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Autoethnographic Reflections on Ageing, Bodies, and Olding as Ontology of Care

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Introduction

This piece traces how I became involved in social research, methodology, and theory—'ways of knowing'—that are concerned with care, bodies, practices, intimacies, materialities, and affects. In the article I have focussed particularly on my early experiences with older people, as both a nurse and a sociologist, and on how I developed a critical, theoretically engaged ethnographic methodology. I know I couldn't have become the writer, teacher, supervisor, and thinker that I have without my early experiences of doing care and becoming-with[1] older people. These helped me realise that I needed to find ways to make visible how, where, and when older people are emplaced and marginalised, and how 'ageing' is situated in and by contemporary culture, including by the very institutions that supposedly support growing older—for example biomedicine, and health and social care.

My early work on medicine, health care, nursing[2] and older people,[3] and more

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[1] The concept of *becoming-with* emerges from feminist science studies and posthuman theory, most notably in the work of Donna Haraway. Haraway uses the term to describe the co-constitutive processes through which beings—human and nonhuman—emerge as a companion species; it foregrounds relationality, mutuality, entanglement, and response-ability across species boundaries, challenging notions of individual autonomy. In my own paper "Being Alongside," I explore *becoming-with* otherness as *being alongside*, a mode of relationality that preserves difference as well as connection. See, Latimer, Joanna. "Being Alongside: Rethinking Relations Amongst Different Kinds." *Theory, Culture and Society*, vol. 30, 2013, pp. 77–104.

[2] See, Latimer, Joanna. "The Nursing Process Re-examined: Diffusion or Translation?" *Journal of Advanced Nursing*, vol. 22, 1995, pp. 213–220; Latimer, Joanna. "Socialising Disease: Medical Categories and Inclusion of the Aged." *The Sociological Review*, vol. 48, no. 3, 2000, pp. 383–407. Latimer, Joanna. "Nursing, the Politics of Organization and the Meanings of Care." *Journal of Research in Nursing*, vol. 19, no. 7–8, 2014, pp. 537–545. https://doi.org/10.1177/1744987114562151.

[3] See, Latimer, Joanna. "Older People in Hospital: The Labour of Division, Affirmation and the Stop." *Ideas of Difference: Social Spaces and the Labour of Division*, edited by K. Hetherington and R. Munro, *The Sociological Review*, vol. 45, no. 1, 1997, pp. 273–297; Latimer, Joanna. "The Dark at the Bottom of the Stair: Participation and performance of older people in hospital." *Medical Anthropology Quarterly*, vol. 13, no. 2, 1999, pp. 186–213; Latimer, Joanna. "Commanding Materials: Re-accomplishing Authority in the Context of Multi-disciplinary Work." *Sociology*, vol. 38, no. 4, 2004, pp. 757–775.

recent research on genomics at the beginnings and ends of life,[4] including dementia science,[5] include many collaborations with other colleagues in the social sciences as well as with nurses, biologists, neuroscientists, and clinicians across the UK, Europe, Australia, and North and South America. This research is ethnographic in the sense that it involved immersion over long periods of time in all facets of where, when, and how ageing and older people are imagined, enacted, and performed. Methods have included analysis of biomedical, media, and cultural representations of ageing, interviews with older people and their families, with scientists and clinicians, and health care practitioners, as well as participant observation of scientific, health care and medical practices in multiple locations—at the bedside, in laboratories, in clinics, and in the home.

It is important to stress here the serendipity of my intellectual development—I did not plan the directions and opportunities I followed. Rather I relied on a mode of attention, rather than intention, and the development of a subliminal capability, organic and evolving, of being open to being 'written' and 'rewritten' by text, knowledge, experiences, practices, and encounters over time. This capability concerns what de Rond refers to as making meaningful connections, seeing bridges rather than holes, as he puts it, especially "those things organizational research seeks to minimize in its emphasis on efficiency" (de Rond 253).

To situate my knowledge-making as partial, located, and critical (Clarke et al. 12), the piece that follows illuminates how this work began with my becoming "intimately entangled" (Latimer and Lopez 252) *with* and *by* ageing persons and bodies early on in my life. Specifically, my encounters with older people helped me understand that how we experience and think being and growing old are situated, by complex socio-cultural, material, and political entanglements, especially by dominant humanist and late modern notions of what it is to be a full person; yet by touching and being touched by older people in my work as a nurse and then as a sociologist I have been able to become-with what it means to grow old and imagine personhood differently.

