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This is Not an Object*

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Textbook

The big textbook is by Sheila Sherlock and it is called *Diseases of the Liver and Biliary System* (1). Chapter 20 of the book is called 'Alcohol and the Liver' and it starts in historical mode:

> 'The association of alcohol with cirrhosis was recognized by Matthew Baillie in 1793.' (425)

A few sentences later it tells us that:

> 'Not all those who abuse alcohol develop liver damage and the incidence of cirrhosis among alcoholics at autopsy is about 10-15%.' (425)

Then we're directed both to a reference (number 84 in the alphabetical list of references for the chapter), and also to a diagram, Fig 20.4 (427). The diagram looks something like this (we've redrawn it):

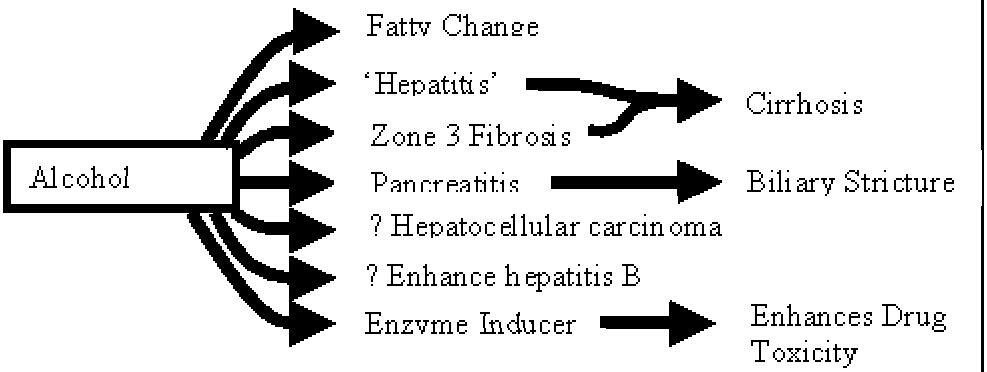

Figure 1: 'Fig 20.4. The hepato-biliary effects of alcohol abuse. 80-90% of abusers have no liver disease

The diagram is a sign of complication. Alcoholic liver disease, it quickly becomes apparent, isn't one thing at all. It's a series of partially connected conditions or problems, and if we want to understand it we are led both towards other partially related terms, and into new literatures. Terms lead to terms. References to references. It is possible to move 'upstream' to more authorities, more literatures, more reported experiments, more truth-claims.

Performance

We want to argue that this textbook is a *performance of reality*, that it makes present a *representation* of reality, and at the same time *makes* that reality.

In pressing what one might think of as the performative turn, we are aware that this will sound counter-intuitive to many. Alternative, and better-established epistemological and ontological accounts of the character of a textbook would rest on realist or pragmatic foundations. Both would assume that there is a reality out there. The realist would argue that knowledge, critically tested and corroborated across a wide range of instances, can begin to approximate to that reality. Whereas the pragmatist would argue that knowledge is better understood as a tool for handling a complex reality – with the obvious addendum that tools are created to do jobs of (epistemological) work, which means that different tools will work in different circumstances, or even for different social groups.

The differences between realism and pragmatism are important, but neither share the performative assumption that reality is brought into being in the process of knowing. Or, to put it more precisely, neither would assume that the object that is known and the subject that does the knowing are co-produced in the same performance, that the epistemological problem (what is true) and the ontological question (what is) are both resolved (or not) in the same moment. The improbability of the performative turn, then, is that it deals as much with ontology as with epistemology. In particular, its implausibility may be that it appears to say that anything can be performed into being. This is an issue, then, that we need to address

Consultant

Dr. Warrington is a consultant gastroenterologist in Sandside District General Hospital (SDGH) (2). It would be easy to caricature him as a stereotypical consultant for when we interview him he indicates that he is an authority, an expert. For instance he says that he has published substantially on alcoholic liver disease (ALD), and written editorials on the condition for the *British Medical Journal*. He also tells us that he spent four years working in one of the major liver transplant centres in the UK. The message is straightforward. He has expert knowledge whereas many others, at least in Sandside, do not:

When they arrive my juniors are sat down, and I tell them how to manage liver disease. The instructions that I give them are quite specific. They are told to follow a written protocol.

Alcoholic liver disease can be quite easy to manage. But very few actually understand the basic principles.

Talking about the written protocols, Dr. Warrington states:

> They lay out a strategy for its [ALD's] management. If juniors don't follow them, then I get a little bit annoyed, and I damn well want to know why. (3)

He also comments more generally that:

Gastroenterology training does not involve rotation into locations which specialise in liver conditions. So liver conditions are a major part of gastroenterology, but they are learnt by osmosis by students, rather than systematically.

Network

Dr Warrington believes that ALD and other pathological conditions of the liver should be treated in a particular way. He would like to *perform* reality in a particular way. But he's surrounded by people who tend to perform other realities – and so to get it wrong. The consequence is that he's clear about the nature of the disease, the proper protocols that should be followed, and is critical about the way in which junior doctors are trained.

