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Paper 119: Personhood and Time: technologies of assessment, ambiguous identities and giving



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Abstract

The paper discusses the relation between technology, time and identity. Drawing on ethnographies of older people in hospital the paper focuses on the making and unmaking of ageing identities in the context of new technologies of assessment. The paper examines how people's histories and futures are mobilised in the making and unmaking of them as persons in medical settings. But this is not to suggest that the relation between time and identity is ever settled: on the contrary the discursive constitution of personhood is deployed in the fabrication of people as medical objects (or not.) Nor are persons ever made present: through these discursive practices, including the effacement of people as living presences, the distinctive features of the medical domain are (re)-accomplished. The findings make evident what is true throughout our lives: the increasing difficulties each of us encounters in rendering self or other in the present as persons. The paper argues that these findings have important consequences for rethinking the social. An age interpellated with the effects of technologies of assessment transforms presence into a space of extraction for stockpiling the future.

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Personhood and Time: technologies of assessment, ambiguous identities and giving people a future

Only to the extent that man for his part is already challenged to exploit the energies of nature can this revealing that orders happen. If man is challenged, ordered, to do this, then does not man himself belong even more originally than nature within the standing-reserve? The current talk about human resources, about the supply of patients for the clinic, gives evidence of this.... Yet precisely as man is challenged more originally than are the energies of nature i.e. into the process of ordering, he never is transformed into mere standing-reserve. Since man drives technology forward, he takes part in ordering as a way of revealing. But the unconcealment itself, within which ordering itself unfolds, is never a human handiwork, any more than is the realm man transverses every time he as a subject relates to an object (Heidegger, 1996:323-324)

Sister - .. if they've [an elderly person] an acute illness it doesn't matter how old they are. Frankly because you are always looking to get them well and home. And it doesn't matter whether you are nineteen or ninety, if *you've the prospect ahead* of you it doesn't matter how old you are, they come in, they're treated and they go home. [emphasis added] (Latimer 2000a)

Introduction

Ageing is a cultural preoccupation. Many children can't wait to grow up, while everywhere we see technologies aimed at putting a stop on the biological clock. Children have their experience and capability called into question because they have not been around long enough; while the very old can be seen as having been around for too long. These antimonies can be disposed of by reference to the life-course and the blurring of life-course boundaries, but this would be to efface how these ambiguities, intensified through the new technologies of assessment, are played out throughout life.

In the paper I am doing post-fieldwork fieldwork (Cohen 1992). Drawing on the past (ethnographies of older people in hospital) the paper explores the relations between age, time and the making and unmaking of persons with ambiguous identities. In my ethnographies of older people in hospital (Latimer 2000, 2004), older people's futures as persons are calculated through a complex set of observations and estimates. Diagnosis as well as treatment flows from these calculations, which are on-going and continuous. One effect is that the older person's concerns are never made present: through these discursive practices,

including the effacement of older people as living presences, the distinctive features of the medical domain are (re)-accomplished.

In their calculations nurses' deploy technologies of assessment, such as the nursing process, to mobilise older people's histories and futures in the making and unmaking of them as persons. The relation between having a future, and past and present identity emerges as critical to hospital organisation. Nurses and others look to check if the older person can continue, more or less, give or take minimal resources and support, as they were 'before'. They look for a future, not just in recovery, but through examination of past and present conduct. Where the current illness is constituted as a part of a continuous decline toward death, there is no future, medical or social. People with no futures risk blocking the hospital flow. They are also a risk to staff: managers calculate staff's performance with technologies of assessment that hold staff's accomplishment against prefigured measures of efficiency and effectiveness. Many of the calculations focus on throughput and bed occupancy rates (see also Green and Armstrong 1993): staff who do not free up beds are classed as inefficient. In this way patients who have the potential to block the flow are also undermining the identity-work of staff.

Time is not simply deployed then as temporal contradictions that subject patients to the production of docile, 'hospitalised bodies' (Frankenberg 1988). While the relation between time and identity is never settled, *having a future* emerges in the current ethnography as critical to a positive identity in the present. Analysis dislocates with past theorising which emphasises tradition, and the importance of a link with the past in the constitution of identity (Schils 1981), or which emphasises the displacement effects of an intensification of technologies to help master or colonise the future (Giddens 1991.)