Playing Nurse

My encountering the old and their care started as a young girl in the early 1960s. When I was about 6 or 7 years old, I would put on my play nurses' uniform and go and help in a private nursing home for older people two houses along from where I grew up. Wimbledon, now, as then, was a much sought-after suburb of London. The nursing home was in a large Edwardian, detached house, all wood panelling, flowery carpets, and chintz

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[4] See, Latimer, Joanna; Bagley, Mark; Davis, Terence and David Kipling. "Ageing Science, Health Care and Social Inclusion of Older People." *Quality in Ageing & Older Adults*, vol. 12, no. 1, 2011, pp. 11–16; Latimer, Joanna. *The Gene, the Clinic and the Family: Diagnosing Dysmorphology, Reviving Medical Dominance*. Routledge, 2013.

[5] See, Latimer, Joanna, and Alexandra Hillman. "Biomarkers and Brains." *New Genetics and Society*, vol. 39, no. 1, 2019, pp. 80–100; Milne, Richard, and Joanna Latimer. "Alzheimer's Disease and the Evolution of a Post-genomic Science." *New Genetics and Society*, vol. 39, no. 1, 2019, pp. 1–12, https://doi.org/10.1080/14636778.2019.1683213.

covered furniture and curtains. It was both a nursing home and a family home.

The nursing home seemed comfortable, but dark and hushed. I can remember the smell—of wood polish and a faint aroma of cooking and stale urine and something else—maybe older, decaying bodies. The matron and owner of the nursing home was a kindly, buxom woman. The family were great friends to myself, my mother, and one of my brothers, who used to help the matron's husband with all the odd jobs. I think they were semi-retired—he had been a travelling salesman at some point, and she a nurse. My memory is of a small pantry on the ground floor, where we made the tea—green Denby China cups and saucers, and white China feeder cups—laid out on trays with biscuits, fruit cake, or sliced bread and butter, which I would take to the residents in their rooms. I have no memory of the residents going outside in the garden, or of them in a sitting room. What I do have is a vivid image of the older women in their rooms, either in or sitting by their beds, as if in a perpetual evening. There were several residents in each room. Many of them were extremely old, pale, almost translucent, wrinkly, and frail—becoming not just invisible but inchoate, slipping into the "dark at the bottom of the stair" (Latimer 186). I have a vivid memory of cleaning a very wrinkled, paper-thin, skinny bottom of small gobbets of shit, pale like putty. I remember the smell and the old woman's wispy grey hair and pink scalp. She was turned on her side, I don't remember there being much of an interaction between us.

For me there was something profound and, in hindsight, perhaps life-defining in the experience of touching and "being touched" (Letiche 63) by such very old people. Here I allude to Letiche's emphasis on Merleau-Ponty's lifeworld paradigm and the concept of the reversibility of touching and being touched, wherein the 'subject' (who touches) and 'object' (who is touched) are radically interrelated and co-constituted. Specifically, I wonder what were the 'conditions of possibility'—the diverse socio-material conditions—that were needed for a child, dressed up and playing nurse, to be allowed to do such a thing? To what extent was it possible because these people were somehow not just invalid, but subject to a process of invalidation? They were being rendered less than full persons. On the other hand, it may not be permitted today for 'health and safety' reasons and to protect both adult and child. Yet this also means opportunities for children and older people to interact may be being missed. This moment in my own history takes place in about 1961. The old people in the nursing home were the "deeply aged" (Turner 114). These very old people were sequestrated, 'stabled' as a colleague once called it, waiting out the rest of their days in an endless twilight—unadorned, seemingly reduced to what we would normally think of as bare life—of becoming merely bodied, merely animal: becoming Other to what is held dear as being fully human.

