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The Empire of Love

Toward a Theory of Intimacy, Genealogy, and Carnality

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1 Rotten Worlds

One

Montreal, 6 August 2000. I am quite sick; definitely sicker than I was in the Sydney airport last week, more nauseous in the day, and then there are these night sweats. I am sitting in a conference on globalization and multiple modernities, but I cannot concentrate on the conversation. I am too busy monitoring my body, waiting to see if these new antibiotics kick in and hoping the diarrhea set off by the previous antibiotics abates. As I sit here, I wonder if this entire medical fiasco is the result of my following too assiduously medical instructions or religiously ignoring them over the last sixteen years, placing too much trust in the local knowledge of my indigenous friends and family in Australia. Yesterday I went to a Montreal clinic on instructions from the physician I saw in the University of Chicago Hospital emergency room, where I had gone right after landing in the United States. "Have a doctor in Montreal change the dressing I've put on your shoulder," he said. And so I did. But along with changing the dressing, the Montreal physician switched my medication from Septrim (co-trimoxazole: Sep-

trim, Bactrim) to Novopen, a semi-synthetic penicillin with a host of other popular brand names: Pen-vee K, Beepen-K, V-Cillin K, Nadopen-V. As a result, I can no longer tell if the infection or the antibiotic cocktail is causing my nausea and night sweats. As my body erupts, I wonder whether I have placed too much trust in people whom I have known longer and more intimately than almost anyone else in my life. In wondering, an affective separation emerges, if only as a slight fissure, between them and me.

28 When the Montreal physician pressed me for more details about the origin of the sore, I told him the somewhat incoherent medical narrative about “sores” that I had standardized during the sixteen years I had been working, on and off, year after year, in northern Australia. I gave a similar narrative to the Chicago doctor when he asked me where and how I had acquired this sore. It went something like this: I am an anthropologist. The sores are endemic in the indigenous communities I visit. They seem to appear and disappear with the seasons, more when it is hot, humid, and wet, less in the cool dry season. They are not obviously related to any previously existing cut or abrasion. This sore on my shoulder, for instance, did not seem to have been caused by any previous cut. Sores just “bubble up” like volcanoes from under the skin, or, using the language of my Emiyenggal-speaking friends in northwest Australia, like *pumanim*, fresh water springs that bubble up from the ground. Sometimes they stay hidden inside you, growing and growing. We call those blind boilers, or just “boilers” in creole and *tenmi* in Emiyenggal. Adults get both kinds. Kids get them, too. Babies can be covered

with them, as if the sore were a bad case of chicken pox. Some boilers grow so large and hang on so tenaciously that they require a hospital stay, invasive surgery, and skin grafts. My indigenous friends are pretty cavalier about them. But so are most of the non-indigenous nurses and doctors whom I have met in various indigenous communities. Over the years, they have told me that the sores are “just” streptococcus or “just” staphylococcus. One doctor, many years ago, told me he thought the sores were a strain of leishmaniasis, caused by sand fly bites, but not to worry about it.¹ (Worry has its own social distribution—it might be needed elsewhere.)

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New York Times: Hundreds of American troops in Iraq have been infected with a parasite spread by biting sand flies, and the long-term consequences are still unknown, Army doctors said Friday. The resulting disease, leishmaniasis, has been diagnosed in about 150 military personnel so far, but that is sure to climb in the coming months, the doctors said. All have only the skin form of the disease, which creates ugly “volcano crater” lesions that may last for months, but usually clear up by themselves. None have developed the visceral form that attacks the liver and spleen and is fatal if untreated.²

The Montreal physician was quite curious about the sore on my left shoulder. And he became as cautious after seeing it, asking me a series of questions. “Where did you get this sore?” “Who cut into your shoulder like this?” “Why are you on Septrim?” “Is it helping?” Answering the last question was easy enough, and I was brief in my reply. “No. The sore is

unchanged and I am desperately ill." The questions of why I was on Septrim, how my shoulder came to look like this, and the origins of the sore would take more time. I described the carnival scene in the Chicago emergency clinic when the bandage I had placed over the sore in Australia was removed. I described how the physician recoiled from me, literally, and shouted to the nurses to bring protective goggles, gowns, and a pair of forceps—as if I were about to give birth to the Andromeda strain.