We're up here, then, against the *limits* of a performance. And it's the character of those limits – or what it takes to organise a successful performance – which we need to address if we want to tackle the implausibility of the performative turn. The argument we need to make is actually very simple. It is that *not all performances are successful*. This is because not all performances manage to line up the objects and the subjects needed to make them work. Not all performances, accordingly, manage to simultaneously resolve the problems of epistemology and ontology. Many are more or less epistemologically and ontologically 'unrealistic'.

There is a convenient line of analysis in the discipline of science, technology and society (STS) which offers us a way of thinking about the problem. It is to treat knowledge-and-its-objects (in the performative mode they are all chained together) as a *network* of elements that are brought into being and given shape in a particular performance. We've already gestured at this possibility above. The textbook, we noted, ramifies out in all directions. It moves to descriptions and accounts of related conditions, to methods of diagnosis, to findings, and to interventions. Along the way it includes numerous pictures (for instance of microscopic slides and diseased livers) tables, diagrams and charts. And it includes, as we also mentioned, references to the literature. So the STS analysis of the textbook is that it is can be imagined as a network of elements which extends through its pages, but then moves out and beyond its covers into an endlessly ramifying set of laboratory experiments, epidemiological surveys, clinical findings, instrumental assumptions – not to mention the authors who produced all these. And if we want to press this idea of a network a little further we can also take in the organisation of the book, including, for instance, the title pages where we read of the eminence of the author, her degrees, the fact that the book has been translated into several foreign languages – all of these also join the network. (5)

If the STS argument is that the book is a network of heterogeneous elements, then what has this to do with performance, and the plausibility of the performative solution to the simultaneous solution of the problems of epistemology and ontology? The answer is that the process of building a network, any network, is a performance. And that the process of building a network that will create a sense of reliable knowledge of a real world is *also* a performance – and one that is even more demanding. The problem is simply stated. Successful and convincing performances cannot be created out of nothing. Raw materials have to be put in place – and then held in place. What the STS literature sometimes talks of as 'allies' (people, facts about the world, laboratories, scientific papers, publishers, instruments, scientific funding agencies, colleagues, referees) have to be cajoled, seduced, bought or forced to play the roles allocated to them. And it is a little worse than this, because it isn't enough to pick this list of potential allies off one by one. To pick any of them off you have to have most of the others already lined up. Which is a way of saying that they all have to perform together – and if they don't, if one bunch of actors goes off script, then the network holding all the others in place is also disrupted, and they too are in danger of going native.

The argument, then, is that making a successful performance is difficult. Having said this, there are however certain short cuts. We can gesture at the character of those short cuts by distinguishing between the efforts to describe and create a medical reality by a textbook like Sheila Sherlock's, and some alternative claim that doesn't seem to carry the same plausibility – for instance the idea that the moon is made of green cheese. Leaving aside the ever-present possibility that the textbook is an inspired hoax, STS suggests that deconstructing the world of the textbook – its knowledge, and the world that knowledge describes – would require a very large and expensive effort. We would have to move upstream, through the networks that it lays out, and start to question all the allies – the results of all those laboratory experiments, clinical trials and clinical case reports and all the rest. We would have to show that they were badly done, methodologically flawed, or misreported.

Against this, the sociology of science also says that it is in principle possible to deconstruct every knowledge claim – and the reality which corresponds to it. This is because every claim is its own network of assembled bits and pieces, a representation and a reality which is being represented. This means that what could in principle be done to Sheila Sherlock's textbook could in turn be done to every report that it cites.

So why doesn't this happen? One answer is that the cost and effort of doing so is beyond all feasibility. (6) To deconstruct medical science and the medicalised body would take the same order of resources as its initial construction. Which means that it, and the corporeal realities which it describes, are here to stay, at least in general and at least in the short run, even though it could in principle be otherwise. (7) All of which is different from the argument about the moon and green cheese. The latter does not (at least on the face of it) have the same investment in a ramifying network. It does not have the same number of heterogeneous allies, people, reports, instruments and all the rest. It would, in other words, be fairly easy and fairly cheap, to deconstruct.

The argument, then, is that performances are difficult to put on unless they build on the networks that are already in place. That realities and knowledges cannot capriciously be performed into being. That we are, in general, somewhat stuck with what passes for the world, and our knowledge of the world. Which in effect, though not in analysis, produces results that are consistent both with the realist sense that there is a world and that we approximate towards knowing it well, and the pragmatist intuition that knowledges change as we approach the world with different questions in mind.