Becoming a Nurse

About sixteen years later, having studied English Literature at London University where I was trained expertly in the analysis of text, I was at an impasse. I was unsuccessful at getting the funding I needed to take up a place at Oxford to do a PhD on *Piers Plowman*, a medieval satirical poem written in around 1380 by William Langland, about an ordinary man, rather than a knight or a king (I was always a bit of a leftie!). It explores the challenges faced by poor people trying to live virtuously in the religious and social corruption of late medieval England. While living in a shepherd's cottage with my boyfriend, the biographer Richard Holmes, and apple-picking on the local farm, I saw and responded to an advert for a cleaner at a small geriatric hospital in the nearby market town. The hospital was in a former workhouse, and I started cleaning there straight away for 50 pence (equivalent to 50 cents) an hour, doing my first shift work, clocking on 7am–4pm or 4pm–10pm. We cleaned everything except the patients and served meals and washed up. The cleaners were all women—farm workers' wives and mothers—and the hospital was spotless. I worked there for about seven months from 1976–1977, moving after 3 months from being a cleaner to being a nursing auxiliary (or care assistant), so I then got to clean and feed patients, lift people in and out of baths and chairs, and endlessly make beds. Unlike the nursing home in Wimbledon, this was a state-run British National Health Service (NHS) hospital for long term geriatric care. These no longer exist. A geriatrician visited once a week (coming from the County Hospital). To my fury, having ensured all the patients were clean and dry before the 'great man's' arrival, we nurses had to stand in the sluice while he did his ward round.

My memories of this hospital are very different from the private, family-run nursing home in 1960s Wimbledon. It was light and airy and, setting aside those people who were kept in bed all the time, patients were a bit livelier. Those who were deemed able were dressed and taken to a sitting room during the day or, on warmer days, to a glassed-in veranda overlooking the garden. While it was not what Erving Goffman calls a "total institution" (12), a closed system where patients are cut off from the outside community, care was routinized and delivered *en mass* rather than on an individualised basis, a form of organization that Goffman describes as managing people in "blocks" (7). But the older people's liveliness stopped at this—they were not included as participants in how the world they inhabited was organized, they were not members included in 'world-making,' they had almost no voice. To put it bluntly, they were treated as non-persons, as less than fully human, cared for in a block, 'processed,' and 'serviced.'

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Fig. 1: The infamous, tippable Buxton chair (www.crcmh.com/buxton1.jpg)

The afternoons and evenings saw quite a few visitors. But there were issues. Some older people seen as "confused" and likely to wander, were restrained in Buxton chairs, tipped back with a table locked in front—trapped in a cage—keeping them in place (Fig. 1). They were also sedated with tranquilizers. When in bed, these patients had a draw sheet tightly tucked around their middles to restrict their movements, and cot sides on their beds to stop them from climbing out. There was one patient who was kept in bed like this all the time—she had contractures and deformities. I never saw anyone taking her out into the garden or involve her in any kind of activity to enhance her abilities. In general, there was no rehabilitation ethos, or even really a sense that people could be helped to have a future or simply a better end to their life.

The routine was rigid—with rotas for baths and washes, as well as two hourly toilet and pressure area care rounds, the latter aimed at the prevention of pressure sores for people with reduced mobility. Pressure area care consisted of washing the bottom, and applying zinc oxide to the sacral area, and heels of the feet, as well as moving the patients' position ('turning' them). All meals were served like clockwork. The food was good—nutritious and home cooked. The patients did not have any choice about what happened to them, how, or when. And there was almost no privacy or variation—everyone got pretty much the same. In addition, the patients were not included in either the organization of the hospital or in doing anything to help—they were served, moved, dressed/undressed, bathed (once a week), toileted or potted, fed, put to bed, got up. Furniture was basic and uniform. Many clothes were like the furniture, communal and ill-fitting. When patients had their own clothes and if their relatives did not take them home to wash, they could be sent to the laundry and were often lost or came back shrunken.

Moreover, and I think this is critical, there was almost no relationship between the nurses and the patients—they were divided from each other. The patients were Othered. During quiet moments, the staff sat in the bathroom having a cigarette and a cup of tea, or some food saved over from mealtimes. While there was no overt cruelty, and the care was from some perspectives impeccable (with minimal falls and pressure sores), the patients were primarily looked upon with distaste—as bodies that were heavy, demanding, and which had gone beyond their sell-by dates, superfluous to requirements. Even death was routinized. My 'first death' entailed my helping a qualified nurse lay out Billy, an old farmer. The nurse showed me how to wash him all over, put coins on his eyes to keep them closed, stuff his orifices with cotton wool to stop them leaking, tie up his penis with a piece of bandage, and lay him out in a paper shroud ready for collection by the undertaker. I was shocked at the lack of love, of care in her gestures and approach. And Billy was very old—91; there were no relatives at his bedside during his last hours. These people were

Fig. 2: A drawing of patients at the hospital by me (c. 1976).

