DOI: 10.1590/1807-57622017.0171

Multiple bodies, political ontologies and the logic of care:

an interview with Annemarie Mol

crédito: NWOIvar

Denise Martin[a]
Mary Jane Spink[b]
Pedro Paulo Gomes Pereira[c]

In this interview with Annemarie Mol we explored important aspects of her academic production. We deal with themes such as: Multiple Bodies, Political Ontologies and the Logic of Care. Annemarie Mol (1958) researches at the confluence of philosophy, medical sociology, anthropology, the sociology of science, and social theory. She studied medicine (a free doctorate that after the ordinary BA mainly included social sciences of health care) and philosophy at the University of Utrecht. She completed her doctorate in philosophy at the University of Gronigen in 1989. Between 1990 and 1995, she worked as a post-doctoral fellow at the University of Maastricht and the University of Utrecht. In 1996, she was nominated Socrates Professor of Political Philosophy and senior researcher at the University of Twente. In 2008, she was named Socrates Professor of Social Theory at the University of Amsterdam. In 2010, she became a professor of Anthropology of the Body at the University of Amsterdam. Her books include: *Ziek is het woord niet* (with Peter van Lieshout); "Differences in Medicine" (edited with Marc Berg); "Complexities" (edited with John Law); "Care in Practice" (edited with Ingunn Moser and Jeannette Pols); and the single authored monographs "The Body Multiple; and The Logic of Care", as well as numerous articles in specialized journals. Annemarie Mol kindly agreed to answer the questions posed by Denise Martin, Mary Jane Spink and Pedro Paulo Gomes Pereira.

[a,c] Programa de Pós-Graduação em Saúde Coletiva, Universidade Federal de São Paulo. Rua Botucatu, 740, sala 404, 4º andar, Vila Clementino. São Paulo, SP, Brasil. 04023-062. demartin.c@gmail.com; pedropaulopereira@hotmail.com

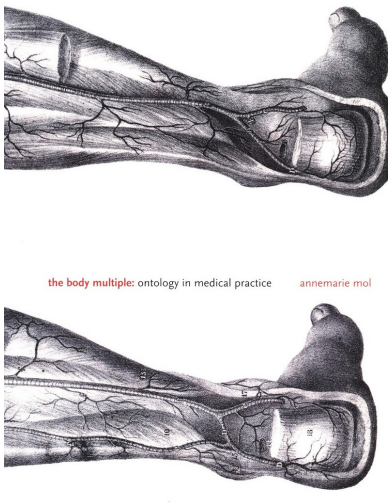
[b] Programa de Estudos Pós-Graduados em Psicologia Social, Pontifícia Universidade Católica de São Paulo. São Paulo, SP, Brasil. mjpspink@gmail.com

In "The Body Multiple"[1], you show how bodies are manipulated through various practices. In order to do away with the dichotomy between the body we *have* and the body we *are*, you remind us that we *do* our bodies in everyday practices: we perform, we enact, we stage. We ask, therefore: How do we deal with our bodies? How is it possible to investigate the bodies that we *do*?

There are many ways to investigate the bodies we *do*. In "The Body Multiple"[1] my investigation focused on hospital practices related to vascular disease, atherosclerosis, particularly of the leg vessels. The body 'we' do in that setting, is done by a wide "we": all kinds of people and apparatus are involved. The patient's whose arteries are at stake actively participates in these doings. In the consulting room she talks (asks and answers questions) and takes of trousers and socks if required and allows the doctor to feel out the pulsations of her arteries and the condition of her skin. In the laboratory she contributes by rather not talking, or not too much, but allowing the technician to measure. For instance, to measure the difference between the blood pressure in the ankle and the arms. Or to measure the blood velocity through the leg arteries. Those are different measurements: the first *does* the disease as a fall in blood pressure, the second "does" it as a local increase in blood velocity. These ways of "doing" atherosclerosis both differ from the conversation between patient and doctor that earlier took place in the consulting room, where the disease rather takes the shape 'pain upon walking' and "weak pulsations" or a "badly nourished skin".