In sum, performances mostly make realities and our knowledge of those realities by surfing on existing networks. And what is true for the textbook is also true for Dr. Warrington. The networks that he mobilises are double: those of medical science on the one hand, and of medical hierarchy on the other. For the hospital is also a performance – the performance of some kind of organisational hierarchy (8). He is one of three or four consultant gastro-enterologists who are performed within the organisation as having charge of the medical treatment of patients with conditions of the liver. In various locations he is enacted as being in charge of, indeed responsible for training, the junior doctors who work under him. So his attempt – apparently somewhat frustrated – to perform ALD and its treatment in a particular way draws on and mobilises the knowledges and the realities both of medical science and medical organisation. It is a *double* performance.

Slippage

Dr. Warrington informs us about Alcoholic Liver Disease and its clinical management.

> One of the problems is that the condition actually worsens at first. This is because we are depriving them of alcohol, which may lead to hypoglycaemia. Also, alcohol is a depressant. Withdrawal from alcohol leads to metabolic outpouring. They may become hypokalaemic, with blood potassium falling, a long with the blood sugar. This may lead to misdiagnosis by junior staff.

In addition, white blood cell count can be high. "Junior staff may think that the patient has an infection, and is suffering from septicaemia. Then they prescribe antibiotics, which is the wrong thing to do." Furthermore:

> What is happening is that patients are being deprived of a source of calories. At the same time the removal of the suppressing effects of alcohol means that the metabolism is like a Jack in the Box. Bingo! The metabolism starts to act. One implication of this is that non liver specialists often manage the condition badly.

And another subtle complexity of ALD and its management is explained by Dr. Warrington.

> The danger is that they may become over-dehydrated, as a result of water tablets [diuretics]. The water balance may be got wrong. Body salt may be high, but serum salt may be low.

A Registrar, second in command so-to-speak, working with all of the consultants at Sandside District General Hospital states, 'Our job is to tackle the presenting symptoms, the acute medical problems.' (9) However, he goes on to say that:

> If patients stay in for a few days then we are faced with the problem of withdrawal.

The problem of withdrawal presents, amongst other things, fitting, aggression and tremor. The acute medical problems of a patient with liver disease become intimately interwoven with those of alcohol withdrawal. In addition:

> The drugs used in withdrawal are relaxants, for example we put the patient on hemineverin. The danger is that it depresses the respiration, so it is important to be vigilant, to keep patients under observation.

Furthermore:

> Other dangers might arise because taking tablets and drinking may lead to overdosing. Patients might drink through withdrawal, this can cause more physical problems.

On diagnosing ALD the registrar comments that:

> Most patients that are diagnosed will have a history of alcohol problems that have led to the admission, even if the presentation is not Alcoholic Liver Disease.

He describes the "varied presentations of Alcoholic Liver Disease". Different sets of symptoms mean that patients are distributed around the hospital on various wards, perhaps never to be seen by himself nor a gastroenterology consultant.

Non-object-ness

Earlier we saw how Dr. Warrington's attempt to perform ALD and its treatment in a particular way is unsuccessful. Junior doctors do not follow the protocols. Their training is inadequate and unspecific and they do not develop the necessary expertise. We used this to show that it is not possible to perform anything into being: the performances of reality have limits, that not all performances are successful. Written protocols don't work by themselves. Juniors make errors. To perform ALD and its treatment is complex and tricky. It demands considerable expertise. (10)

But something else is happening too. Perhaps we might think of it as *slippage*. For there is continual displacement between the condition of ALD itself on the one hand, and its treatment on the other. The two are performed together, they are interwoven. Indeed, it is often difficult to distinguish them at all. (11) One implication of this is that – as in the case of the textbook – Dr. Warrington and the Registrar perform ALD as not having a definitive presentation. As not being one thing at all. Instead. ALD (and the treatment of ALD) is performed as not *any thing*.

As Dr. Warrington's and the Registrar's performances slip between ALD and its treatment we learn that ALD is not a specific set of symptoms, not a particular clinical presentation, not a definitive series of interventions. Alcohol withdrawal interacts with presenting symptoms of liver disease, which interact with physiological changes, which interact with the drugs that are administered, and so on. In the performances of Dr. Warrington and the Registrar ALD is a slippery *non-object*.

Abstinence

> Dr. Willems: Some patients may have the occasional drink, but we do insist on abstinence. They may start off with six pints, but this rapidly increases to fifteen pints a night. Alcohol is a dangerous and addictive drug. (12)
>
> Dr Warrington: People have brought alcohol into the hospital, for instance by injecting fruit. You would be amazed how much alcohol it is possible to inject into a banana.
> John: What do you do with those patients?
> Dr Warrington: The answer is we discharge them. The argument is that they enter into a contract with us. We will try to help them, but only if they also try to help themselves as well. If they are taking the Mickey, then there is no basis for continuing.
>
> Sister Fraser: Success is if they don't drink.

This, one might say, is the reality of the hospital. The need for abstinence from alcohol. But it isn't the only reality. Here is another consultant, Dr. Nixon, this time a psychiatrist, who is involved in the running of the community anti-substance abuse services from a number of clinics dotted around the area. We are asking him whether success means that people have to stop drinking:

> Dr. Nixon: No. It is not just a question of being substance-free. It also has to do with improving other aspects of life. Such that the substance, or the alcohol, becomes secondary. Then people begin to be free, free of the substance, and enjoy health and a social life. These become more important than the substance. So, for instance, success would be talking with the children a couple of times a week in the evening, instead of going to the pub the whole time.