At the end of the paper these findings are theorised to suggest much wider shifts in the nature and place of modern technologies in social relations. Drawing on the work of Martin Heidegger the paper explores the possible effects of contemporary modes of social ordering which draw upon technologies of assessment. It is argued that under some circumstances such as those presented between older people and nurses in a hospital setting, as at the same time as technologies of assessment become social actor's materials for extension, to help them perform their own identity, they in turn work social actors (Strathern 1991) to transform the social in ways that promote characteristically instrumental and future-oriented relations. The subjectivities of social actors, like those of patient's and staff's, are mobilised, in the name of enhancement, in the production of relations of evaluation.

The study

The focus of the study was the assessment and care of twenty people over the age of seventy-five years admitted as 'acute medical emergencies'. The study took place in an acute medical ward in a prestigious British National Health Service teaching hospital ('Royal University Hospital') and extended over an eight month period. The unit consisted of one male and one female ward (Wards One and Two). Fieldwork included, observations of skill mix, availability and use of resources; routines, guidelines, care protocols, and admission policies; reporting mechanisms; transcription of all nursing and medical in-patient documentation; and participant observation of the following:

- * the admission of the twenty patients from Accident and Emergency Department (A&E), and for subsequent two hour periods at regular intervals during their stay¹;
- * 'nursing handovers' (or change of shift reports) before and after each period of observation;
- * doctors' ward rounds and the 'social' round or 'geriatric ward round' (a form of multi-disciplinary case conference focusing on people aged sixty-five and over);
- * home assessment visits where these were arranged by the occupational therapist.

Added to participant observation, and the many occasions in which I talked with patients and their families, I also interviewed, using a tape recorder, each patient at the end of their hospital stay. This interview was aimed at exploring their versions of their lives, their troubles and of events in hospital. Having this material I could then, in the analysis, compare and contrast the ways in which they presented and understood their troubles and experiences in their interviews with me, with the ways they conducted themselves in their relations with practitioners, and with the ways in which practitioners configured them. Towards the end of field work I also interviewed all the qualified nurses, in order to extend material relating to the ways in which they underpin and justify their practices. Analysis of these accounts as 'moral tales' helped make visible the multiple authorities and orders to which the nurses were working, and which prefigure the ways in which they conduct themselves.

All field material was constructed into a 'text' (Silverman 1993). The text was analysed using a constant comparative method (see Baruch, cited in Silverman 1993), which drew on aspects of anthropological (Marcus and Fisher 1986; Strathern 1991, 1992, 1995,

2003), discourse (Fairclough 1992; Deetz 1992; Silverman 1987; 1993) and conversation analysis (Silverman 1993, 1996). Analysis of field material as a text allowed me to trace the ways in which different patients' identities were being configured, both over time, and across interactions, in different registers (written, verbal, electrocardiographic, thermometric, radiographic, etc.), in different locations and by different assemblages of people and things.

Time and medicine

It is a truism that technologies create their own demands. The clinic needs patients - no matter what it is doing for them. But not any patient will do. In the current global 'crisis' of a medical profession and health services under strain, only some patients make suitable medical materials. Problems of suitability and appropriateness (Charles-Jones et al 2003) are intensified in university hospitals, where patients do not just constitute research subjects (Fox 1979) but also educational objects (Elston 1997).

Time matters a lot - the length of time someone has been ill, the length of time it might take to get them better. Both of these things are connected to the patient's age - their are important statistical correlations between age and length of hospital stay and the chronicity of illness. In today's health service division of labour, it is acute troubles which are being made the focus of attention of hospital specialists, those troubles identified as having a past run the risk of being the potential blockages to the flow of beds and medical performances. Chronic ailments are relegated as for long-term management, and are increasingly figured as the responsibility of primary care practitioners, or as social and personal, the responsibility of the family, the individual or the community.