However, it is also possible to investigate the body this or that "we" performs in other settings – outside the hospital. In the consulting room of dieticians, for instance. There it is not "pain upon walking" but, for instance, "overweight" that is the crucial problem tackled. In relation to that, people's bodies are done as either greedy, or as needing nutrients, or as used to certain kinds of food, and so on[2]. Or they are done rather differently, as lacking in satisfaction, or as craving care and hungering for love[3].

How it is possible to study all that? By attending to what happens in a practice, wondering what each of the elements in the scene suggest about the reality (problem, concern) at stake in that practice, asking those present questions so as to learn about their take on things, reading around. And most importantly: by also study *other* practices and learn about both from the contrasts between them.



Capa do livro The body multiple

Along the same lines, how do we deal with illness? How can we think and talk about illness?

As I have studied physical diseases mostly, in most of what I wrote the doing of the body and the doing of illness flow over into each other. Even if my body multiple book is called "The Body Multiple"[1] the multiple it displays is primarily the disease 'atherosclerosis' rather than 'the body'. But 'Disease multiple' would have been a less intriguing title. At the same time: different versions of a disease and different versions of the body go together. An anatomical version of atherosclerosis is situated in a spatial body. A body served by arteries with a certain width. This may be narrowed by a plaque. That is called a stenosis.

Physiology, by contrasts, suggests that atherosclerosis is not a structure in space but a process over time – in which plaque may gradually form. Hence, it also envisions as processual body, constantly transforming. And then there is a daily life version, which is translates in the hospital to a clinical version, of both body and disease. Here, the body is something lived with from day to day, hour to hour and the disease atherosclerosis takes the shape pain upon walking.

The crux of drawing out these distinctions is that going with one version or the other has different practical consequences. Pain upon walking may gradually diminish if a person walks a lot – twice a day for at least twenty minutes. But while walking solves the problem pain, it doesn't alter the fact that the artery has a stenosis. Hence, if walking therapy is evaluated by measuring the width of the vessel it seems to fail, while if it is evaluated by assessing the complaints it is successful. An interesting tension, a relevant clash.

You use the term "enact" to show that objects (such as body and disease) exist as articulations of the practices that produce them. As you have shown, disease arises through the different modes through which it is enacted. *Enact* carries the sense both of staging and of causing to exist, of acting. Could you comment a little more about this central concept in "The Body Multiple"[1] (such as, for example, in relation to Judith Butler's theory of performativity)?

There is not much difference between the way I use *enact* and the way Judith Butler writes about the "performance" of reality. Performance has a historical background in which there was a 'true' reality behind the stage where reality is performed. Butler doesn't think there is a back-stage, but some of my reviewers did. That is one reason that I didn't use the term: I wanted to avoid that connotation.

But listen, enacting has nothing to do with causing. Nor with making. Those are words that stress the past (in which 'causes' lie; or when "making" happened) and they stabilize the outcome, the present. The crux of the shift to performing/enacting is that the present itself is and remains unstable. There is a here and now, in which 'doing' happens, but it is "not" explained by what went before – there are patterns and routines, but there is also always the possibility of surprise.

"The Body Multiple"[1] is a powerful statement about praxiography, about practicalities and materialities, and about a type of ethnographic method that converses with multiplicity. As you say, doctors and patients ascribe meaning in different ways. However, practices at some point become words: either through field notes or though conversation about what one is doing. And these discursive practices are composites of linguistic repertoires that are embedded in meanings; hence, in interpretations, or differing versions. How, then, may we conciliate practices and discourses (or records) about practices? How can we consider language as practice?

There is a misunderstanding here, a confusion. I do *not* say that doctors and patients ascribe meaning in different ways. I tell that other authors have worked that out and that I want to take a further step, go beyond that. I hope to tell an additional story, which is that doctors and patients perform, or enact, reality "together". So rather than the difference between them, I stress their collaboration. Doctors and patients collaborate, they need each other to *do* the reality of a disease. Without a patient telling about her/his concerns and complaints, a doctor has nothing to attach meaning to. And without a doctor offering explanations, diagnostic tools and treatments, the patient has problems, but these are not 'atherosclerosis'.