30 Or perhaps the up-to-date reference for this young physician would be Ebola, as if I were about to dissolve in my own bloody juices from a virus picked up in a remote part of the world. I told the Montreal doctor, "I couldn't tell if he was freaked out because the flesh was necrotic or because I seemed so blasé about that fact." "He didn't seem to believe me that these sores are commonplace where I work, though I labored hard to convince him that they were no big deal and could be cured with a few shots of penicillin." To be honest, I had told the Chicago emergency room physician, "*I think* I just need a few shots of penicillin, *I think* it's penicillin, or in the tablet form, *maybe* something called amoxa-something. I know it rhymes with Bob Dylan." The imprecision of my pharmacological language was one index of the deep recess of everyday life in which these sores fester for many indigenous and non-indigenous residents in northern Australia. Familiarity breeds this nervous system. "You think," the Chicago doctor repeated, nonplussed. Not surprisingly, he did not give me penicillin or amoxicillin. Instead, he cut into my shoulder for what felt like an hour, took a culture from the core, and

packed the hole with a "wick" to allow the fluids to drain out. (As he put it, he "packed it like a gunshot wound." As the assisting nurses put it outside his earshot, he packed it "like a ghetto wrap.") He then gave me a prescription for Septrim. He had wanted me to stay in Chicago until the culture came back, but I insisted I had a plane to catch.

Do you always take antibiotics that rhyme with Dylan, the Montreal physician asked. "Yes, why is that?" He didn't answer me, asking instead whether I had ever been given Septrim before—in Australia. "No. Why?" He answered me this time. "Because Septrim doesn't kill subcutaneous anthrax." It was his hunch that anthrax was dispersed throughout pastoral northern Australia and that anthrax spores were the cause of the sore on my shoulder. If the Chicago doctor had no immediate referent for this sore, the Montreal doctor did. Opening one of his textbooks, he explained to me that he had heard about these kinds of sores on people working in the cattle and sheep industry.

I have to admit that in the beginning I thought it was cool to have anthrax, to have had anthrax all along without knowing it. I told everyone, including, later that same week on a phone in a Montreal airport terminal, my older sister, who is a microbiologist. She wisely cautioned me not to shout this information too loudly before passing through customs. This was a year before my girlfriend and I had watched the Twin Towers collapse from my studio in Williamsburg, Brooklyn; before anthrax was mailed to media offices along the East Coast and to members of Congress; and, in the shadow cast by these attacks, before international terrorism became an ar-

ticulation point between the medical and legal subject of anthrax. Anthrax Man was just a comic figure, Judge Dredd, spun from the heavy metal band, Anthrax. In August 2000, my Chicago doctor would have been hard-pressed legally to constrain my movements, not knowing what it was that I had. The Montreal doctor, believing I had anthrax, did not have "international terrorism" as an immediate or self-evident referent. I appeared before them, and was treated by them, as a woman making perhaps a foolish but nevertheless a sovereign choice about how to treat her own body and its health. It was my body, my health, as long as it was not a public menace.

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Even after these events, I made jokes about anthrax being passé, or got furious that, when the professional classes in the United States acquired anthrax, vast arrays of governmental and discursive resources were immediately mobilized, but the treatment of the same in poor indigenous communities is apparently left to a dedicated few health activists. Of course, this is not fair. Middle-class postal workers were most often at risk. Besides, what I noticed had been noticed long before. The differences between ordinary and extraordinary illnesses are dependent on a biosocial spacing—often organized as a *geophysical* distribution of ordinary and exceptional bodies and of ordinary and exceptional life, death, and rotting worlds.³ The geographical component of this biosocial spacing of environmental harm presupposes and constitutes the connection between race, class, and health, but these presuppositions in turn lean on legal, medical, and social distinctions between *intentional harms* and *unintentional* or *unconsidered harms*. Intentionality—whether personal or

birds oriel
+ hr/mg

corporate—is one of the key legal pivots in tort law that distinguishes ecological *pollution* such as that found in poor Australian Aboriginal communities and in poor African American neighborhoods from ecological *terrorism* as it was practiced or threatened after September 11, 2001.⁴

pollution
terrorism

As for my sore, the Novopen that the Montreal doctor prescribed did not rid me of the infection, whatever its biological cause. Just as the largest sore began to heal, satellite sores emerged around the central infection. By this time, I was heading back to Darwin, and so I decided to put my faith in local doctors. Perhaps their casual, deeply familiar approach to these sores was just the remedy I needed. As I predicted, the doctor in Darwin laughed, at times uproariously, as he listened to my stories, especially the anthrax punch line. "It's not anthrax. Just tell them it's a bad case of streptococcus or staphylococcus." "But what is it, really?" I asked the doctor. "I've never taken a culture, but I'm sure it's just staph," he said. He explained that he, too, had been shocked when first witnessing one of these sores soon after his arrival in Darwin from Sydney. All his medical colleagues had reassured him that they were just staphylococcus or streptococcus and easily treated with penicillin. He found, over time, this diagnosis to be true; and so, while not cavalier about the sores, he was no longer shocked by them. "o.k.," I said, "but how do I get them? Doesn't there have to be a pre-existing abrasion to get staph?" He replied, "You can't see every little pinprick you get on your body. Who knows, maybe a mosquito bit you on your shoulder and you scratched. The real reason you get sores, though, is because you're living in an Aboriginal com-

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munity and they're filthy places. You can't break the cycle of infection in those places. If you give Aborigines antibiotics, they start them and then they leave them on the shelf to rot."