Deleuze and Guattari's "weary old ones" who may only "pursue slow moving opinions and engage in stagnant discussion by speaking alone, within their hollow head" (214). And yet this was an expensive institution—24 hour care on the NHS's budget, for people who were very unlikely to go anywhere else except to their graves. It was rather like a waiting room. Lots of people died in the six months I was there.

At night when I got home, all of this—the injustice, the inhumanity—made me weep with anger, frustration, and anguish. I loved the work, and I loved the patients—I was seared by compassion and care. And weirdly some of the patients seemed to love me back—we lifted each other. Like Billy, who always used to hold my hand when I talked to him, down close and intimate. So, I decided that I had to do something to help and applied to all the London teaching hospitals to train as a nurse. All but one rejected me—put off perhaps by my degree in English and sensing I could be too questioning! Fortunately, University College Hospital (UCH) School of Nursing, a progressive and revolutionary school, accepted me. At UCH, I worked in every kind of environment from intensive care, acute medicine and surgery, emergency medicine, orthopaedics, oncology and radiotherapy, to sexual diseases, labour ward and post-natal care, paediatrics and gynaecology; from learning how to manage a cardiac arrest, to delivering a baby, to how to look after burnt twin babies on ventilators as well as the terminally ill. I was so lucky because the people who trained me, on the wards and in the school of nursing, encouraged my critical imagination and helped me learn how to become a practical, informed, conscientious, creative, and highly organized nurse.

My first ward as a student nurse was a geriatric ward at St Pancras Hospital. In many ways, this was very similar to the hospital in Kent but with marginally more of a rehabilitation ethos—people were walked, given physiotherapy and occupational therapy to try and help them get home or into a long-term institution such as a nursing or residential home. There was a sense of some patients at least having a future. This unit too was in an old workhouse. One of the wards (not the one I worked on) was locked—it was called "Ward 9." This is where the psychogeriatric patients were kept. But at St Pancras, there was some dedication to the patients as individual persons—as students we got to 'know' them and were endeared to them. But still it was about getting through the work of administering to their bodies, keeping them maintained, in the hope that we could get them back on their feet enough for them to get out. The problem of course was that for the very disabled, there were so few places to go and often little support for them at home.

In all three of these institutions, the work was profoundly heavy: the older people I looked after had lots of trouble—difficulties walking, speaking, moving, eating, pissing and shitting, thinking, expressing. There was a lot of incontinence and disability—as nurses we were, to be honest, buckling under the work. But it is through these locales that I experienced how older people and old age were being thought of in a British context at that time: as extremely ambivalent and problematic to not just medicine and health care, but to society.

The downgrading of the work and the value of the people who needed it was accomplished by how they were being instituted: it was in the very fabric, smell, and texture of the buildings and in the sense of the patients not being mobile—socially or literally—and the sense of stagnation. Dennis Norden, a British comedian and writer, once said to my father that the trouble with marriage is it's daily. The trouble with care of the elderly is it's daily—and it jars with a cultural ethos which is, in late modern Britain, increasingly becoming more and more about mobility, change, direction, speed, attitude, competition, and productivity—being in a state of perpetual becoming. And older people's care is expensive, with not much *gain* if you are a health economist.

Older People, Health Care, and Medicine

In the early 1980s, a focus on older people as a problem to be managed in the NHS began to be made more and more explicit. I had two jobs which made me a participant in the management of the problem of older people. The first was helping to set up a Community Hospital in West London.[6] The hospital was supposed to be a revolutionary approach to help keep people at home. As I found, the aim of its inception was to help prevent unnecessary use of Accident and Emergency (A&E) and services designed to address conditions requiring rapid intervention and stabilization, rather than long-term or chronic care, at the nearby teaching hospital. The Community Hospital was thus the in-between—in-between the acute sector and the community sector. Its other political relevance was that it allowed General Practitioners access to beds and the opportunity to look after their ill patients in a hospital environment, and so begin to extend their scope, something that the Royal College of General Practitioners was pushing for at the time, and which was supposedly in their as well as the government's interests.

The hospital had a fixed maximum length of stay (3 weeks). Our patients could be of any age (from 16 upwards) and be suffering with any illness providing they did not require hi-tech interventions or would take longer than 3 weeks to sort out, or die. GPs referred a patient, but it was the nurses who had the authority to do a home assessment and assess their suitability for care at the community hospital and admit and discharge patients. We also designed our own policies and practices and instituted a special person and family-centred ethos. What patients got was low-tech medicine, but intensive *nursing* care, as well as physiotherapy and occupational therapy, tailored to their specific situation—both their health as well as their psychological, emotional, and social situation.