The linguistic repertoires relevant to this collaboration do not come "after" them – they are a "part" of what happens in hospitals. This is different for my field notes – that, I would say, are particular kinds of digestions of what happens in the hospital. They are fairly irrelevant to hospital practices then and there, but they are in their turn part of other practices. Academic ones, maybe policy conversations, they could be made relevant in teaching – also teaching in medical schools – or in framing new research.

It is fully well possible to study language-in-practice. Of course, in many human practices there is a lot of talk! As it happens, it is one of my more recent projects to explore that. I am more particularly interested, one, in how this talk relates to the bodies of those present in the situation and, two, in the differences between languages-in-practice. For the fact that international academic work gets done in English has huge consequences for what we end up writing. You might like this, I hope you do: with a colleague who is an anthropologist working in Bahia we have written about the difference between *chupar fruta* and *comer fruta*[4]. About the way the practices that are linked to those words differ – and do not neatly map onto practices that one can talk or write about in English[4].

In "The Body Multiple"[1], you state: "…what I want to stress for now is just this one thing: that my theoretical investigation into the coexistence of the various versions of a multiple object were, indeed, localized[1]" (p. 182). What does "localized" actually mean in the context of praxiography? Is the size of the field of little importance for praxiography? Can one follow practicalities and materialities when the field has no boundaries?

Localized here means situated. The point is that the 'atherosclerosis multiple' that I learned about in hospital Z, where I did my research, happens "there" and nowhere else. Things are already different in a hospital ten kilometers away. And if someone else would use similar research methods to study this atherosclerosis in a hospital in Bordeaux, Osaka, Salvador, she would not find different versions of this disease that would be coordinated in different ways.

The specificities of the field are therefore of great importance for praxiography – a practice is always somewhere, never everywhere. But I am not so sure that we do well to talk about this in terms of "size". For practices are small or large, they are things that happen – they take place in time. The more relevant question might well be if they happen rarely or frequently. Not how big they are, but how often they occur.

I wonder why you talk about a field having no boundaries – it was a criticism on the notion of the network that networks have no boundaries. But fields actually do – take the metaphor literally, fields – like meadows or football fields – have a limit. That said, practices tend to not stay stuck in fields. They travel and hence a researcher may try to follow them around as they travel.

What a praxiographer cannot do is fully map out a field – in its totality, as a whole about we may tell everything there is to say. Instead, praxiographic research rather resembles following a trail, walking a path. As researcher I can be present in one moment and then in another and wonder how they are connected. Likewise, I can ask questions in one place and then another and wonder what kind of links there might be between them. For instance, in Hanoi people eat the same kind of bread as in Paris – if not as long baguettes, but far shorter. Does that mean that these two cities jointly form a field? No, Hanoi bread eating is rather an interesting trace of its French colonial past. It raises the question how it is that French bread has endured there for many decades after the French left. It must have something in its favor that locally make sense. Or taste good.

In science and technology studies there have been lots of interesting studies into technology transfer. They have critiqued the idea that a technology that works in one particular place works always and everywhere, works in general. Some 'thing' only works in a site if the conditions of possibility that allow for its working are in place. If you pick it up and transport a tool, machine or other thing – bread ! – to another setting, the question is always what will it do there, in that second site? Will it be accepted, celebrated, fail, fall apart? That is something that a researcher following the technology in question can study. Without the need to then say something general that would be true in other places.

It would be interesting to think of places and journeys, of topological figures such as networks, fluids, and regions. Could you speak more about the concept of topology?

Yes, I can say more about topology. About the "term" – but not about the *concept*. A concept is a firmly defined term that the author outlines clearly and then tries to keep stable. I am not invested in stabilizing words in that way. Instead, I take it that terms shift and change – get adapted as they travel. Hence, the question you ask about journeys may be reflected back on the terms in which we get to talk about those journeys. Terms, like technologies and other things, do not necessarily stay stable as they travel. They are fluid. Here is the story.

