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Exemplary: The case of the farmer and the turpentine

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By Annemarie Mol

This post is part of our new series, The Ethnographic Case***.***

In 1976, when I was eighteen and he was eighty-four, my grandfather told me the case of the young farmer and the turpentine. By then this case was more than fifty years old. It stemmed from the time that my grandfather, Chris Mol, worked as a general practitioner in what was then a poor, sandy region of the Netherlands. When he settled there, the people and the land still looked pretty much as they had when, forty years earlier, Vincent van Gogh had been drawing and painting the local farmers. At the time, being a family practitioner meant receiving people who came to see 'the doctor' in his house throughout the day. His was a big house, painted a warm yellow, in the style of Vienna (where after graduating in Amsterdam my grandfather had extended his studies). Farmers regularly came for a consultation after Sunday mass, when they had already made the walk to the village centre. And, when a young boy running, or a neighbour with a bicycle, were sent to fetch him, my grandfather would go and pay house visits to the spread out farms, traveling by the motorbike that he had bought as soon as he could afford it.[1]

The case of the young farmer began with such a house visit. The doctor found the young man in bed with a fever and a nasty, infected wound in his left leg. He made a cut in the skin of the abscess, to allow for the escape of the *pus bonum et laudabile*: the good and praiseworthy pus. A body liberated of pus would heal faster. But the young farmer didn't heal. When the next day the doctor was called in once again, he feared an imminent sepsis, from which the patient was likely to die. What to do? There were as of yet no antibiotics. There were no other treatments either. Or were there? My grandfather remembered a case history that he had heard from an older colleague. In that case, too, the problem had been an infection in a leg that had become compartmentalised, festering and putrefying, while the rest of the body had not got itself involved in the defence.[2]

This is where the turpentine comes in. Chris Mol asked the young farmer permission to engage in an experiment. The patient readily agreed. "Yes

doctor," he said, "if you do nothing I will die, I feel I will." So my grandfather steered his motorbike to the workshop of the local painter and asked for dirty turpentine. Back in the farm he injected a small amount of this into the dying man's right leg, the other leg. The experiment worked out well. The nasty stuff injected aroused a fierce, overall reaction of the immune system. This vehement immune response also reached the wound in the left leg and the bacteria infecting it. For a while the patient was critically ill, but he healed. That is the case of the young farmer and the turpentine. My grandfather told it to me as a lesson about both the human body and medical practice, a layered pedagogy that is typical of medical case histories. This is the lesson about the human body: it is complex and not quite predictable. And this is the lesson about medical practice: don't just depend on your textbooks, they may fail you. If they do, be inventive, daring. Case histories may help here as they relate what, often surprisingly, worked out well in other sites and situations.

As I reiterate this story here I seek to add another lesson, a lesson about sharing knowledge. To my mind 'the case of the young farmer and the turpentine' is an exemplary case of a *case*. A case carries knowledge, not in the form of firm rules or statistically salient regularities, but in the form of a story about an occurrence that, even though it may have happened just once, is still telling, indicative, suggestive. It condenses expertise that is not general, but inspirational. As cases are idiosyncratic, those who seek inspiration from them still have to think for themselves. They have to adapt the lessons learned to the situation in which they find themselves.

Cases, then, do not transport knowledge smoothly. It requires work to draw on them. The implications *here* of a case that occurred *elsewhere* have to be carefully thought through and tinkered with. Such tinkering may serve highly varied goals. Medical cases may inspire doctors who, under slightly different circumstances, with other specificities kicking in, have to solve a similarly intractable problem. Judges may seek guidance from cases as they consider how to judge the next particular intractability. For ethicists, discussing past cases or imaginary vignettes is a way of sharpening their skills of appraisal. For historians a case begs questions about its conditions of possibility: what all had to be in place for this particular event to occur?[3]

Cases are also good for those of us who craft theory as we work with empirical materials. For even if cases index situated events, it is still possible to make them pertinent elsewhere. Not everywhere, mind you. It remains to be seen where a lesson travels and where it doesn't hold. The genre of theory that cases inspire does not aim to be empirically encompassing or universally valid. Instead it carries a set of sensitivities that emerge from the case at hand. And then begs the question what might be different elsewhere. For example. The case of anaemia may

exemplify relations between clinical and laboratory ways of separating out the normal from the pathological.[4] (But in cancer the clinic relates differently to the lab.)[5] The case of diabetes may be used to argue that 'choice' is not a particularly helpful term in the context of living with a chronic disease, where other terms, like 'care', make better sense.[6] (But within caring practices there are moments when choices impose themselves.)[7] The case of meat may illustrate the multiplicity of natures within the so-called West – for however much this 'West' is mono-naturalist in theory, in many of its practices, meat-practices included, reality multiplies.[8] (A complicated message for there are also instances where mono-naturalist visions impose themselves upon practices).[9]

And the case of the young farmer and the turpentine? Since 1976 I have tenaciously kept it in the back of my head as I worked on other cases. And as finally I now write it down, I am curious if beyond my specific situation, that of a granddaughter to whom it was passed on as a heritage, it may hold up as both a compelling story *and* a convincing case of a case.

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[1] For the separation between work and private space and time of general practitioners in the course of the twentieth century (in Britain, but the Dutch case is strikingly similar) see: David Armstrong, (1988). Space and time in British general practice. In Lock, M., & Gordon, D. (Eds.) *Biomedicine examined,* Springer (pp. 207-225).

[2] For the immunology that was rising at the time, see: Cohen, E. (2009). *A body worth defending: Immunity, biopolitics, and the apotheosis of the modern body*. Duke University Press.

[3] A great example of an history quest for conditions of possibility is Michel Foucault (1973/1963), *The birth of the clinic*, trans. *A. Sheridan, London: Tavistock*.

[4] Mol, A., & Berg, M. (1994). Principles and practices of medicine. *Culture, medicine and psychiatry*, *18*(2), 247-265; Mol, A. (1998). Lived reality and the multiplicity of norms: a critical tribute to George Canguilhem. *Economy and Society*, *27*(2-3), 274-284.

[5] Jain, S. L. (2013). *Malignant: How cancer becomes us*. University of California Press.

[6] Mol, A. (2008). *The logic of care: Health and the problem of patient choice*. Routledge.

[7] Callon, M., & Rabeharisoa, V. (2004). Gino's lesson on humanity: genetics, mutual entanglements and the sociologist's role. *Economy & Society*, *33*(1), 1-27.

[8] Yates-Doerr, E., & Mol, A. (2012). Cuts of meat: Disentangling western natures-cultures. *Cambridge Anthropology*, *30*(2), 48-64.

[9] Bonelli, C. (2012) 'Ontological Disorders: Nightmares, Psychotropic Drugs and Evil Spirits in Southern Chile', *Anthropological Theory* 12(4): 407-26.

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