As the London postcodes of W2–W9 had the highest population of older people living on their own in any UK city at that time, many of our patients were in fact elderly. It was here that, unknowingly, I first experienced the concept of 'bed-blocking.' Bed-blocking was a term applied to patients who were supposedly medically ready to leave the hospital but who could not because of lack of suitable care or support in the community. My experience at the community hospital introduced me to the importance of tying timeliness and appropriateness to healthcare practices. While there had always been rules of thumb over how long someone should take to recover from a heart attack or a specific type of operation, what I was introduced to at the community hospital was an explicit notion of needing to manage how hospital resources, especially 'bed days,'

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[6] See, Latimer, Joanna. "Nursing in a Different Way." *Senior Nurse*, vol. 6, no. 2, 1987, pp. 28–29.

were used: we had specific policies about how long someone could be in hospital and kept track of this including setting targets for when and how they would be discharged. These policies directed my practices to regiment bodies around specific temporalities: a way of organizing, underpinned by asking—always and constantly—if someone was not getting well enough to meet their discharge date, then why not? Did we need to revise their treatment, change our approach, or were they at the end of their life? And if so, did we need to change gear, provide end of life or palliative care and help them achieve a reasonable death? And most importantly, how did all this connect to their situation, them as a person, and what they wanted.

This way of organizing can be understood as a new approach to managing what was called the 'bedstate'—the production of turnover or throughput so that beds could continuously become available for new admissions. Bedstate management makes the flow through the beds as important as the care given to the patients while they are in them. But I realised later that it does more than that—it is a strategic value that creates an assessing gaze, a way of looking at patients from the perspective not of their health or treatment but from the perspective of managing the hospital resources. As a new young Ward Sister, I was also sent on management and leadership courses, and my boss (the District Director of Nursing) talked to me about having my own budget, asking me to think in terms of what resources I needed to do the job we were tasked to do. I was experiencing the NHS under new management.

Later I took over the running of an acute medical ward at the Edinburgh Royal Infirmary, where the association between older people and 'bed-blocking' became more and more explicit. The ward I took on had to have beds available for emergency admissions every seven days and was notoriously blocked in the winter months. For example, one of the patients I inherited, aged 82 and who could not be discharged because she had dementia and there was nowhere safe for her to go, had been blocking one of the ward's acute medical beds for two years. My experience and skills at organizing and assessing patients and maintaining throughput was partly what got me the job.

Critically, I was immersed in the historical politics being enacted around being old, figured as being alive beyond the capacity for personhood, and questions over who is responsible for their care. These are the people now thought of as in their fourth age, the people needing not medicine, but what has become categorised as personal or *end-of-life care*. Bed-blocking is still in the UK news as what is plaguing the efficiency and efficacy of the NHS, with stories of acutely ill patients being treated in hospital car parks and corridors because there are no beds available for them to be admitted to.

Becoming a Social Scientist

Having published research undertaken while practising as a nurse,[7] I was invited by the Director of the Nursing Research Unit at Edinburgh University to apply to the Scottish Home and Health Department for a fellowship to train as a social scientist. I won the fellowship and joined Edinburgh's Faculty of Social Science doctoral program. It was a

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[7] See, Latimer, Joanna. "Stress and the Student Nurse." *Nursing*, vol. 10, 1980, pp. 449–450; Latimer, Joanna. "Learning to Listen." *Nursing*, vol. 27, 1981, pp. 1186–1187.

mind-blowing experience—more serendipity, perhaps—because the program not only cherished the experience and contribution of those of us who had been practising nurses, but also introduced us to continental post-structuralist philosophy and epistemology of science alongside ethnomethodology, the Chicago School of Sociology, ethnography, and contemporary thinking in Anthropology. My research, an ethnographic study of older people's assessment, diagnosis, and care in an acute medical unit, like the one I had run myself, was later published as *The Conduct of Care.*

My research approach combines the skill of textual analysis learnt as an English literature scholar with the theoretical and methodological grounds I was learning to work with as a social science doctoral student. Drawing ethnography together with textual analysis helped illuminate the relationship between discourse, everyday interaction and practices, and the production and reproduction of power relations. There are many different approaches to, and uses of both, ethnography and textual analysis. My own approach brings together the traditions of ethnography and textual analysis in a way that enabled me to focus on the cultural, social, and experiential significance of how care, medicine, and science are practised and situated. The analytical approach helps unpack the worlds people make together and the politics they are entangled in, particularly making processes of inclusion and exclusion visible.