A region is a bounded space. A network – such as it was outlined in early actor network theory – was rather a syntax, a way of connecting elements. The original idea was that if a technology worked in two different regions (say, Sweden and Nicaragua) apparently the network held stable in both sites. In both regions there were enough, and similar enough, relevant elements around it that could stabilize it. That is what Bruno Latour meant when he introduced this tempting term "immutable mobiles": things that do not change (are immutable) while they get transported (are mobile) from one region to another.

What we added to that (I did this in work with John Law[5] and Marianne de Laet[6]) is that there are also "mutable mobiles": things that keep working from one region to another, not because they stay the same, but rather because they adapt themselves. With Law[5] we proposed this in relation to the 'anemia' – diagnosed and treated differently by Dutch doctors in the Netherlands and Dutch doctors practicing in diverse settings in rural Sub-Sahara Africa. Anemia travels while it transforms, we wrote. It is fluid. That is where we introduced the idea that the space in which "anemia" remains the same is a fluid space. It does not have a regional shape, it is no network. It is fluid. In that context we imported the term topology from mathematics – where this is a term for a space through which an object shifts shapes but does not rupture. I don't cling to that term very much. What I find important is: that we do not take the three dimensions and linear scales of Euclidean space as the only way to imagine spatial reality.

With De Laet[6] we wrote about a bush pump in Zimbabwe that kept working, not because it was fixed and never broke, but because if was adaptable and easy to repair. There have been various good critiques of that piece – that both build on it and amend it. Thus, Uli Beisel and Tillman Schneider[7] warned the rest of us that fluidly adaptable may sound nice, but that is not always nice. If the technology involved is not a water pump but a car, and if this is adapted from an ambulance to a bush taxi, this may lead on to bumpy rides and an increased risk of accidents. And what happens to the car once it is broken? It gets discarded which raises further problems. In his turn, Peter Redfield[8] argued that the bush pump that we studied in the late nineties may have held promises at the time, and may have looked beautiful to us, but was tied to a kind of nation state politics that is no longer in place. He makes a contrast with a straw that cleans water but is a small, marketable good. A very compelling comparison!

I give these examples to illustrate that rather seeking to fix concepts, such as topology, or fluids, I find it more relevant to engage in conversations about the realities our words help to explore. The aim of doing theory, after all, is not to fix and consolidate some highbrow verbal apparatus, but to find ways to give words to rising concerns or to old concerns that continue to be pressing but in a new form.

Within the social sciences, there is a growing interest in ontology. Some theoreticians talk about an "ontological turn." You have an important article on "Ontological Politics[9]". Could you comment on this interest, and on your own particular treatment of it?

This term 'ontology' in the social sciences is doing different things for different authors. In anthropology it can be used to stress that different cultural traditions do not just attach different meanings to the same solid reality – the reality that Western science alone knows for sure – but that people order 'reality' seriously differently – and may, in their own ways, compete with Western science. May have different "ontologies". That is a fine use of the term.

My own use of "ontologies" is slightly different. In the nineteen nineties we were exploring how we could escape from the overwhelming 'truth character' of biomedical registers. And what we invented is: by contrasting different ways of speaking the truth and then show that they clashed. For me, this had started in the early eighties with the question "what a woman is[10]". If different disciplines answered the question 'what a woman is' in different ways, without taking each other for granted, then that gave feminist a lot of freedom, too. We no longer had to take any of them as fixed and given. It was always possible to ask: why, when, where is this truth realized? What does it depend on? What are its alternatives?

When we started to use "ontology" in that context, the idea was to play with that term in a provocative way. In post-Kantian philosophy ontology had been the term for a reality that the sciences could never reach as they inevitably sought to know it in their own categories, their own terms. We said: but the point is not to reach out to reality and never reach it – in knowledge practice realities (in the plural) are various brought into being. In order to stress *that* we mobilized the old term ontology, put it in the plural and tried to give it a new meaning. Not as preceding knowledge, but as done, enacted, performed, in the processes of knowing.