The tricky thing is assessing who has a medical future and who hasn't? Here new technologies of assessment have been drawn into the medical domain. They include 'geriatric assessment' (Latimer 2000b) and 'the nursing process' (Latimer 1995.) Within medicine these technologies are designed to make the revealing of need both more systematic, more comprehensive and individualised. In practice they are deployed in the current setting to help make the patient's future more visible. Of course as will be seen they do in a sense help construct that future in more ways than one (see also Latimer 1997). Drawing on these technologies of assessment nurses extend the medical gaze to make the patient visible not just as a medical object but as a functioning and social being.

Critically, nurses engage in these technologies of assessment as a way of transforming their own precarious and ambiguous identities: these technologies of patient assessment help

nurses to answer the call or the challenge of the technologies through which they themselves are being assessed (Latimer 1995). These are technologies of evaluation, managerial modes of assessment that call upon nurses to reveal their practices as efficacious in terms of outcomes and demonstrable health gain. To distinguish themselves as different from ordinary carers nurses put into play technologies of patient assessment to perform themselves as professionals with a knowledge-base and technical expertise. In enrolling technologies of assessment nurses take part in ordering as a way of revealing. But the unconcealment itself, of nurses' identities on the one hand and of older patient's futures on the other, which ordering itself unfolds, transforms the realm nurses transverse as subjects relating to patients as objects.

In sections which follow I introduce the reader to the form of nursing assessment mobilised by nurses in their admission interview with patients. I then go on to

Nurse-patient encounters: technologising the social

Nurses interview patients in a way which mimics a medical history. They have a structured set of questions, and forms to fill in. These are referred to as the patient profile. This is important because the ways in which the admission is performed helps to make the nurses' conduct here visible as rational and important work. The forms, and the ways in which they are operationalised, are nurses' props, they help make nurses' work visibly systematic, official and purposeful.

Nurses deploy the nursing profile form to legitimate their survey of a patient's social and functional life. But this survey reduces aspects of patients to traits and parts, it *technologises* the social. So the nurse conducts the admission as if she is looking according to 'a grid of perceptions and then noting according to a code' (Foucault 1991:56). Through these encounters a particular form of nurse-patient relationship is developed. The patient has become the object of a nursing gaze. But nurses' conduct relays that neither the nurse or the patient are sources of signification or legitimation: authority lies far from the bedside. So that, in complete contrast to calls from theories of nursing, neither nurses nor patients author(ise) needs.

On the contrary, the admission period is a time of initiation through which nurses' conduct relays to patients that the bedside cannot be a space of discretion. Authority and legitimation lie elsewhere, in other disciplined bodies of knowledge. Patients learn through the admission period how to conduct themselves to enable their transformation from person to patient, but not just any patient. They efface their social and personal concerns to fit the constituting of

classes (see Latimer 1999). To have a medical future a patient must have a social future, only then can they be transformed from patient back to person within a short period time.

The key feature here is that to be rendered 'appropriate' in the acute medical domain depends upon the possibility for transience: to have a medical future as a treatment space means that troubles must be reversible. For troubles to be reversible they must not be chronic. These are the conditions for a class of patient termed the 'acutely ill': their movement from person to patient back to person can fulfil the need for visible outcomes. Only these kinds of patients will do: they fit the medical agenda for a particular kind of research, as well as the new world of health care dominated by the politics of waiting-lists.

Nurses' conduct helps patients to learn to efface the complexity of their troubles and to allow others to author their clinical needs. In the next section I present how nurses constructed their assessment practices in their interviews with me.

Nursing assessment: a new technology

At one level it is simple. Knowing what is 'wrong with patients' appears to be critical to knowing what patients need:

Staff Nurse 3: So that you can plan their care appropriately, for example whether or not they're to mobilise, whether or not they can eat, just anything really.

For nurses to have a plan, a requirement of the nursing process, the patient has to have a future. Assessing the patient helps the nurses to read the patient in relation to their future.