My critical, theoretically engaged methodology has developed over time in collaboration with many others, particularly my husband Rolland Munro,[8] a philosopher of organization. Writing brings into view how different kinds of knowledge, work, and persons are easily devalued, including attending to the experiences of those who are easily marginalized (for example older people, children with rare genetic diseases and their families, as well as non-human animals). My underlying aim is to critique the conditions of possibility that underpin these hierarchical relations, including helping sociology pay more attention to how the ordering of the social involves much more than just human beings. Here I often draw upon different artists and poets to help illuminate these complex relations of inclusion and exclusion.

The New Sciences of Ageing

Most recently I have been exploring how scientists, doctors, politicians, families, and communities are beginning to be confronted by the fact that more and more people are living longer but not necessarily well. My latest work with biomedical scientists and colleagues in social sciences explores how different alignments and associations are constituting a "new dynamics" or "new sciences" (Walker 2) of ageing, and the way this new dynamic is affecting how growing older is being thought and done, both inside medicine, inside science, inside culture, and inside persons.

My own research on ageing explores scientific, medical, and health discourses, policies, and practices that together seem to constitute this "new dynamics" of ageing as a shift away from seeing ageing as inevitable biological decline linked to age in years, towards exploration of how individual ageing is "subject to influences over the

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[8] For example, Latimer, Joanna, and Rolland Munro. "Keeping & Dwelling: Relational Extension, the Idea of Home, and Otherness." *Space and Culture*, vol. 12, no. 3, 2009, pp. 317–331.

lifecourse" (Walker 2). I am concerned whether the new sciences of ageing, while attempting to prevent or protect us from ageing's worst effects, devalue older people and what getting old means.

My analysis of how biomedicine represents ageing and of laboratory practices and processes focussed on ageing, shows that in their laboratory experiments investigating aging scientists rely on animal models such as nematodes and mice.[9] As such, human biology and nature get reduced to organisms who in turn get reduced to genes and their effects. For example, in one program focussed on ageing and dementia, scientists investigating how a specific gene effects neurological function in nematode worms measure how slowly or quickly or how often a nematode worm thrashes its tail as evidence of dementia. What gets made absent is a situated, embodied subject. For example, how these worms were bred and programmed to represent a genotype, or how they were observed and treated as a consequence of the experiments themselves.

Moreover, with experiments using animal models, situatedness is represented as 'environmental forces,' figured by scientists of ageing in terms of very specific notions of stress, toxicity, and chance. These forces together with the specifics of species biology are seen by biologists as influencing how an individual or population ages (or doesn't). They do not in their experiments take account of wider social or cultural influences on how an individual or population ages, including their own experimental cultures and processes.

I have also shown how bioscience's reimagining of the ageing body reinforces how the ageing of social body is being reimagined. On the one hand, some of the scientists in my research represent ageing as burdensome and in need of curing. For instance, during a visit to a laboratory where the scientists are studying the genetics of cell senescence through experiments with skin cells,[10] one of them shows me a sample under the microscope. As I peer down the lens, the scientist explains that senescent cells are cells that no longer replicate; he describes them as "stagnant," and as "accumulating in the body and causing disruption." In framing ageing cells as obstacles within the biological body, the scientist is mirroring how older people and the aging population are viewed as burdens within the social body—both ageing cells and ageing persons are enacted as problematic, as clogging up both the social and biological body. On the other hand, I found bioscientists enacting biological ageing as dynamic and adaptable, with scientists increasingly describe ageing to me as 'plastic' and 'malleable'—as processes that can be influenced and potentially improved.

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[9] See, Friese, Carrie, and Joanna Latimer. "Entanglements in Health and Well-being: Working with Model Organisms in Biomedicine and Bioscience." *Medical Anthropology Quarterly*, vol. 33, no. 1, 2019, pp. 120–137; Latimer, Joanna. "Science Under Siege? Being Alongside the Life Sciences of Ageing, Giving Science Life." *The Sociological Review*, vol. 67, no. 2, 2019, pp. 264–286; Latimer, Joanna, and Alexandra Hillman. "Biomarkers and Brains: Situating Dementia in the Laboratory and in the Memory Clinic." *New Genetics and Society*, vol. 39, no. 1, 2019, pp. 80–100.