At the time, climate change deniers, and so on, where not yet an issue. Later they emerged and that complicates the analysis. Where first we had needed to stress the flexibility and diversity of knowledge, later insisting on the limits of that adaptability became relevant as well. As it is, I am concerned that when terms like 'ontological politics' get fixed and firmed up, it becomes difficult to adapt our work to what is relevant here and now. With politicians thinking they are free to belief of not belief scientists who warn them about global warming, we might need other terms. Nobody should get the idea that ontology readily obeys the decrees of rulers.

There have been some difficulties in the Portuguese translation of the term "Ontological politics". You state that this is a composite term: a joining of ontology, used in standard philosophical parlance to define that which "belongs to the real, the conditions of possibility we live with," with the term politics. Therefore, the term "politics" underlines the process of shaping reality and its character as that which is "both open and contested". The suggestion is that "the conditions of possibility are not given". Further on, you bring up the issue of choice, and choice derives from multiplicity; therefore, from ontologies in the plural. Trying to follow the argument, the translation could be "*Ontologias políticas*", i.e., if we talk about reality as multiple, then ontology is best used in the plural, and if reality is performed in many different manners, the issue of politics becomes foremost. Thus, it is not a policy but a philosophical position that implies choice, and therefore has political implications. However, various colleagues in Brazil and Portugal have translated the term as *Política Ontológica*. "*Política*," in Portuguese, means the art or science of governance. Therefore, the translation would imply that opting for an open-ended ontology is a political act with governamentality effects. It would be wonderful if you could help us on this translations issue, perhaps by telling us how you translate the term in English.

If you give me this short lesson in Portuguese, it is easy for me to tell you which translation I prefer: the first one. Ontologias políticas. For indeed the point is that reality does not come in a single version, but is multiple. There is not just one ontology – be it closed or open ended, rich or rigid. What with our work we tried to stress is that 'ontology' does not precede knowledge practices, but is done (performed, enacted) in these practices. And because there are many practices, there are also many ontologies.

But where various practices are closely linked, such as in a hospital, the ontologies are linked as well, in practice. Hence, the "word" best be put in the plural, but we are not talking pluralism. The different versions of reality that are done in hospitals are connected. A patient who talks to a doctor in

a consulting room may receive a clinical diagnosis, while laboratory measurements 'do' her disease in a different way. However, these versions of reality relate: the lab tends to come *after* the consulting room. What is more, the normal values of the laboratory tend to be established by measurements on people who are clinically normal – hence there one version includes the other.

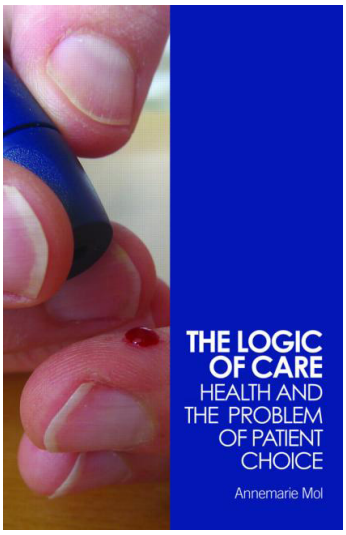
Reality might be organized differently – for instance the lab could come first – the blood pressure in everybody's ankles could be measured, say, every year. That is the "politics" part, that things may be organized in different ways. But I would not want to call this a choice. I wrestle with that in my text about 'ontological politics'. There may be different possibilities, but often there is not a clear cut moment where a 'choice' is practically organized. And choices do not just follow from there being different ways of doing things. They also depend on there being moments where these different ways can be considered and weighed and where it is then possible to go one way or rather the other. Take the organization of health care: in most cases the starting point of care is not population measurements, but people going to the doctor because they feel they have a problem. This is so firmly embedded in so many institutions that it would be hard to change. It would also be far too expensive. Hence, where might the choice lie?