Difference

Different performances – abstinence and reduction. Multiple realities are being performed.

Recent work on performance within STS reminds us that every performance is, indeed, a new performance in a new location. This patient is not the same as the last patient. The evidence brought forward at this case conference is not the same as the evidence brought forward at the last. This new work – which in particular focuses on medicine – stresses the continuing uncertainty of performance. It also stresses its specificity, insisting that *what works on one stage may not work on another*. One of the implications of this is that subtly – or not so subtly – different realities may be performed into being in different locations. This is what the empirical philosopher Annemarie Mol calls the *problem of difference*. (13) Even things that are ostensibly the same turn out to be different or multiple.

The problem of difference is dramatically illustrated by the data above. Dr Willems, Dr Warrington and Sister Fraser (but also others) stress that complete abstinence from alcohol is necessary to successful treatment and any hope of recovery. And this is, indeed, a reality that is rigorously performed in the hospital: the consultants and the nurses indeed attempt to police the alcohol that is sometimes smuggled into the wards, and any sign of drinking excludes patients from the (admittedly very slim) chance of being considered for a liver transplant. Having heard these stories there was a moment when it appeared to us that this was the only reality available. But this turned out not to be the case. For as the data also show, a reality that is quite different, indeed contradictory, is being performed within the community programmes, a reality which says that any reduction of alcohol intake is better than nothing.

There is a straightforward explanation for the difference in realities (though its implications for indicators of NHS performance and success are profound). The gastro-enterology wards of the SDGH are faced with desperately ill people – they are, precisely, in need of acute care. This is in contrast with those seeking community support who are less ill, at least for the moment. This means that there is hope of improving other aspects of their lives if they simply cut down their intake of alcohol. But the explanation doesn't wash away the problem of difference. For if different realities are being performed into being – and especially if those realities are about 'the same' object, then we are likely to find that there are endless *problems of co-ordination*.

Sister

We interviewed Sister Fraser during a busy shift in a small room off her ward, the room where the nurses make cups of coffee. She's an experienced Ward Sister. Indeed, she's worked on her current ward for fifteen years. Talking of ALD patients, she says:

> Most patients come from medical admissions. … They are generally very poorly. Most don't want to admit that they have a problem.

She continues:

> When they arrive we create a care plan for them. This is in three parts. First, we assess them …. Second, we create a nutritional care plan. Third, we assess them for pressure sores. (14)

Then she talks about the 'social':

> Some patients have partners who are also alcoholics. We won't be able to help them very much. Socially, 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 Alcohol Information Centre, which offers counselling and support one-to-one. Many patients prefer that to the group sessions of Alcoholics Anonymous. We don't give patients an appointment. With just advise them, and give them the information. (15)

Regions

The sister describes another performance, a nursing performance which mobilises its own knowledge and enacts its own reality, one which depends on and creates its own networks. Now we want to note that the elements of those networks are *heterogeneous* in character.

This again is an argument which comes from the sociology of science. The elements which go into her performance are, for instance, *materially* heterogeneous. Implicit, if not completely explicit, in the notion of a care plan and the work that goes into it, is that it involves *texts* and documents of one kind or another. The care plan itself takes the form of a document and a set of protocols adapted to the reality of the patient. Alongside texts there are, of course, *people*. The nursing staff, other medical specialities such as the psychiatrists, social workers, technicians, nutritionists, counsellors, all of these appear in the network, alongside the patients themselves. All have their role. All are required to stay in role if the performance is to be a success. And finally, though more implicitly, there are the instruments, the technologies, the *material stuff* of the scene: the syringes for taking samples or giving medication, the drips, the microscopes in the laboratory, the specially adapted mattresses, the bedpans, the drugs. Again, the list is endless.

The argument that the elements directed in performing a scene are materially heterogeneous can be seen as a restatement of the ontological component of performance. (16) Knowledge, a solution to the problem of epistemology, grows out of and helps to perform the material realities with which it interacts. But here we want to attend to another aspect of heterogeneity. This is the fact that, to a greater or lesser extent, within particular performances different realities perform themselves – or are performed as – different and unlike one another, which also means that they come, or are performed as coming, bounded and separate from one another. And, correspondingly, that each is performed as *internally* consistent, so to speak a region of relations which 'naturally' go together and cohere. What's important here is that some performances subsist primarily *within* such a region, while others have visibly to do with stitching regions together – with boundary relations. Think of the latter kinds of enactments as performances of *regional heterogeneity*. (17)

We've come across several examples of regional heterogeneity. The most obvious is the work of Sister Fraser.

1. She is concerned with the performance of a medical reality – here the diagnosis, treatment and care of patients with ALD.
2. She is concerned with nutrition.
3. She performs nursing care – the risk assessment and treatment for pressure sores.