By the time I arrived in Darwin, I had already come to think that the sores were just a bad case of staphylococcus or streptococcus, or some nasty combination of both. Right after my conversation with the Montreal physician, my Chicago doctor left a message on my home phone machine saying that my sore had cultured for staphylococcus. And while I was still in the United States, a friend who had co-written an early textbook on HIV/AIDS prevention looked up anthrax on the Centers for Disease Control and Prevention's Web site. It noted that once anthrax seeps into an environment it is hard to get it out—and expensive to do so. Schooled by HIV/AIDS activism, she observed that the incentive for a government or a business to diagnose a contaminated environment was small, because they would then have to clean it up for a poor black population or justify not cleaning it up. She also pointed out that the CDC said a doctor had to culture specifically for anthrax and that culturing anthrax was not especially easy, and certainly not routine. Even so, the anthrax theory, if interesting for a moment, seemed a bit far-fetched. The Chicago tests had come back with staphylococcus. The CDC described anthrax as having a telltale black scab. My sore, and all the sores I had ever had or seen, were volcanoes of rotted flesh, filled with greenish-yellowish squish, and without a scab. Moreover, the signs that dotted fences on the pastoral properties I routinely passed in northern Australia listed tuberculosis and drucellosis as the diseases of record, not anthrax. Tuberculo-

sis I knew about. I had watched a Belyuen brother of mine die of it in 1987. And I am regularly tested for it because of its circulation in Aboriginal communities.

In any case, by the time I left Darwin, I had more than enough stories for my friends at Belyuen. I tucked them away in the backpack of my brain and headed across the harbor. They enjoyed my stories, as I had expected, and we shared them with other family and friends up and down the coast. I soon stopped caring what the biological agent of these sores was as long as they went away with the right treatment. Besides, in September 2000, the CDC were reporting that there were no long-term effects from having subcutaneous anthrax, so if it was anthrax, who cared? And if it was staphylococcus, or a bit of streptococcus, so what?⁵

This is an essay about that "so what." In it, I show how discourses of the autological subject and the genealogical society create attitudes of interest and disinterest, anxiety and dread, fault and innocence about certain lives, bodies, and voices and, in the process, form and deform lives, bodies, and voices. Recent innovations in research, theory, and method in medical anthropology and science studies are, of course, the necessary conditions for what I am doing here.⁶ But this essay is not a medical anthropology of tropical ulcers or a science studies account of the social life of rotten things. My object is neither the medical sciences nor the medical subject, but a broader dynamic of discourses and practices that is continually shaping and directing bodies and voices in settler colonies such that some appear as coherent and others incoherent and such that the source of this coherence and incoherence

seems to reside inside these various subjects and their social formations.

36 The sore is, on the one hand, simply a means by which I can make visible the various levels, modes, and forms by which these discourses of autology and genealogy saturate social life, allowing some voices to be heard, others dismissed, and allowing some bodies to be treated or left untreated. On the other hand, the sore is a challenge to this and any study seeking to grasp discourse in its materiality. Where, after all, is this sore? Whose is it? What is its biosocial nature? Are discourses of autology and genealogy obligated to this sore, constitutive of it, or merely in an accidental proximity to it? This is the question: In a post-essentialist theory how do we make the body matter? To answer this even partially, I track how modes of address and their material anchors presuppose and constitute the autological subject and genealogical society as if they were different in kind even though these subjects and social worlds are in fact thickly emotionally, socially, and discursively conjoined. And I track how these practices of address meet, order, and deform a multitude of material anchors—i.e., how they *enflesh* worlds; how they depend on previous *enfleshments* of the world; and how they apprehend this enfleshment both in the sense of the ability of these discourses to grasp the importance, significance, or meaning of this flesh and in the sense of the ability of these discourses to create a feeling of anxiety or excitement that something dangerous or unpleasant might happen in the vicinity of this flesh.

The narrative strategy of the essay is to remain as close as possible to the multitude of citational practices—law, medi-

cine, medical ethics, research procedures, speculative pleasure, personal affection—and to the multitude of material anchors in which these citational practices emerge and are reinforced, challenged, or deemed irrelevant. My hope is that this tracking will better capture the immanent, performative struggle over how embodied social life is shaped and how these immanent dependencies steer material goods and resources.