The nurses talked about what was wrong with a patient in terms of knowing their diagnosis, what their signs and symptoms were and what treatments or investigations they were to have. Diagnosis-symptoms-treatment actually act to situate a patient in the nurses' world. But other aspects mediate the nurses' assessment: especially age:

Sister 1 - I find it very difficult because I honestly don't think it's the right place for an elderly person to be if they're not ill. Because they're low priority in an acute hospital, em, they are not given the time they need. And we tend to, Bay 4 is Bay 4 [the Bay that the long term patients are put in]. Rarely changes. It's very basic nursing care, and basic nursing care is all they get for most of the time. Because the priority are the, em, acutely ill, whether they're young or geriatric they need more nursing time than somebody who is 91 and waiting for a long term bed in a geriatric ward. It is certainly not ideal, although most of these ladies have come in with an acute condition and very

soon after they've arrived their acute condition has resolved and they are back to their em best, which often is a chronic senile dementia. And once they're in hospital you really find out how unable to cope in the community they are so that you don't send them back out. And they're left to sit in an acute medical ward waiting for 18 months to 2 years for a geriatric bed.

In Sister's account the people in bay 4 do not have appropriate futures – they are chronic, they are waiting, waiting for a bed in a nursing home, where they will wait to die. In themselves there is no hope of a progressive future. Sister later explicates at my request her distinction between the acute patient and a geriatric patient:

Sister - I think loosely the term geriatric is used by most people for a lot of people over the age of 65. But I find there are some geriatrics who are only forty.

Researcher - What do you mean by that?

Sister - Well it depends upon the person, there are some very young, mentally young 90 year old who I would never describe as a geriatric, I would say they were elderly. Geriatric I would say are dependent people, elderly dependent people who need a certain amount of nursing care.

Researcher - Physically?

Sister - Physically dependent. Ladies who are confused...

So not all older people are 'geriatric' or 'social.' Authentic acutely ill people require purely clinical care. Where the social intrudes upon the present there is something wrong, not with the nurses, but with the patient, they become less than authentic.

These discourses indicate something deeply embedded in the ways in which the nurses conceive of the differences between older people and other ill people, in what they conceive of as acute illness. Illness is constituted by them as something medical and as detached from the social. This extends to how they conceptualise their nursing care: they constitute themselves as nurses who prioritise the medical and technical aspects and who do not really operate in a social dimension, except as a luxury. And further the social can act as a *drag* on the medical/technical, it gets in the way, to produce patients who are not medical but whose problems are 'caused' by their age, and by their lack of support, and who need social care.

One of the Sisters and Staff Nurse 5 said that as they primarily nurse the condition rather than the patient, and that this constitutes a fair and rational way of going on, then it follows that any patient, no matter what their age, is treated by them in the same way. However, they both gave the proviso that this depends upon whether the patient's medical condition is being

actively treated: the elderly 'are very much judged on their own merit' and 'should have the care that they require' given their medical condition no matter what their age.

There are differences: if 'they are not to be treated', if they are 'not for resus [resuscitation]' then their nursing care will be different from that which would normally be given in the circumstances of a particular medical condition:

Sister - Well if they [an elderly person] come in with an acute illness they are nursed as though they are, if they've an acute illness it doesn't matter how old they are. Frankly because you are always looking to get them well and home. And it doesn't matter whether you are nineteen or ninety, if *you've the prospect ahead* of you it doesn't matter how old you are, they come in, they're treated and they go home. [emphasis added]

Here then there is a notion of being treated fairly, according to your medical condition, regardless of age, but with the future acting as a condition of possibility: 'if you've the prospect ahead of you' then you will be treated fairly and squarely, and the nurses adjust their care on that basis.

With age comes a difference in the treatment of patients which is dependent upon assessment of a patient's future prospects. Patients must be in a liminal state of becoming other than ill: they must supply the materials capable of being rendered through medical and nursing technologies. For the transformation of their identities from something sick into something less troubled (and disposable) is the material for the performance of nurses' and doctors' identities. Without these transformations they would have no futures. It is very important to note that older people were also figured by the nurses as having a past which is important, while their future is figured as not so important to them. Having no future means that they are vulnerable in the present. So how do nurses help assess whether or not a patient has 'the prospect ahead of them'?

Prospecting

The nurses referred to how they need to know about a patient's 'social situation'. Other ways of referring to social situation were 'home-life', 'context' and 'lifestyle'. The survey of a patient's social and functional life is called getting a history. In a history a patient's 'home' or 'social' situation is connected to family support, usual 'self-care' ability, mobility, and community services (either health or social). Taken together these aspects indicate how capable a patient is *normally*, not in the present in a state of illness, but in the immediate past, before the illness event.