In your book *The Logic of Care*[11], the word "patient" carries an association with passivity and subordination to the biomedical model from the very beginning. In Brazil, patients in the public health system are referred to as "users" and not as "patients." Taking advantage of your invitation to use the ideas in your book actively, it would be especially interesting to consider the professional formation of health care professionals in Brazil by introducing the concepts of "doctoring" and "patientism" in a creative and contextualized way. Could you comment further on these concepts?

The association of patient and passive is an etymological fact. In my "Logic of Care"[11] book I mention it and turn against it. I write about 'active patients' – if only because modern day patients with chronic diseases have to *do* so much. A doctor may "prescribe" pills, but the patient is the one who has to "take" them. Remember them, find them, swallow them. This already indicates why the term 'user' is not particularly fitting. For this suggest that there is something on offer that a person may 'use' – there is health care, please, come in, pay, and make use of it. But usually that is not the situation. One may "use" the services of a laboratory that offers blood measurements – once in a while. But the rest of the time, at home, people with chronic diseases have to do their care themselves, including a lot of measurements. They do not "use" health care, but *do* health care, are actively engaged in it.

The term "doctoring" suggest a particular way of doing, of working, that is not linear. It resonates with tinkering, with trying and adapting and trying again. If you look it up in an English dictionary, 'doctoring' also stands for cheating. But I turn against that meaning of the term, I suggest that that meaning follows on from expecting processes to be linear and follow a straight course. In situations where we have no firm control – and I would argue that means in "most" situations – doctoring is a good word for attempts to still get things done.

And the term "patientism" I suggested in analogy to "feminism". In the "Logic of Care"[11] I argue against the liberal model of the rational decision maker (see also question 11). Rather than having to fit with the model of the buyer or the citizen, I suggest, patients should be taken seriously as what they are – as somehow coping with a disease, that throws up problems, that they try to tame and live with one way or another. This is not just their particular deviant situation, but when it comes to it a more fitting model for many other moments. Just like "feminism" refuses the idea that men are ideal humans, "patientism" refuses the illusion that being fully healthy is the standard situation in life.



Capa do livro The logic of care

In *Ziek is het woord niet*[12], written with Peter van Lieshout, you examine medicalization and the monopoly of medicine. Yet in "Differences in Medicine"[13], written with Marc Berg, you seek to distance yourselves from medicine as a coherent and unified way of thinking, showing a variety of forms of practicing Western medicine. In your ethnography of Hospital Z, in "The Body Multiple"[1] – in which you focus on medicine, medical knowledge, medical technology, medical diagnostics, and medical interventions – you explore medical differences from within. Has your perception of medicine changed throughout your intellectual trajectory? Could you comment on this trajectory?

In the book *Ziek is het woord niet*[12] (published in 1989) we do not study "medicalization" but the "term" "medicalization". And we argue that that term does *not* fit very well with what happened in Dutch health care in the forty preceding years, that is between 1945 and 1985. For when it was first coined the "term" medicalization was not just used to talk about the monopoly of medicine. It was more particularly used to indicate that various behaviors that were earlier condemned on *moral* grounds (like having homosexual relations; or getting pregnant without being married) had gradually come to be called deviances. They were turned into a *medical* concern – but still not accepted. What we saw in the Dutch medical journals we analyzed was that from the sixties onwards general practitioners and mental health practitioners were themselves reflexive about this and sought to limit and restrict their domain. They did not want to medicalize. Moreover, they fairly rapidly stopped calling homosexuality and single motherhood deviances. Other things were going on.

Hence, in relation to your question, I have *not* changed very much – just asked different questions time and again and investigated different materials and settings.

In your proposal of a *logic of care*, you critique "Western clichés," with their valorization of individuality and autonomy. What are the relations between these values and practices of care? You define "practices of care" as heterotopias. Can you speak more about this subject?