4. She performs links between these and a further region – that of the social, and of social work.

All four are worlds with their own realities, their own knowledges, their own networks. The 'regional heterogeneity' of her work is that she indeed enacts all four within a single performance that stitches them together.

Two comments. First, as the work by Annemarie Mol mentioned above suggests, we need to be very cautious about assuming that medicine (or any other region) is really coherent: her studies show, for instance, that lower limb atherosclerosis is performed in different ways in the different departments of the same hospital. Thus in her analysis the average case conference is a more or less tricky attempt to patch together different atheroscleroses to produce a practical decision about intervention. In this instance, then, it is the different medical departments and their claims that count as regions, rather than medicine as a whole. The corollary to this point is that *coherence itself is a performance*: for instance atherosclerosis from the radiology department in a case conference; or the diagnosis and treatment of ALD as performed by a consultant in the context of ward care for a patient. Some 'packages', as it were, are *performed* as packages in any given location. Coherence – and then the need to link different coherences – is itself an enactment. (18)

Second, there is one way in which the performance of what we are calling 'regional heterogeneity' is also a sociological commonplace. Many sociological literatures argue that certain kinds of low status work – usually done by women – are all about patching together different regions that don't go together particularly well. Nursing is a case in point, dealing, for instance, with the demands of relatives, the exigencies of the medical profession, and practicalities such as nutrition. Each of these regions performs its own reality. A skill of a nurse such as Sister Fraser is to balance them in a single performance, to hold them all in place and to enact their different realities simultaneously. This is a requirement which, at least in some measure distinguishes her from, for instance, Dr. Warrington. That is, perhaps the latter faces the need to relate two regions – medical knowledge on the one hand, and a contrary organisational failure on the other. But the priority of these regions is beyond doubt. It is Dr. Warrington's job to perform the reality of medicine, not that of organisation – even if his position in the organisation powerfully helps him to do so.

General Practitioner

We have moved to another location, a general practice. The building is brand-new, pleasant. It is made of brick, glass and wood with an atrium – though it turns out that to get to the GP herself we have to pass through three locked doors which are operated by remote control, or by punching a code into buttons. Because, though it's a new practice in a new building, this is in the centre of one of the sink estates in Sandside. We'll call it Heathcote. We're going to learn that there are 6,500 people living on Heathcote. Here's an except of our interview with Dr Bowland:

> Vicky: Do you talk to patients about the consequences of drinking?
> Dr Bowland: This is not an issue. It isn't really possible to talk about the physical consequences of alcohol abuse. I can't talk about such things to many of the clients – to do so might provoke a violent response. The issue is just not relevant to them. They aren't interested in long term questions, don't take them into consideration. Most people who live in Heathcote have accepted that they will never work again and don't aspire to a fancy car or to different and better housing.' (19)

Neither, she adds at a later stage, are they the 'worried well'. To put it differently, if they come to the surgery at all then this is because they are already feeling very ill.

> They aren't interested in long-term questions, don't take them into consideration.

Here's an example. A consultant in gastroenterology at the SDGH had told a patient from Heathcote that if she carried on drinking she'd kill herself. This was a piece of news intended to frighten the patient, indeed to shock her, into stopping drinking. But when the patient turned up later in Dr Bowland's surgery her question was: 'How many months have I got left, Doctor?' A different way of thinking, a different reality, which in medical sociology is sometimes called fatalism. (20)

And then this question to us from Dr. Bowland:

> Did you see the dealers as you drove past the parade?

For it turns out that many people living in Heathcote are on hard drugs, crack cocaine, heroin. She adds:

> Frankly they'd be better off on alcohol.

Alcohol is the lesser of the evils. So, yes, she is saying, there are alcoholics and people with ALD. This isn't wonderful, but it is perhaps a better solution to the horrors of poverty and deprivation than some of the most readily-available alternatives. (21)

Subordination

First let's say that Dr. Bowland is not a cynic. She's a committed person who is also (in the common-sense use of the term) a realist. Having noted this, let's also note that her performance as a GP is also a performance of regional heterogeneity. This is no particular surprise. If the job-description of the nurse is to sustain multiple partially separated realities by managing regional heterogeneity, then so too is that of the GP. In their performances GPs sustain the (differing) regions of medical science while simultaneously enacting and stitching together other regions which march to the beat of quite different but equally realistic drums. (22)

That this is the case is dramatically illustrated by what Dr. Bowland has to say about alcohol abuse, and (at least by implication) ALD. She lives in a world whose reality, whose logic, is short term for many patients. The idea that cirrhosis of the liver might be better avoided in the long run is scarcely relevant, let alone important, when the major problem is to live through the next week. 'I can't talk about such things to many of the clients – to do so might provoke a violent response.' So she tiptoes between the regions, their multiple and different realities, and their logics, piecing together a reality that works, that performs the reality of the worlds of her patients while responding in some measure to the logics of the regions of medical science.

