Sensing and smelling healthy and diseased bodies

Patricio Rojas
Department of Sociology
Goldsmiths, University of London

I am going to talk about smells and diseased bodies. My starting point will be a proposition that can be found in Katie's blog in relation to how to find new fragrances and scents to wear[1]. Katie suggests two different approaches: one is to search online and read what other perfume users have to say. The second is to try different scents at the perfume counter, and live with the four of them you liked the most for a day. This way, you can be emotionally drawn to one of them by what Katie calls a "perfume voodoo"[2]. What I want to explore now is what could happen if we experiment with these two possibilities in a different setting, like the hospital. What kind of possibilities do they open for becoming a nose?

First, I will use the example of an article published in the Argentinian journal "Medicine", titled "The case of a stinking girl" (Cuestas, Busso, Barcudi & Tapia, 2005). It proposes the discussion of a clinical situation: a three and a half year old girl is brought to the hospital many times by her mother. The reason was "an unpleasant and offensive smell" that emanated from the girl's whole body. The mother explained she had tried to mitigate it using all the cosmetic products and perfumes she had at hand. However, the bad smell was so stubborn that she decided to seek for help. The problem was that the girl's physical exam was normal, and laboratory tests showed no abnormal indicators. The puzzle was solved quickly: one of the doctors localised the girl's left nostril as the most intense source of the smell. After an "interrogation" of the mother, the practitioner realised that a month before the consultation the girl used to play with dolls, bathing them with a sponge. The physicians examined the girl's nostril and found a "strange body" –a small piece of sponge- inside of it. When it was removed, they encountered an ulcerated nose with several bruises. After taking care of that, the bad smell quickly disappeared.

This article presents a case of medical success, and uses it to foster the use of the sense of smell as an asset in the practice of health care. It does so by discussing smell, and proposing classifications that pair medical conditions with their corresponding smell: e.g.

[1] The references to "Katie's blog" throughout this paper refer to www.katiepuckriksmells.com. Katie Puckrik was the main speaker of the seminar, and her perfume reviews a starting point for this presentation.
[2] http://www.katiepuckriksmells.com/2000/05/faq.html

“foreign intranasal object” goes with stench, “liver failure” with fish, “urinary tract infection” with ammonia, and so on. Thus, a semiotics of odours is created, opening up a sensitive world and acting as a guide for the practitioner that tries to learn to be affected by them. If we return to the case of the stinking girl, we can see that this engagement with scents makes some assumptions: The sense of smell seems to be an individual property of each one of the individuals involved in the medical situation. Bad smell itself is a sign, a disgusting indication of a transgression of boundaries because - when the doctor/sniffer, the patient, and the little piece of sponge are detached- a healthy body with no smell is produced.

But, what might happen if instead of becoming a nose through medical literature, we let us be affected by the way smell is lived and practised in the hospital? I will now consider a different example: Chile’s largest mental health care centre, where I worked as a clinical psychologist[3]. In his book “The five senses”, Michel Serres (1985/2008) proposes that taste and smell could be considered a “second mouth”, one that is anaesthetised by the first mouth of speech. He discusses how these senses can be awakened, for example, through the tasting of a good wine. But a hospital can wake them up in a very different way. I remember the hospital: the smell is a mixture of coffee and cigarettes. In the dining room, a strong odour of boiled food can be constantly felt. Down the hall, the scent of hydrogen peroxide surrounds the infirmary, and gets dissipated by the wind coming from outside and the bedrooms, carrying a mixture of smells of old clothes, humidity and stagnation. In addition, the smell of urine springs freely from bathrooms that have no walls or doors in order to avoid suicides, or patients locking themselves inside. And you cannot stop smelling all of this. You cannot cover your nose or close your mouth forever. You cannot stop responding to these differences. Scents circulate, getting mingled with bodies and things. Despite the ideals of public health, odours in the hospital cannot be tamed by air-fresheners or sterilisation procedures. A stable semiotics of smells, substances that produce them and places to locate them is almost impossible. Smell flows and gets stuck, from wind to skins, from fabrics to walls, refracted and reflected by perfumes, soap, sweat and pharmaceutical substances. It is part of consultations, dinning, sleeping and talking.

Smell affects you. Brian Massumi (2002) says that affect has to do with intensity, flowing in a non-linear process full of resonances and motion. A pre-individual set of forces that emerge in the in-between-ness of the entities of a world in constant becoming. Those of you familiar with Massumi’s philosophical project might be aware of how hard is to think of an actual example of this. Perhaps the key is in change, motion, and its limits. Some people

[3] Dr. José Horwitz Barak Psychiatric Institute, Santiago, Chile.

have commented in Katie's blog how the use of perfume might be a way to transform and re-create your future self[4]. But what happens if we think not only in the way we play with smells, but rather in how smells might play with us? Let me share a memory with you: I was at the hospital having a conversation with one of the patients. Suddenly he told me something like this: "I won't get out of here soon: I smell like a patient". Then he added: "someday the smell on me, and on you, and on this place will change. Things will be different. We won't even notice. I'll just be healthy, and leave". We were in an institution that is considered an embodiment of the perpetual regulation of movements, speech and gestures. However, the patient was making a bet on motion and change. He wasn't talking about deliberately acting on himself to influence doctors through smell. He was stressing how something else –where shifting smells played a part- could generate a difference, passing through us and our capacities to resonate with the rhythms of this world in ways we were, perhaps, unaware of. But we would still, somehow, feel it.

If we are to become a nose this way, smelling would be a work of transformation, and sensibility would reveal the possibility of a change of direction. This version of sensing and smelling is very different from the purified version of the medical article I mentioned before. Each one of them responds to disparate practical constrains, and opens different possibilities to engage with bodies and the world. There are, of course, many others. We could be interested in experimenting with them and, following authors like Vinciane Despret (2004), getting involved in the evaluation of how they do (or do not) give our practices a broader system of references, a chance to raise new questions, or perhaps even more opportunities of producing different versions of ourselves, of what we do, remember, and feel.

References

Cuestas, E.; Busso, R.; Barcudi, S & Tapia, N. (2005). El caso de una niña maloliente. Medicina (Buenos Aires), 65 (4), 341-344.

Despret, V. (2004). Our Emotional Make-Up: Ethnopsychology and Selfhood. New York: Other Press.

Massumi, B. (2002). Parables for the Virtual. Durham & London: Duke University Press.

[4] http://www.katiepuckriksmells.com/2012/09/fumes-in-news-juliette-binoches-perfume.html

Serres, M. (1985/2008). The Five Senses. London: Continuum.