Getting a 'history' has different uses. First, knowing about a patient's normal mobility or self-care ability enables comparison with the present to know what is abnormal. Knowing what someone was like normally, some of the nurses claimed, gives something to aim for in their rehabilitation of patients: a history gives you a 'goal'. In the following extract, Staff Nurse 4 is talking about a patient she admitted the previous day. This patient had been described by A&E staff as a 'total wreck' with a 'knackered heart':

Staff Nurse 4 - ...so in that case we were able to see she was capable of quite a lot....so already we could assess that she was capable of doing a lot for herself. So I spoke to the patient, I spoke to her daughter, and, em, I got a clear picture in my mind and then wrote up the care plan according to what I thought her needs were from there.

Researcher -So what sort of things did you get from them?

Staff Nurse 4 - Basically a history of what has happened over the past few days, for a start, leading up to the admission, so the recent history leading as to what led up to the admission. A history of what she was like before she took ill this time, so that at least for long term means you know how good you're trying to get the patient back to.

Researcher - You got a base to..?

Staff Nurse 4 - You've got a baseline picture. Now, I know that up until Sunday this woman was em, totally self caring, so if we were thinking now in the long term we're trying to get this patient back to that, to that level. So up until Sunday she was totally looking after herself.

Staff Nurse stresses how knowing about the patient in the past in terms of their capability acts as a 'baseline picture'. A baseline is important in terms of being able to aim for something: her metaphor, 'baseline' and 'level' implies that the past acts as an objective measurement by which to judge the patient's rehabilitation.

However, Staff Nurse 4 also implies that she is going to nurse the patient in the present in a different way because 'up until Sunday this woman was, em, totally self-caring'; she was 'totally looking after herself'¹. Staff Nurse 4 implies that she is going to nurse this woman in a way appropriate to someone who is normally totally self-caring, rather than nurse them as someone who has been totally dependent for the last x number of years. Tacitly the past transformed the present by offering the possibility of a future.

¹ The pre-occupation with self-care has been described by Rudge (1997), drawing on Rafferty (1996), as a nursing hegemony.

Both Staff Nurse 3 and Staff Nurse 4 talk in terms of 'goodness' in relation to capability: through this realism there can be optimism (something to work for). What is emerging is how for the nurses there is a notion underpinning their assessment practices which parallels the medical staff's need for a patient to provide a treatment space. I would like to refer to this as a 'space of rehabilitation.' A patient is assessed in relation to whether or not they provide both a treatment space and a space for progress and movement, up a hierarchical set of conditions. This means that a patient has to be available to the nurses as a *project of recovery*.

For example, Staff Nurse 4 talks explicitly about 'levels': she talks about moving from total chaos up to something better, this is measured in terms of the patient's capability and this is related to 'goodness'. Being 'capable' and being 'knackered' or a 'total wreck' are juxtaposed, and act as indicators of the good, or presumably its opposite, 'chaos' which is 'bad'. In some way knowing about a patient in terms of their previous, pre-admission state gives the nurse a sense of their worth².

From the nurses' talk it would appear that a patient's 'social situation' and their past life was important in a strategic relationship to managing the future: the disposal of patients. This in turn has revealed how nurses *estimate* patients in relation to some notion of value, which revolves around patients' conduct, their capability, and their motivation and ability to self-care. So that what emerges from the nurses' talk is how older patients, unlike that other 'proper' class of patient, the 'acute medical patient', cannot be viewed simply in relation to their ascribed medical condition. Nurses calculate their worth as materials of extension by prospecting their future.

A new division of labour: the hybrid medical gaze

The division of labour between doctors and nurses hides a distribution of medicine which is complex. Nurses and doctors work together to sustain the flow of beds, and to achieve and demonstrate medical outcomes (i.e. progress and recovery.) But the relationship between doctors' diagnoses and nurses' assessments of patients is far from one of succession. Here, both doctors and nurses are engaged in configuring and, importantly, reconfiguring patient's identities. Their work together enables particular patients to access medical and nursing care. That is, both doctors and nurses work to distribute medicine as an important social resource.

² Strathern (1997) helps elucidate how Euro-Western thought proceeds by drawing relations of comparison.