So far the story of her work is like that of Sister Fraser. But there is also an important difference. For as she has done this, wrestled with and performed the exigencies of conflicting knowledges and the worlds that they inhabit, what has happened to ALD? Indeed, what has happened to the medical science of SDGH? How have they been performed in this version of regional heterogeneity? The answer is that medical realities and their knowledges have been *subordinated* to quite other realities and knowledges. This means that her version of regional heterogeneity has more in common with that of Dr. Warrington than it does with Sister Fraser's. This is not a politics of 'equal time' for different realities, different regions. Instead it is about *inequality between realities*. Medicine is subordinated in Dr. Bowland's performances – while it was the realities of organisational structures which were subordinated in those of Dr. Warrington. (23)

So Dr. Bowland is not a cynic, but she implies that ALD is much less worrying to her than a number of the alternatives. Addiction to alcohol is not a good, but it is less of a bad than, say, addiction to heroin which, in the context of Heathcote is one of the major alternatives. In this performance ALD has been subordinated to alternative medical and non-medical realities. ALD exists, it is performed, but it is nowhere centre stage even for many of the patients who come to the surgery ill as a result of alcohol abuse. So we add to the list of treatments for ALD. We have met abstinence (within the hospital), and reduction of intake (in the community trust). Now we need to add that at least sometimes in the consulting room ALD is being performed as, 'leave well alone'.

Organisation

> Consultant Psychiatrist: Originally people with alcohol-related problems were directed into the psychiatric services. But over 10 or 15 years this has changed. There are now separate services for alcohol abuse. The Psychiatry Service only sees alcoholics if they also have a psychiatric problem. (24)

So what are the separate services? Who provides community services for those with alcohol dependency? What happens when the immediate physical threat to health has been dealt with in the acute medical wards? A social worker talks about one of the Community Trust Hospitals:

> This is a protected environment, but one in which patients get dressed themselves, and go to table for meals. This is mainly for geriatric patients. Where alcohol dependent patients go to very much depends on where the consultant has beds. Sometimes families may press for a patient to be moved, shifted to another hospital. Then the consultant has to negotiate with another consultant who has got beds in that hospital. (25)

Getting into the community hospital as a patient with alcohol-related problems, if those problems are not deemed 'medically acute' isn't particularly easy.

In addition there are other community issues. For instance the consultant psychiatrist talks of the way in which a community NHS Trust – Cockermouth Trust – in a neighbouring area about twenty miles away has successfully bid to provide the alcohol advice and out-patient services in the locality, even though there was a rival bid from the local Sandside community trust. And he goes on:

> It was also anticipated that the service would develop in-patient facilities on a local basis, but this has not happened. (26)

It seems that the development of such local in-patient facilities needed a go-ahead psychiatrist to head it, but no appointment has been made. And along the way the psychiatrist mentions the general position of psychiatry in the UK which, he says, is rather low status. His conclusion about what the Cockermouth Trust offers?

> It is quite a good service for what it is, but there are gaps.

An employee of the service offered by the Cockermouth Trust tells us that there is no community rehabilitation centre. People go to Alcoholics Anonymous, or do (as he puts it) 'their own thing'. (27) And a social worker based at SDGH talks of the liaison between the social service department and the hospital on the one hand, and the several community trusts on the other, before adding in passing:

There are two social work teams here. There is Sandside on the one hand, and also the Pale. With the creation of a unitary authority the team has divided. The office itself is divided. The end room is used by the Pale Council team. The Pale were very tight and restrictive about how we worked. They limited support, or tried to, to a four week care plan. Sandside are more flexible. They listen to their staff more. So things are better now, than they were before. (28)

Displacement

Our previous stories about the performance of ALD and its treatments have centred around specific performances in particular locations, the work and the worlds of a textbook, a consultant, a registrar, a ward sister, and a general practitioner. In the last section we have done something different by telling several stories and juxtaposing them. This is because while these stories are *individually* about difference they also *collectively* tend to perform difference, multiplicity – and, as we are going to suggest, displacement or mobility. But first, what do the individual stories tell us?

- In the story by the consultant psychiatrist alcohol abuse is being performed as other to 'psychiatry' – the only alcohol abusers who pass through the doors of the acute psychiatric services are those who also have a major psychiatric illness. So alcoholism and its treatment are *marginal to psychiatry*.
- The stories of the social worker are various but these too enact ALD as other to important regions including the *community hospital*. The latter is intended for quite different community purposes (care of the elderly?). The need for consultants to negotiate beds in alternative locations suggests something similar: that performance of the in-patient community care of alcohol dependence is subordinate to other more powerful regional realities. (29)

- The organisational marginality of chronic alcohol abuse and treatment is also being performed in the stories about contracts. The acute trust is concerned only with acute cases. But since care has been contracted to the Cockermouth Trust, it is also marginal to the local community trust too. And then, at the end of this chain of regional marginalisations there is a hint, perhaps no more than a hint, that the whole issue may be rather marginal to the Cockermouth Trust too – if only because it can't recruit an appropriate psychiatrist.