[10] Samples of skin cells being used in the experiments are 'models' of ageing; the cells come from a very specific group of people with an inherited early ageing genetic disorder known as Werner's syndrome.

In summary, I found that ageing bodies are depicted in the bioscience I investigated as declining, losing vitality, and threatening to drain resources; and at the same time, I found biological life being framed by scientists in molecular terms, that is as programmable and flexible, so that ageing, with the right technological interventions, can be subject to enhancement. Bioscientists thus help justify the need for intervention in ageing, and help to show that ageing can be managed, delayed, or even reversed, for the benefit of both individuals and society. As one biologist put it to me, her research on delaying ageing was more valuable than focusing on a single disease like Alzheimer's Disease, because "not only do you not have the disease, but you are younger, fitter, and more productive."

Thus, through my close encounters with *how* the biology of ageing does its work I can illuminate how and when the new sciences of ageing are caring for, about, and with ageing, and when they reinforce negative depictions of ageing bodies and persons.

Olding

Contemporary cultures celebrate the promise, hope, and voluptuousness of the new, the young, and the productive, while the processes of becoming old are constructed in an alignment of biomedicine and politics as deeply troubling and disordering. While the emphasis in the late 20th century has been on ideas of fluidity and perpetual becoming (Bankston 3), this beautiful idea runs alongside the facts of perpetual unbecoming; of how over time, living beings also seem to be perpetually becoming Other: old frail, diminished, burdensome, inhuman.

Chronological age has been a key category in most cultures—from personal and social identity to kinship relations and cultural categories (e.g. infant, child, teenager, adult). In Euro-American societies, age underpins institutions—it is used to shape and underpin socio-legal infrastructures, social policies, education systems, employment structures and practices, health care organization, and finance and insurance. It is difficult, for example, to get a mortgage after a certain age, and you certainly can't get one before a certain age. Mary Douglas might describe 'age' as a "classification system" (17), infrastructural to cultural systems of value, with deep old age, as already discussed above, and older people, marked as of little value, even monstrous, for the biological as well as the social body.

But age and ageing are also deeply problematic in terms of personhood and the lived experience of growing old. As the science fiction author, Ursula le Guin stresses, 'ageing' is an existential event, material and affective, embodied and figurative. She writes about "geezerhood" and the "diminished thing" that the older person is made to represent, asserting that "Old age isn't a state of mind. It's an existential situation" (13). Debunking the myth that you are only as old as you feel, she says: "To tell me my old age doesn't exist is to tell me I don't exist. Erase my age, you erase my life – me" (14). In addition, Pat Thane the historian of ageing argues in her essay "Old Age," that there is very little that is uniform about how an individual ages—ageing up close expresses a situated and positioned individuality. For me, *Mumbling Beauty*, Van Gelder's marvellous collection of photographs of the artist Louise Bourgeois in her later life, depicts some of this complexity.[11]

Given that growing old is both a biopolitical construct and a lived condition of being-in-the world, I want to suggest a term other than 'ageing' that helps us hold onto this doubling. The term 'Olding' rather than ageing, keeps hold of the idea that aging is embodied, situated, and of existential importance as at the same time as it captures the possibility of becoming-with ageing and older persons as matters of care. Ingold and Palsson in their book suggest the mattering over time and space that is growing old as a form of "biosocial becoming." But I want to press how ageing is simultaneously situated as a process of perpetual *unbecoming*, and of perpetually becoming Other. Flesh, time, materialities, language and culture, and the socio-political, entangle in the ongoing production of ageing and of older personhood. The difficulty is that the unbecoming of growing old is situated by how personhood in the contemporary moment is figured in terms of keeping younger, fitter, and more productive for longer, of keeping becoming *somebody*; in contrast, growing old is figured as unfitting, inappropriate, unseemly: as a process of becoming Other. So, in pressing the ontology of Olding I am pressing the need to not just think-with but become-with, even live-with as Donna Haraway (5) might put it, Olding. Specifically, Olding helps hold on to the recognition that how persons age is situated and often hard, but that older people do not be need to be othered as a result of becoming differently. While ageing is often imagined through the perspective of dominant notions of personhood as a process of degeneration, decline, and loss of all that is most valued about being human, the ontological shift that Olding demands—a shift to touching and being touched by and with ageing and older people—shifts how being and growing old are thought and experienced; as even, perhaps, of becoming less masked by all that situates, including accomplishment and adornment—social, material, cultural—and as such, as more rather than less human.