Consultants' ward rounds are key occasions for accomplishing and circulating the orders of the clinical domain. In summary the ward round can be described as having several dimensions: First, they are functional - they are about reviewing and accumulating evidence to enable prompt diagnosis and decisions about treatment to keep things moving, to facilitate diagnosis and treatment issues, what Berg (1992) has termed 'medical disposals'. As a Professor of Geriatric Medicine put it in an informal interview with me, the ward round served as a time 'for evaluation', 'to keep exit always in mind', 'to stop things drifting'. The ward round at this level constitutes a form of inspection and audit, of both doctors' work and aspects of nurses' work.

Second, they are ceremonial (see also Strong 1979). As a ceremony the ward round is confirmative (Turner, 1967) to help produce and reproduce the power relations of the hospital. Through the conduct of the ward rounds (the placing of the patient and the different members, the routinization of turn-taking) and through it as a discursive practice, identities are confirmed. Importantly, the social is held apart from the medical as a purely clinical domain, and the division of labour and the distribution of medicine between nurses and doctors is accomplished.

Third, the ward round is also a ritual through which transformation (Turner, 1967) of a person into a patient of a particular type, and, critically, their return from patient to person to enable their discharge, can be accomplished (see also Latimer 2004). This entails an ascription of patients to classes: patients are ascribed to a class, which acts as permission or instruction to deal with patients in particular ways. These classes configure around constituting a patient's 'troubles' as either somatic (acute or chronic), social (age is also constituted as an aspect of the social), or psychosomatic.

Classifying patients helps facilitate their disposal. Disposal can be literal, in the sense of accomplishing shifts in a patient's identity so that they can be discharged, or disposal can be metaphorical, in the sense that staff dispose of their responsibility for patients because they are rendered or figured inappropriate to the acute medical domain. There are some patients whose problems might be so serious, and long-term, that they are simply not going to go away. Staff can only dispose of patients literally by disposing of them as the objects of their concern and responsibility. By reconfiguring their clinical identities, staff shift patients into categories (the chronically sick, the psychosomatically ill) for whom they do not consider themselves responsible. In this way staff accomplish a patient's literal disposal, and the disposal of their own feelings of responsibility towards them.

This said, the parameters and definition of what constitutes medicine is also constructed by the work that nurses and doctors do together. This is the second way in which nurses and doctors distribute medicine. Front-stage (Goffman 1958), doctors (with the exception of geriatricians) perform those aspects of patient assessment which make it appear that a medical decision is taken on a purely clinical basis. Backstage (Goffman 1958), nurses' work of observing, exploring and interpreting a patient's 'social situation' provides the context which in turn affects medical decisions.

Nurses' *contextualise* patient's troubles. They also in some cases where there is potential for problems to the flow of beds, help maintain an undecidability over the grounds upon which a patient's troubles can be interpreted. Maintaining an undecidability over interpretation helps provide the *motility* (Munro 1996) necessary to keep patients on the move. This is important in an environment where a patient can stay acutely ill only for so long. So that nurses' assessments affect diagnosis: diagnosis itself is a moveable feast and depends to some extent upon the wider context of a patient's troubles. Here, troubles can be 're-figured' as the consequences of biological decline or psychosomatic illness, rather than as the effects of acute illness. These sorts of moves provide the flexibility necessary to keep patients moving through the beds.

Yet the ward round and doctor-nurse relations are instituted to efface the contextualising work provided by nurses. It is kept virtually invisible. Effacing nurses' contextualising work has three important effects. First, it helps maintain the appearance that diagnostic and discharge decisions have been taken on a purely clinical basis. The dirty-work of socialising troubles is kept separate from the work of clinical decision-making. Second, effacing nurses' contextualising work maintains the supplementary, rather than complementary, status of nurses' work. Third, effacing nurses work as 'non clinical' renders it as 'other', and as 'social' rather than technical work. Thus effacing nurses' contextualising work does not just efface how medicine is distributed between doctors and nurses, but is another instance of how the constituting of classes is maintained and circulated.