Sure I can speak more about it, I wrote a whole book about it… But to go short. I called practices of care a heterotopia, because they offer a site, a place, which is *other* to the dominant western ideal of individuals who make rational choices. In care practices this ideal doesn't work so well – if only because people do not 'choose' to have, say, type 1 diabetes (the case that I follow in my book[11]). Instead, this happens to them. It is not attractive at all, it is a problem they face, or a set of problems. And then, say, they do not 'choose' to measure less often than their nurse suggested they should, but this may still happen. Somehow they may fail to get their daily life organized in accordance with the many life rules that come with their disease. They may not get their act together. That is my point: care is not first and foremost about making decisions, but about getting things organized in practice. All too many social scientists had repeated each other by saying that in care practices people are oppressed and dominated. Of course this may happen, but it is not inherent to care practices. Domination is opposite of choice. The opposite of care is neglect.

Hence, the interest of studying the heterotopia of care is to learn about other, non-liberal, caring ways of organizing our life and our practices.

You aim to establish dialogue with epidemiology, especially thinking of the idea of "collectives." How can we mobilize epidemiology in a different way? How can we create different categories?

Different categories get created all the time. For instance, in relation to some concerns epidemiology makes a difference between "women" and "men". However, in relation to other concerns it doesn't, but rather differentiates between "premature born" and "born after full gestation". Elsewhere again, it makes categories like "people with diabetes" and "people without diabetes"; or "young adults" and "the elderly". And so on and so forth. Categories get made that fit the concerns of a particular setting – be it research or health policy. So "we" – if by we you mean social scientists – can make categories according to what fits our research, too. Sometimes it makes sense to contrast "Brazilians" and "Dutch". But not always. Sometimes it makes more sense to differentiate between, say, "people working in universities", "people working in industry", "professionals", "the jobless" – and so on. As you know fully well, in some settings Brazilian and Dutch academics have more in common with each other than with the people with whom they share the streets. It is somewhat strange that the same categories – of gender, class and race/ethnicity – keep appearing again and again in social science text. These are obviously relevant categories, but they are not relevant always and in relation to everything. The art is to always be attentive to what matters, to what "exactly" matters, in this or that specific practice.

The art for an academic is to not get caught in concepts, but to think while adapting the tools we think with for the problems at hand.

Translated by Samantha Serrano

References

1. Mol A. The body multiple: ontology in medical practice. Londres: Duke University Press; 2002.

2. Mol A. Mind your plate! The ontonorms of Dutch dieting. Soc Stud Sci. 2013; 43(3):379-96.

3.Vogel E, Mol A. Enjoy your food: On losing weight and taking pleasure. Sociol Health Illn. 2014; 36(2):305-17.

4. Port M, Mol A. Chupar frutas in Salvador da Bahia: a case of practice-specific alterities. J Roy Anthropol Inst. 2015; 21(1):165-80.

5. John L, Mol A. Complexities: social studies of knowledge practices. Durham: Duke University Press; 2002.

6. De Laet M, Mol A. The Zimbabwe bush pump: mechanics of a fluid technology. Soc Stud Sci. 2000; 30:225-63.

7. Beisel U, Schneider T. Provincialising waste: the transformation of ambulance car 7/83–2 to Tro-Tro Dr. Jesus. Environ Plan D Soc Space. 2012; 30(4):639-54.

8. Redfield P. Fluid technologies: the bush pump, the LifeStraw® and microworlds of humanitarian design. Soc Stud Sci. 2016; 46(2):159-83.

9. Mol A. Ontological politics: a word and some questions. In: Law J, Hassard J. Actor network theory and after. Oxford: Blackwell Publishing; 1999. p. 74-89.

10. Mol A. Who knows what a woman is… On the differences and the relations between the sciences. Med Anthropol Theory. 2015; 2(1):57-75.

11. Mol A. The logic of care: health and the problem of patient choice. New York: Routledge; 2008.

12. Mol A, Lieshout P. Ziek is het woord niet. Amsterdam: Boom; 1989.

13. Mol A, Marc B, organizadores. Differences in medicine: unraveling practices, techniques and bodies. Durham: Duke University Press; 1998.

Keywords: Praxiology. Political ontologies. Multiple bodies.

Submitted 03/04/17. Approved 13/04/17.