37 However, the narrative strategy I have chosen for this essay runs into the very discursive trouble that I am trying to analyze. Two problems seem especially pressing. First, how and why these discourses show up in the following narrative have everything and nothing to do with my biography. If someone else were writing this piece who had the “same” sore and the same theoretical and methodological aspirations, the specific manifestations of these discourses might nevertheless show up differently—for instance, if this other writer were a white man, or straight, or African American, or indigenous Australian. My wager, however, is that discourses of autology and genealogy would still be the citational field in which this person played. Second, if I am interested in the ways that some voices and lives within settler colonies are made coherent and others incoherent in quotidian practices, then the coordination of narrative voice and narrative event in this very essay is a good example of exactly this. After all, I am the author of this essay; the authorial voice is my voice and this voice emerges from the intersection of the narrative event and the narrated event fairly coherently and unscathed, especially the more I try to demonstrate exactly where I am becoming unhinged.

No matter what I said to the Montreal and Chicago doctors, my Aboriginal friends are not cavalier about all kinds of sores, nor are they uninterested in the vectors of their transmission. They know that some kinds of sores can kill you whether or not you treat them with Western medicine and other kinds of sores can cripple or kill you if you do not treat them with local or Western pharmacies.⁷ Indeed, they live in a landscape of sores built in part out of what is known in the anthropological literature and the English-speaking world as the Dreaming, what I will be referring to as the *geontology*—and in part out of the structural conditions of poverty and racism that constitute everyday life along the northwest coastal region.⁸ It is important to note at the beginning that these two kinds of landscapes are tightly intertwined. Though ancestrally oriented, local geontologies are not mimetic to the genealogical imaginary of customary law. Instead, people I know treat the ancestral past as the geological material of the present, the flesh as it is now arranged. How people live within a structure of poverty has a direct effect on geontological sites. Who gets staphylococcal-infected sores, whose faucet works, and whose water is used to flush whose toilets? These mundane socio-economic variables often determine who knows and is able to care for various sacred areas in the region. Irene Watson has made this point powerfully: The Law is not in the past as a pristine template, but is thoroughly within the worlds made and inhabited in the present.⁹

One outcropping of the geontological landscape is Maliya,

a small mudflat off the west coast of Anson Bay exposed during the huge king tides that help define the coastal ecology of the region. On 14 July 2000, just two weeks before traveling to the Montreal conference on multiple modernities, I was boating with some of my male brothers and husbands around Anson Bay, helping them map their respective countries and sacred sites in the region. We were boating during a nip tide—a tide that is neither up nor down—and as a result I do not know for sure whether we passed by the side of Maliya or accidentally passed directly over it. Perhaps I should mention that Maliya is an extremely dangerous sore Dreaming. I had first heard of the site in 1985, when men and women living in several Aboriginal communities stretching down the coast from Darwin were worried that one of their male relatives living at Balgal would release—some worried he had already released—the huge blowflies (*kalangak*) that live inside the site. Four years later, a Belyuen sister of mine, Daphne Yarrowin, asked her aunt if her *kuga* (uncle) had chucked the poison that the blowflies carried, but was reassured that he had not because he felt sorry for all the children who would never survive the plague. If released, the *kalangak*, which are as large as sea eagles, swarm from the site, enveloping people, biting them viciously on their lower backbone (*deditunggu*), and leaving them covered with horrible, fatal sores. I would subsequently learn that the first written reference to Maliya was by researchers working on a land claim in 1978.¹⁰ They listed the site as *durlk moliyer* (“Dreaming Sore”) and as belonging to the Emiyenggal people, specifically two men, Wanggi and Roy Young Miringa.

Not just anyone can properly release these *kalangak*. You have to know what to do and what language to use when doing it. Treated improperly, say if you have accidentally bumped Maliya while boating, the “poison” in the site can “come le [at] you.” But even when releasing the *kalangak* properly, “in every country you name, no matter what place,” innocent people fall, “die for good”—this according to Ruby Yarrowin, the daughter of Wanggi. Ten years after I first heard about Maliya, Ruby Yarrowin described to me the harrowing scene she had witnessed when she was young and living near Maliya.

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You try coverimim up, blanket. But they still biteimbet, *deditunggu* (backbone). People been lying down, dead, everywhere. Wula sore eatimupbet; bone, imliedown everywhere. I think hard now. I am going to finishup: *Ngayilewudanutheni, ngaladumari*.

Maggie Timber, who likewise traveled up and down the coast during the 1920s and 30s, told a similar story about Maliya before she died in the mid-1990s. She had a set of distinctive elements in her story, such as the existence of houses and window louvers, but her story shared elements of Ruby Yarrowin’s version of the regional geontology—the same blanket, the same *kalangak*, the same *deditunggu*, the same reflexivity of imminent personal demise. “They try coverimup blanket, they try shutim louvers, that Banagula area, but wuliya getin, getin, wagaiyentha gaiya. You think hard now, ‘I gana die.’”¹¹ Many factual elements of Maggie Timber’s story could be disputed, from her assertion about the agency of the geontology to the factual problem that there

were no houses in the Anson Bay coast during the 1920s, let alone louvers in their phantom windows. I remember thinking this when Maggie Timber first told me this story in 1989, pointing to the louvers in the community housing in which we were staying at the time, and saying to her, “Wulgaman, no louvers that Anson Bay.” To which she replied, “that true,” with the disturbing inflection that this fact intensified the power of the *kalangak*, rather than diminish it. When doing research for my first book, I learned that influenza epidemics had raged throughout the region during the same period in which Maggie Timber and Ruby Yarrowin saw the dead and the dying.