It seems then that it is nurses who are made to appear as the ones who press the organisational need for movement and flow, the dirty work of the clinical domain. It appears to be nurses who pull patients through the beds. In reality nurses are helping to accomplish the medical agenda of having patients who are good for first class medicine, patients who can be seen to recover, patients who can be seen to be processed. Those patients who block the flow are also those patients who do not fit the medical bill. But in being seen as the ones who

do the dirty-work of organising, nurses take the brunt, and help maintain the purity of clinical practice as the doctors prerogative.

Being Caught between the past and the future: a liminal space

The case that I have presented is an example which I think illuminates aspects of the conditions of late modernity. Time has emerged as an artefact which like anything else we make can both incorporate socio-cultural relations, but which can also be put into play in ways which enable particular power effects.

And in a sense this paper hopes to act as an addition to the literature concerned with the precariousness of identity. While there is common consensus that identity is always in the making rather than made, there is also a general concern to show how identity is predicated on present performance. However, as Strathern, and Munro suggest, if identity appears as the effect of the relations that people in extension have with one another, under the pervasive effects of technologies of assessment, there has been an intensification not on present performance but on the future: one of the spaces for the performance of identity made available through modern technologies assessment is the future. The future self. The future person. The future member. Performing the future self is made doubly precarious because it is just that - the future. It is by its very constitution less easily substantiated than the past or the present - where after all is your evidence, how can the future be made manifest, substantiated? It is up to you to amass it.

So that the ways in which the evidence is amassed is through the technologies of assessment - so the technologies create their own demand for more technologies of assessment. In revealing they create their own orders. In this sense they are out of the control of any one social actor or group of social actors. No-one can escape the subjectification or the objectification of technologies of assessment. They are everywhere (just think of the pervasiveness of academic audit, Strathern 2000).

I want to suggest that the precariousness which technologies of assessment keep in play over identity, is constructed through the ways in which modern technologies of assessment emplace (and displace) persons between their past and their future, but not in their present. And that there are particular sites of intensity where such an enframing can be observed. These include the Research Assessment Exercise, the CV, and, as in the current example, service institutions such as the hospital. But I want to suggest that the effects of these social technologies in eliciting a performance directed always at the future, are

intermittent in their operations, but utterly pervasive and intense in their effects. So that, there are, at least, two problems.

The first is that the present is in danger of being made into a space of exploitation, but instead of nature itself it is us who are doing the exploiting (of our selves, of each other) and being exploited. To pay the present attention is becoming, I want to suggest, increasingly hard. To retrieve the present is to some extent to demand a gestalt switch **in** ones' self. While paying attention to the other as present, rather than as a means to a future end is increasingly difficult. The past is just what has already gone - the past - tradition, culture, a drag.

Second, and specifically I want to suggest that these technologies are enframing in ways that elicit subjects engagement in identity-work which projects themselves as having a future of a particular kind. That is what these social technologies are at risk of doing is not enhancing and dignifying identity, but of encouraging a setting upon and a challenge to demonstrate how persons can be rendered as stockpiles, as, in short, resources. That is modern technologies of assessment can render not just our selves, but *each other as materials for extension*. For example, as academics we do not just select a PhD student because their work is interesting; rather, the student is surveyed for their potential to enhance our CV (either as an individual, or in the motility of the modern academy, our university or department). A failure to submit or complete is through the RAE, the annual research plan and CV, and the TQA rendered as our failure. This kind of instrumentalism is I think beautifully explicated in Maggie O'Neill's work on sex workers: they assess *every* man they encounter for their potential as a future trick (O'Neill 2000).

So that rather than being a vessel made up of the past and of presence, what is being compelled is the making present of the future. Further, the elicitation of modern technologies used to assess individuals makes others' identities as themselves the materials for extension through which we will perform ourselves as future stockpiles of efficacy. Our forces are made coherent through the ways in which we are made to stand in advance of our selves, so that we become, more or less, in an inexact way of course, that which we once projected, but then of course we never notice what we have become because we are always becoming something else, something futured.

So held in this space between the past and the future with no substantial present, subjects are more vulnerable to an exercise of power - they are in short more susceptible not as in Barne's (1995) typology, to one another, but to an exercise of power coming from afar. From the centres of discretion constructed far from the present.