For example, in his contemplative late poem "Lebensweisheit Spielerei" ("Playing with the Wisdom of Life"), first published in 1954, Wallace Stevens associates later life with an "indigence of the light, a stellar pallor that hangs on threads" (504):

> Weaker and weaker, the sunlight falls
> In the afternoon. The proud and the strong
> Have departed.
>
> Those that are left are the unaccomplished,

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[11] *Mumbling Beauty*, Van Gelder's photographs of the artist Louise Bourgeois in her later years, offers a deeply nuanced portrayal of ageing as both an intimate and complex process. Through these images, Bourgeois appears neither simply frail nor purely resilient, but instead as a figure who embodies the contradictions of growing old—wisdom and vulnerability, presence and withdrawal, endurance and transformation. The collection resists the conventional tropes of ageing that often depict older individuals as either diminished by time or heroically defying it. Instead, Van Gelder captures Bourgeois in moments of quiet contemplation, playful irreverence, and artistic engagement, emphasizing the fluidity of identity in later life. The photographs highlight the way ageing unfolds not only in the body but also in the textures of lived experience, memory, and creative expression. In this way, *Mumbling Beauty* challenges reductive narratives of decline, inviting viewers to see ageing as a layered and ongoing negotiation rather than a fixed state. It aligns with broader cultural and philosophical inquiries into ageing as a process that is as much about transformation as it is about loss.

The finally human,
Natives of a dwindled sphere.

Their indigence is an indigence
That is an indigence of the light,
A stellar pallor that hangs on the threads.

Little by little, the poverty
Of autumnal space becomes
A look, a few words spoken.

Each person completely touches us
With what he is and as he is,
In the stale grandeur of annihilation. (504)

The poem's *bathos* turns the impoverished light of the evening of life into an almost false light. The fall, of the day, of the year, of the light, appears cosmic in its associations: the dwindling in which "the proud and the strong" have departed is when we can be touched by each other as "unaccomplished," revealed for "what (s/)he is and as (s/)he is." Growing old may be "annihilation" of sorts, stale, but it is nonetheless grand, the antithesis of the life-giving light of "accomplishment" and the adornment that makes us proud, it is when we become "finally human." Stevens himself, playing with the idea of what gives life wisdom, seems to be suggesting that wisdom is earned through the experience of the ordinary and the everyday, what elsewhere he describes as the "plain sense of things" (502). My relation to the double figure of Olding—as simultaneously biosocially *unbecoming* and as becoming differently to all that is most valued in contemporary ideas of personhood—is possible in the moment when I touch and am touched by the plain sense of being "after the leaves have fallen" (Stevens 502).

Concluding Remarks

My lived experience of both becoming-with older people through immersion in their care and of becoming entangled in how the needs of the aged are positioned—aroused in me a sense of it as a critical site of social in/exclusion and (in)justice. This lived experience has also always helped me ground my theorizing, research, and teaching. Moreover, my research on the politics of care which draws out of my experience as a nurse and an ethnographer of many different care contexts, has helped to explicate how healthcare enacts power relations as well as mundane processes of inclusion and exclusion.

In this biographical account, I have offered some insight into the serendipity in my life through which I have developed an approach that reveals and addresses the assemblage of discourses, practices, political machines, cultural values, iniquitous distribution of wealth, and the disinterest of medicine, which constitute how ageing and being old are thought and experienced. I have drawn on my own experience and research to suggest that someone entering this category of being old is an event—a situated process of emplacement.

Here I have sought and continue to seek ways to rethink ageing and 'being alongside'[12] older people, to propose a new kind of ontology, Olding. The ontology proposed by Olding involves a doubling: touching and being touched by the plain sense and materiality of ageing as a process of unbecoming while simultaneously not framing unbecoming as becoming Other. My own lived experience of caring helped me to understand that thinking and becoming-with Olding can help us rethink what it is to be human and a full person. This involves, as I have suggested, a recognition that how persons age is relational, and that the very institutions that are meant to support ageing and older people can figure older people as less than human and intensify their invalidation.

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[12] In this paper, I argue for being alongside as well as becoming-with those who can be made to seem and as less than human. See, Latimer, Joanna. "Being Alongside: Rethinking Relations Amongst Different Kinds." *Theory, Culture and Society*, vol. 30, 2013, pp. 77–104.

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