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If I had told the Montreal doctor about Maliya, I would have told him of only one of the many active ancestral-based sources of illness in the north. Take, for example, a set of conversations that occurred in August 2003 at Belyuen, Daly River, and Wadeye. These conversations described how a group of people from Oenpelli, an Aboriginal community in coastal Arnhem Land, *tjukpiya mungarra* at a funeral at Barangga; that is, they intentionally spread a bad cold from an Oenpelli sacred site at the funeral, reportedly because no one from Barangga had come to the funeral of a senior ceremonial man held earlier that same year at Oenpelli. From Barangga the bad cold spread from Aboriginal community to Aboriginal community as people traveled back to their respective homes after the funeral, eventually reaching the city of Darwin. When the local Darwin newspaper reported on the severity of the flu and pinpointed its origin to Beswick (another name used to refer to Barangga), women and men

commented, "Don't say Barangga *munggarra*, that Oenpelli *munggarra*, that *durlg* (ancestral site)."

42 The sheer fact of the geontology is not, however, the beginning or end of many conversations among indigenous women and men I know. The speculative pleasure of the Dreaming as cosmology may rivet the social sciences and publicly provide just the kind of material necessary to animate theories of radical translation, undecidability, and indeterminacy at the intersections of cultural difference. But locally, the existential fact of Maliya, the Oenpelli *munggarra*, and other sites like them is usually placed in a kind of discursive bracket, giving way to other social concerns. Who knows how to release the dangerous powers of these sites? What are the personal motivations for doing so? What are the networks of social obligation, expectation, and exasperation that cause these geophysical catastrophes? Almost everyone agreed that, in the case of the Oenpelli *munggarra* as well as the Anson Bay Maliya, this form of punishment is, in the common parlance, "the hard side of the Aboriginal law." What rivets people I know—what intensifies their conversation beyond the sheer fact of the event-catastrophe—is the reason someone or some group, or the *durlg* itself, would resort to such a fatal and crippling mode of social retribution.

Answers to these questions focus on a set of social sentiments that men and women refer to as "jealousy" and "sorry business."¹² In their use of these words, to be jealous and to be sorry covers an intersecting emotional terrain that in part overlaps with the average English uses of the word "jealousy" and the word "grief." Thus, when people along the northwest coast use the term "jealousy" they are usually referring to

emotions that occur when a desired object is possessed or taken by another. The desired object remains within the world of the person who desires it. The question is who possesses and has access to the thing, place, or person. In contrast, persons in a state of "sorry business" are claiming, or experiencing the fact, that a person or object has moved between ontological realms or that the vital connections between ontological orders have been ruptured. The desired subject or object is removed from the world in which living persons have regular and ordinary access. The "thing" might be a material object, a lover, or a landscape. And people can continue to be encountered in places thickly saturated with their sweat or ancestral presence.¹³ But this does not change the fact that sorrow is experienced as the emotional response to the irrevocable passing of a thing from one ontological realm to another.

43 Men and women speculate that geontological catastrophes occur where jealousy and sorrow intersect. This intersection ruptures social ties and produces the experience of radical aloneness, isolation, and abandonment. The state of being alone (*gamaparking*, "He is alone, isolated"), the severe isolation of the subject, is seen as the root cause and consequence of states of sorrow and jealousy and their subsequent geophysical catastrophes. There are various levels of catastrophe and various consequences of being jealous or sorry. Large catastrophes include the kind of geontological manipulations and shifts that can result when people or places feel abandoned, the kinds of catastrophe exemplified in people's worries that a grieving relative would activate Maliya. Smaller catastrophes resulting from sorrow and jealousy include the

burning of clothes and domestic wares as a dramatic statement that persons have been ignored a bit too much by their families and left alone (*ngamaparrking*, "I am alone, isolated").¹⁴

44 People are not the only agents of such geophysical catastrophes, however. Ancestral sites often register their sorrow by literally moving—going underground, shattering, or shifting location—when a significant ritual leader, a family head, or the last member of a social group has died. From the point of view of the ancestral site, the death of the elder person severs the connection between the ontological orders of human space-time and ancestral space-time by removing the living human membrane.

Perhaps not surprisingly, conversations circle around how this emotional intersection can be avoided or contained, as conversations did in the wake of the Barangga *munggarra* attack. The answers to how the more devastating effects of this emotional terrain can be avoided are surprisingly simple—visit, sit, and live with each other. In this manner, men and women diagnose the cause, consequence, and cure of these catastrophes as running along the same axis. The severe isolation of the subject is the route into the problem and the re-socialization of the subject is the route out. This tactic works as well with ancestral sites as it does with people. Men and women observe how a geontological site might be "building back up" or "falling away" depending on whether it is visited or neglected, just as they talk about the bodies of their relatives as building up or falling away according to the tides of social visitation.