How, then, is ALD and its treatment being performed here? The answer is that in each case it is *subordinate or marginal* to other organisational realities and regions. It is always pushed somewhere else.

And by putting the different stories together in the way that we have, we have also sought to perform it in a particular location – this text – as *multiply marginal*.

What we're saying, then, is that in this version the problem of difference takes on a particular form. It becomes the performance of *endless displacement*. But this is not the creative displacement, the mobilities of nomadism, celebrated in the romantic stories of Deleuze and Guattari. Instead it is something much less productive, much more destructive. Because once it is out in the community ALD and its treatment *never belong here but always somewhere else*. Somewhere, yes, but not in my back yard. (30)

Centre

To get into the building you have to ring. You ring a bell next to a grotty and battered door – for there is no easy access here. This is a necessary precaution, of course, given the potential violence that can be meted out to the workers.

The building is terrible. Up all those flights of stairs, people have to come who can hardly walk, and in some cases are drunk. Steep stairs, they are poorly carpeted and seem to stretch out for ever, up, around a half landing. They are long because it is one of those big Victorian houses that have fallen upon hard time – an old terraced house.

And then we walk into the main room, which was perhaps the second bedroom when the house was new. But now it is a grubby chaos. It's a place filled with, bits of paper, tables, chairs, filing cabinets, card indexes, old bits of furniture, everywhere. There is no spare space. Everything is occupied by clutter. Including the leaflets. Twenty, thirty, forty different leaflets. Advice on drinking. How to tell if you are drinking too much. Drinking and driving. Drinking and pregnancy. Drinking and diabetes. Leaflets about liver damage. Endless leaflets advertising different facilities, clinics, within a thirty or fifty mile radius of Sandside. A short stay residential home here. Another there. A clinic that is open mornings in this suburb. A centre for young people just down the street. The meeting times of Alcoholics Anonymous. Of the advisory service. Leaflets from the Social Service departments, several of them, departments that is, since there are several local authorities. A booklet listing some of the services, voluntarily funded and otherwise. A cascade of leaflets.

We start to talk. It turns out that the workers don't have their own rooms. If they have too many clients at the same time, then they are in trouble because there is nowhere to counsel, nowhere to conduct interviews. The result is that there is a constant shuffle. 'You take Mary's room. She's out for the morning.' 'Where is Alex?' 'Oh my god, I wasn't expecting this client to show. It's only eleven and I can smell the alcohol on him.'

Witnessing

We have learned that performances make realities, and the knowledge of those realities: they make, as the jargon has it, objects and subjects. We have learned, too, that some performances are much easier enacted than others, some realities much easier to make than others. This is because they surf the networks of relations that are already widely performed instead of trying to raise the energy and the allies that are needed to cut across these and to make a different world. Then we have talked about the performances of what we might think of as the homogeneities of regions – sets of more or less entrenched relations that hold themselves together with something like a single order in particular locations – and of the

nature of the performances, often women's performances, which enact the relations between these regional homogeneities. Which stitch them together.

In tracing the performances of alcoholic liver disease and its treatments, we have found that there is continual slippage between performing ALD on the one hand, and the *treatment* of ALD on the other. ALD is, in some locations, performed as not any thing. Further, we have found that ALD and its treatment is sometimes performed as superordinate, sometimes it is performed in a politics of equal time, but that more often it is subordinate to other regions, other realities.

And so it is, that as the performances of ALD and its treatment pile up in the particular corner of the world that we have visited, we find not only that it is multiple – for multiplicity is always to be expected in a performative world – but that the multiplicity becomes disarticulated. Fragmented. And that the heterogeneous work of stitching together its performances lags behind the other performances of order, professional, organisational, moral. In this way we re-learn the old lesson: that to order is also to beget disorder; that to garden is also to make weeds. (31)

But, and this is the purpose of our paper, this is the reality that we have sought to perform, it is also the case that the order and the disorders are not distributed evenly. Disorders pile up in certain places and in certain enactments. Some networks articulate themselves while others do not. And so it is with the treatment of alcohol abuse in Sandside – it is layer upon layer of disorders.

The consultant gastroenterologist who initiated this study said:

> 'I would like to work more closely and effectively with an alcohol strategy for this district.' (32)

He knows that something is wrong. But the pattern we have performed through these stories – that of a subordinated multiplicity with its continual and destructive displacement – suggests that there *is* no strategy. It suggests, instead, that there is the performance of *fragments* of alcohol abuse realities, fragments that are poorly articulated in relation to one another. Another indicator, another symptom of the slipperiness of this displacement: when we embarked on this research we imagined that we would build a route-map, a route-map for those diagnosed with ALD or related conditions, a route map which would show how patients are moved between facilities and locations. But in practice we found it near to impossible to draw such a map. The locations simply didn't perform themselves as being related to one another in any consistent manner. The stitching work – perhaps we should say the work of triangulation – wasn't being done. More than multiplicity, this is the performance of disarticulation and displacement in the slippery and vicious sense we have described above. It is too far from the orderings necessary to generate a region – or even a set of determinate displacements between regions – that could be called 'the treatment of alcohol abuse'.