Conclusion

Technologies of assessment such as the one explored in my example, work social actors by challenging them to pursue and entrap self and others into a “calculable coherence of forces.” (Heidegger 1996:326.) In the name of enhancement or correctness technologies of assessment insert the authority to evaluate, calculate and estimate into relations between persons. As we have seen this is to intensify a focus on the future: in the particular case presented, the calculation of future efficacy is conditioned by the past and present conduct. In other cases the intense focus on the future may vary in its operations - the RAE, TQA, IQA, and even the ways in which CV’s work, means that we are all focused on *our* futures. We being turned by these technologies of assessment to calculate everything we do in terms of how *we will* rate. This challenges us to scrutinise our values as well as our activities and changes what we are prepared to do. This in turn changes who and what we are prepared to engage with - for nurses, doctors, academics, the identities of others (such as students, patients, co-writing colleagues etc.) become the materials for extension through which we perform our identity. To put it in consumption terms - the question is not just do they look good on us now, but will they look good on us in the future, down the line when the next assessment exercise takes place. Thus technologies of assessment enframe us to enframe others, as technologies of assessment are put into play (and kept in play but a web of devices and discourses) to calculate our potential efficacy with regard to the making up (or the unmaking) of our own futures we are incited to technologise our relations in the calculation of others potential as materials of extension. And so on and so forth - a never ending Yeatsian gyre.

But, and critically, what is to count as *valid* for the future is usually ambiguous: expectations and objectives embedded in technologies assessment or running alongside (such as those incorporated in performance measures, standards, benchmarks, etc.) are often giving out conflicting messages (e.g. Goffman’s orderlies, 1958, must maintain order without physically constraining patients).

So that while technologies of assessment set upon each of us to incite and excite a state of angst in all involved, it is what they are making absent by what they set out to unconceal which is of greater importance. Technologies of assessment are transforming the social. Specifically, under conditions of modernity where identity is always multiple and in the making (and as a result, fluid and precarious) identity can no longer be considered as *prescribed* through the relations of tradition (Schil 1981) or through stratification effects.

But nor does identity simply unfold through the dynamics of local interaction (Goffman 1958), driven by the susceptibility of self to others (Barnes 1995).

Technologies of assessment incite social actors to respond to their challenge: these technologies challenge self to deploy appropriate materials and devices for the performance of identities. But the materials for extension for the performance of valid identities are set to turn social actors away from the local, and toward centres of discretion lying far from the present, far from the relations of the local. Importantly, the materials for extension become under these conditions the technologies themselves, together with the identities which they help make up: like the older people in my ethnography, technologies of assessment incite social actors to set upon each other. They encourage instrumental relations. The panoptic effects of technologies of assessment mean that self and identity is in a constant state of rating - self regulates self in line with ambiguous, sometimes implicit, sometimes explicit, criteria of efficacy (in the nurses case, her identity is rated against a complex alignment of medical and managerial objectives as well as calls to care for whole persons coming from nursing discourse) Critically, these criteria to be effective have a moral component (in my example what presses the nurse and squares her account of herself to self and others is the myriad of future acutely ill people pressing for a bed on the horizon of the nurses' imagination.)

As we have seen then technologies of assessment help stabilise the present because they elicit an engagement of social actors as subjects. As Munro (2000) argues, it is not knowledge but identity which is circulated in the ordering of (post)modern social relations. I have suggested that these technologies of assessment make all identity precarious - they create even greater conditions for ambiguity over what will pass as valid, rather than invalidated. We have seen the work nurses do to hold older people's identities (just) on valid grounds. Older people and nurses are both already in precarious positions, intensified by the alignment of a medical and managerial objectives.

But an unintended and dangerous consequence of these technologies is that they circulate a challenge, they set man upon self and others: what is revealed, brought into being is the enframing itself. My ethnographic material shows how older people are set upon (challenged by the nurses assessment practices to show themselves as still worthy as persons. As having in short a social future from which their medical future flows. But other social actors may not have such spirit of generosity, particular in circumstances of competition, such as assessment for promotion (increasingly technologised in universities as well as other institutions) or the RAE. The danger is that the present is challenged, the social space of the

present become instrumental and presence is forced into, enframed only one way, into the future. An age interpellated with the effects of technologies of assessment transforms the present into a space of extraction for the future.

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