Maximally embodied social relations—what I sometimes think of as *thick life*—make physically and psychologically healthy persons. From this perspective, we can see that these discussions about the causes and ameliorations of radical sorrow are not simply or primarily a hermeneutical exercise. They are not for the production of texts that then lend themselves to interpretation and the generation of meaning. Instead, these discussions and others like them, whether supporting or contesting the reason for sorrow and its remediation, constitute both local socialities and their enfleshments. These discussions are one means by which the social relations that constitute this mode of sorrow, the activities that surround it, and the fleshes that animate it continue to be relevant to local life. Referring to grief and sorrow, speculating on what pushes someone into acting catastrophically, and urging a mode of socially proximate emotional relief continually reconstitute the actual concrete world in which people live as a world where these things matter in terms of social and material supports.

45 Because these discussions occur within the present-time of the settler colony, they also are always already about the difference between the emphases that settler and indigenous people place on social relations and the self. At Belyuen this emphasis is sometimes put in terms of "clean skin" (skin without sores, lice, scabies, or scars). To be within a socially thick world is to expose the skin to its play and its care. "Who gave you those *mimbi* (lice), Beth? Patsy-Anne (*menggen*) or John Moreen (*nera*)?" In these scenes, intimacy is an intensified form of a social relation. It is to become more kin-like,

more ritually oriented, more for and from an ancestrally or residentially saturated place. People with too many lice, too many sores, too much scabies have too few if any family, but so do people with no lice, sores, or scabies. For them, the sore on my body is not my sore, though whose sore it is may be unclear, may take social work to unpack, may lead me into the mud of Maliya or more simply to the kinship of husbands and wives. In any case, here at Belyuen, my flesh is always already stretched across multiple possible material anchors. In perhaps their most damning social analysis of settler society, indigenous men and women from the northwest coast observe how comfortable white people are living alone, how they seem satisfied by the thinnest embrace of the conjugal couple, how they would rather be alone (gamaparrking) than have one little louse.

46

Three

But even *here* at Belyuen some of these material anchors demand very different presuppositions about the body, its location, and its care. Belyuen friends and family might focus on the social and geontological conditions of enfleshment, and by doing so, iterate them, but they meet medical, legal, and economic institutions that address these social and geontological conditions in more or less diagonal and tangential terms. For instance, no one from Belyuen or from surrounding coastal communities has ever traveled with me to the United States, let alone to the clinics I visited in Chicago and Montreal. They do, however, regularly travel through local community clin-

ics, hospitals in Darwin, and sometimes hospitals in southern cities. Over the course of their lives, they have encountered significant changes in how these clinics and hospitals approach their health care and indigenous health care generally. In recent years, particular attention has been paid to the dynamic relationship between culture and indigenous health. Aboriginal health activists have fought hard to place respect for cultural beliefs at the forefront of indigenous health care research and practice. And they have, in concrete institutional ways, installed a culturally sensitive, indigenously controlled approach to health into procedural and substantive aspects of research and policy. For example, in 1986, the Aboriginal Health Research Ethics Committee (AHREC) was implemented for all research in South Australia. The AHREC stipulated that

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the ethical guidelines set out by the National Health and Medical Research Council be adhered to in relation to securing individual and community consent to participate in the research. *Acceptability of Methodology.* That the culture and geography of the Aboriginal community be taken into consideration in developing research methodology that is acceptable. *Benefit to Community.* That research assists Health Workers in better management of health problems in the community and that intervention studies are preferred in that the community would benefit directly from the research being carried out as opposed to investigatory research. *Feedback to Community.* That the right of individuals to gain

access to information resulting from their participation in the research be acknowledged and provided by researcher and for the Aboriginal Health Research Ethics Committee to be furnished with data resulting from specific studies.¹⁵

48 In 2003, the National Health and Medical Research Council discussed some of the sociopolitical conditions for separating ethical guidelines pertaining to “all Australians, including Aboriginal and Torres Strait Islander People” from a “complementary set of guidelines covering research in Aboriginal and Torres Strait Islander Health.”¹⁶ The report notes a number of social changes that propelled this separation, including increasing collaborative partnerships among research institutes and communities, more Aboriginal and Torres Strait Islander people involved in research as researchers, and a general increase in the level of interest in indigenous health research. The immediate end of the new guidelines was to standardize the ethics of research in these new contexts. But the guidelines were also meant to establish a sense of trust in “the enterprise of research itself”¹⁷ among indigenous people in the long run.