Witnessing is a process that comes from giving voice in performance. From *making* a witness. A modest witness that can move just a little more from one performance to the next. That can join things together. A text such as this is no better than the alcohol centre at making an order that is the treatment of ALD in Sandside. Rather, this text performs, somewhere else, the terrible dislocation of ALD treatment – and the impossible heterogeneities of its subordinated performances.

Notes

* A number of friends and colleagues have helped us to think about performativity and politics. Important amongst these have been Claudia Castañeda, Anni Dugdale, Donna Haraway, Maureen McNeil, Annemarie Mol, Ingunn Moser and Helen Verran, and we thank them all. We are particularly grateful to the anonymous interviewees in the Sandside area who generously offered their time an expertise to the study.

1 See Sherlock (1989).

2 All local names and locations have been altered to preserve anonymity.

3 Notes (not transcript) of interview held on 10th March, 1999.

4 The sense of science as a ramifying network of interconnected elements brought together in a specific location was first explored in this way by Bruno Latour and Steve Woolgar in their (1979). See also Bruno Latour's (1987) and the papers collected together in Callon, Law and Rip (1986)

5 For an example of the analysis of the structure of a document see John Law's (2001).

6 This is one answer. Another might be that one may choose not to deconstruct a particular knowledge-claim, report or whatever.

7 We write 'in general' and 'in the short run', because medical science is always reconstructing itself in a piecemeal fashion. Particular bits and pieces of its reality may well be undone. In the long run who knows how much of what we know now will remain?

8 This point has been explored in John Law (1994).

9 Interview notes, 19th March 1999.

10 See Singleton (1998) for an account of how laboratory technicians positively problematise the process of analysis of cervical cell samples in order to redefine their work as requiring considerable skill and increased recognition.

11 See Sacks (1991) for a fascinating analysis of the ways that disease and treatment co-evolve in a complex and unpredictable process.

12 Notes (not transcript) of interview held on 8th February, 1999.

13 She has developed this argument though a series of important publications which include: Annemarie Mol (Mol 1998; Mol 2001; Mol and Berg 1994).

14 Notes (not transcript) of interview held on 10th March, 1999.

15 Notes (not transcript) of interview held on 10th March, 1999.

16 See, for instance: (Callon 1986; Latour 1992; Latour 1993; Law 1986; Law 1987).

17 There are substantial STS literatures on this problem in a number of different traditions. Leigh Star and Jim Greisemer displace the argument from symbolic interactionist concerns with nursing work to the role of objects in their important (1989), and the argument is developed in Star's (1991). The argument is developed somewhat differently, in terms analogous to those being used here, by Annemarie Mol and John Law in their (1994), and in (Law 1999; Law and Mol 1998).

18 This point is not lost on the actor-network part of STS which talks of punctualisation or black boxing, often using this to refer to artefacts which come as, and are performed as, standardised packages. See, for instance, Michel Callon's (1986).

19 Notes (not transcript) of interview held on 11th June, 1999.

20 See, for instance, the overview discussion in Sarah Nettleton's (1995), pages 55-56.

21 Hilary Graham makes an interesting analogous argument about smoking drawing on research with women. See Graham (1994).

22 For an analogous argument, see the paper on care by Alice Stollmeijer, Hans Harbers and Annemarie Mol (1999). The argument may also be posed in terms of a distinction between 'regional', 'network' and fluid connections. See Annemarie Mol and John Law (1994) and John Law and Kevin Hetherington (2000).

23 This is an argument which bears some, but only some, similarities with that developed by Peter Berger and Thomas Luckman (see their (1967)). The difference is that there is no equivalent of a 'paramount reality' in the varying regional heterogeneities of performance.

24 10th June, 1999.

25 11th June, 1999

26 10th June, 1999.

27 21 May, 1999

28 11th June, 1999

29 What the social worker is doing, of course, is something like Sister Fraser or Dr Bowland: her performances enact and stitch together different regional realities with the difference that the regions she deals with - and the boundaries between them - are primarily organisational in character.

30 The romanticism of Deleuze and Guattari (1988) has been widely commented on. For an example in an empirical mode that is related to science, technology and medicine, see Ingunn Moser and John Law (2000). Other related STS writing has commented more benevolently on fluidity (Mol and Law 1994). On the UK cervical screening programme see Vicky Singleton (Singleton 1998; Singleton and Michael 1993). On medical protocols see Timmermans and Berg (1997)

31 On the relations between organisation and disorganisation, see Bob Cooper's (1986). On modernity as gardening, see Zygmunt Bauman (1989).

32 17th June, 1999

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