Now, for the first time, we sense the blindness of the all-seeing eye. For the lust to map *creates* its blindness. That which it cannot see – it simply cannot see it. Which leads us to want to say that for a long time, for too long, we have been caught in one or another of the limited regimes of cartography. And that, as a result, we have lost the art of detecting that which is not told in that which is. And we have prided ourselves too much in telling it as it is. But for us this exercise in cartography, which started so grandly, ended in ontological humiliation. We could not see. We could not trace the trajectories. We could not even draw the boundaries. Was it simply that we were not up to the job? Or was it, as we now believe, that the very forms of the world, its heterogeneities, rendered much unseeable and unsayable? In which case knowing is as much about feeling and sensing and smelling difference, as it is about telling or drawing. It is as much about appreciating the textures of performance, or performing, of reading between the lines, as it is about the lines themselves. It as much about evoking as it is about describing. *The art of evoking*.

Leibniz wrote:

> In a confused way [monads] all go towards the infinite, towards the whole; but they are limited and distinguished from one another by the degrees of their distinct perceptions.[68]

If we use Leibniz' terminology, then we can say of Castle Street that it is a monad. It evokes *everything* in the world: some things directly and distinctly, and others allegorically or (as the translation puts it) 'in a confused way'. A monad which (as monads do) defies the understandings of scale built into cartography. Which turns those understandings inside out by including that which is 'big' within that which is 'small' or local. But don't let's forget: in Leibniz' monadology *every* location of consciousness is a monad. Here that means that all the other places that we've visited are monads too: the hospital ward; the community doctor's; the community clinic; the office of the specialist doctor. It is not, then, that Castle Street is

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John Law (2002a; 2002b). On motility see Kevin Hetherington and Rolland Munro (1997) and Kevin Hetherington (2002).

[67] On the notion of conjoined alterity and absence/presence developed in an explicitly spatial context see John Law and Annemarie Mol (2000).

[68] Part of section 60 of the Monadology, Leibniz (1973), page 188.

specially allegorical. Indeed, if there is anything special about it at all, then perhaps it is something to do with humility. In a place where it is difficult to see well, to command boundaries or trajectories into being, in a place, in other words, far removed from the privileges and the hubris of the cartographies of power, there it is perhaps easier to feel, to smell, to taste, and to read between the lines, to know the ontological heterogeneity of the world by indirect means. There it is perhaps easier to practice the evocation needed in a *sensibility to allegory*.

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