These new ethical protocols do not meet a virgin world, however. They circulate into indigenous worlds already conditioned by previous interactions with health research and care. The same Ruby Yarrowin who watched Maliya kill family members in the Banagula region experienced the irrelevance of her beliefs about death and dying when she was a young mother. In the 1940s, she was detained in a small Darwin jail

cell without a translator because she had buried her baby boy in the bush after he died of a bronchial infection. Speaking no English, she had no idea why or to what end she was being held. In the early 1980s, Ruby Yarrowin, Maggie Timber, and other middle-aged and elderly women and men were sought out by academic and popular students of Aboriginal Bush Medicine to provide detailed accounts of their local pharmacopoeia. Ruby Yarrowin refused to participate, though others did.

49 In the late 1990s, Ruby Yarrowin also refused to have physicians remove a large lump from her arm and refused to say consistently why she refused—the reasons were her “secret.” To be sure, in local vocabularies “secret” often signals an extra-physical, often geontological, reasoning. But her reasons could have been based on any number of things, including her sense, brewed in the mid-1940s, that white doctors lie or are cruel. The physicians called on her daughters to convince her that the lump was “just a physical condition” in case she was worried that it was associated with some other “cultural meaning.” And, as in many such instances, indigenous health care workers and local family members were asked to mediate between the non-indigenous doctors and Ruby Yarrowin. The lump was eventually removed. In the process, sensitivity was shown to local social practices and cultural beliefs. Yet, here we see the precise point Emma Kowal and Yin Paradies have recently made, that researchers and practitioners trained in cultural sensitivity attempt “to escape neocolonialism” only to find that they are left in a “bind common to many postcolonial situations. They must relieve the ill-health

Bind of cultural sensitivity in production, — the demand's still to change people (medically) while seeming all to

of indigenous people without acting upon them; change them without declaring that change is required.”¹⁸

This bind is not merely the result of an internal tension within the field of culturally sensitive medical research and delivery, but an effect of the impossibility of quarantining the medical subject from other types of subjects within the nation-state. For instance, if Ruby Yarrowin were to base the medical care of one of her children or grandchildren on her belief about Maliya or other sites like it, a medical condition might quickly change into a legal condition—social welfare policies or statutes pertaining to child abuse might suddenly be cited as the relevant framework for understanding such “care.” And yet even though Maliya cannot maintain its status of truth in certain instances of medical treatment—its geontology cannot trump biomedical epistemologies—in other legal settings it is not merely the basis of casual pleasures and coffee table books on bush medicine, but the demand of law.

Take, for instance, Ruby Yarrowin’s rendition of Maliya’s powers during the Lower Daly River Land Claim hearing.

Mr. Keely: He is dangerous one, you have said?

Ruby Yarrowin: Yes, dangerous that one. If you chuck him, you will die. If you touch that people.

Mr. Keely: If you chuck them?

Ruby Yarrowin: Yeah.

Mr. Keely: People?

Ruby Yarrowin: Yeah, they’re dreaming.

Mr. Keely: If you chuck them, people might die?

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Ruby Yarrowin: Everyone. People.

Mr. Keely: Right, what are you talking of—chucking? Chucking what?

Ruby Yarrowin: Chucking the water . . . or bamboo.

Mr. Keely: Chucking water or poking him with a bamboo, you are talking.

Ruby Yarrowin: Yeah.

Mr. Keely: In that dreamtime story, where does the blowfly bite you? He bite somebody?

Ruby Yarrowin: Yeah.

Mr. Keely: He bite people?

Ruby Yarrowin: Yeah, they are to kill him, killing you, and you fall down.

Mr. Keely: He kills you—

Ruby Yarrowin: Yeah, back one.

Mr. Keely:—by biting you in the back.

Ruby Yarrowin: Yeah. Everyone died. Didn’t even look.

Mr. Keely: At Maliya.

Ruby Yarrowin: Yeah.

Mr. Keely:—there are some bones there? Before, did you look at some bones there, that place?

Ruby Yarrowin: Yeah, bones everywhere really, bone really—everywhere, taking my people everywhere.

They fall down and die everywhere. Have a look bone.¹⁹

For her narrative to be effective in this legal setting, Ruby Yarrowin’s voice needs to index—refer to and entail—discourses of the genealogical society that situate her within the counter-world of the autonomy of reason. The confirmation

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of this counter-world's conjuring pivots on an actual event that is transformed into a mythological event—Ruby Yarrowin's personal account of witnessing the horrific effects of sorrow is transformed into a "dreamtime story." In this narrative conjuring, "bone really" and "bones everywhere" become moments of speculative reason and speculative pleasure, the "what if" of a fairy tale. The pleasure of these "stories" arises in part from the figuration of the customary as rationality's receding horizon.²⁰ They become part mythological and part archacological, even as they cease being about actual being and start being about the cultural encrustations of facts. Of course, legal assessments of the "traditional Aboriginal" do not draw only from these modal transformations. They draw equally on racial and sexual discourses—education level, skin pigmentation, marriage practices. The closer these and other indices come to creating a visual and sonic field compatible to current thematizations of the "traditional Aboriginal," the tighter the projection of Ruby Yarrowin into this field.

The kinds of transfigurations occurring in this land claim do not merely occur in land claims. In a doctor's office, Maliya and *munggarra* are interesting stories, a cultural *poesis*, but they are unable to maintain their status of truth or even practical knowledge when push comes to shove. In legal contexts other than land claims, the indigenous subject is stretched across an autological and genealogical divide rather than beached on one side of this divide. In criminal procedures in Australia, cultural beliefs and attitudes are not a basis for criminal charges but can be taken into consideration during sentencing. If a crime was committed because of a custom-

ary obligation then the sentence can be lightened—the crime is mitigated but not excused. Many younger indigenous men and women living along the northwest coast are well aware of this sentencing flexibility—one of my husbands steering the boat during our trip to Maliya has relied on this distinction between charge and sentencing to mitigate several assault charges.²¹) of Sumatran

What is important here is not whether Ruby Yarrowin is or is not traditional or whether she did or did not see the devastating effects of *kalangak*. Ruby Yarrowin could remain silent about her beliefs and still be as "traditional" as she is when she is talking. Or she could not believe a hoot of what she was saying. But no matter what she does, the doing is already embedded in a network of discursive matrixes that apprehends her actions under the sign of the autological subject or genealogical society. *And she must do something.* She must care for herself at the multidimensional and multifunctional intersection of law, public culture, and practical knowledge. She must navigate clinics, dreaming sites, legal protocols, and camping grounds as well as navigate their games of truth about the indigenous self, even as she makes decisions in the context of very local debates about what knowledge should circulate through the community and beyond. She and others must continually ask and answer the question of exactly when a law, economy, or health care plan pertains to "all Australians, including Aboriginal and Torres Strait Islander People" and when it pertains only to Aboriginal and Torres Strait Islander people. In clinics, Ruby Yarrowin must act as if her knowledge and belief in Maliya and the *Barangga munggarra*

status of truth / custom / legality and
her use as mitigation

did not *really* matter, in legal hearings as if it did. She must do so even though she cannot be sure what would happen if she actually acted on this knowledge and belief.

In other words, one aspect of the cunning of recognition is the transformation of a discourse of demand into a discourse of recognition—the demand that Ruby Yarrowin have a specific kind of knowledge about Maliya and a specific propositional attitude toward it if she is to be recognized as a “traditional Aboriginal subject.” Another aspect of the cunning of recognition is the bracketing of the incoherence of these multiple external demands on the indigenous subject as she traverses the incommensurately coordinated social institutions. This second bracketing is especially significant since the ways that indigenous subjects move strategically across the various demanding environments of law, health, economy, and social welfare are recycled into the disciplinary apparatus of the state. (The lack of traditional attitude toward health care and ritual practice can be, and has been, used to undermine land claims.)

Equally important is the fact that this second bracket allows critics and practitioners some distance from the grotesque misalignment of the rhetorics of cultural preservation within the practices of life preservation. These critics and practitioners can claim that these other contexts are not relevant to the case in hand. But we must break this bracket if we are to see how legal imaginaries of the flesh and the actual temporality of indigenous flesh are out of joint. The speculative pleasure of the law of cultural recognition as well as its legislative force pivots on a delicate intersection of knowledge

and age—old people with old knowledge. But because of the health collapse within Aboriginal society, age is the one thing people usually don't have. On the small boat mapping Maliya and other sites along the Anson Bay coast was a man, Trevor Bianamu, a brother of mine who was about thirty-five at the time. As we sailed along the coast, the men shared what they had learned from their relatives about its historical and spiritual contours. And they discussed the pressure that would fall on them if a legal contest over the land took place. My brother quipped that he was not worried because he would just make the “old people” do the talking. We were at that point passing by his country, Banagaiya. His brothers and I looked at him and said, “*Mana* (brother), you are the old person got your family, man side.” And he had been, since he was 26, the oldest male member of his patrilineally defined family.)

When Trevor Bianamu said he would make the old people talk, he was just repeating what he had heard and seen in other land claims and consultations over the years. He had witnessed several land claims by this time and knew that lawyers preferred to have the eldest members of a descent group speak for their family group—usually meaning people in their middle fifties or sixties, and, where possible, seventies and eighties: “*Pulupiya* people,” or grey-headed people. He and his age mates had been endlessly passed over as “too young” or too drunk when lawyers and consultants arrived in the community looking for the proper people with whom to discuss traditional land issues. And whose fault is that? Most indigenous bureaucracies are grossly under-funded, chronically under-staffed, and constantly under political assault.

They do not have the time to find, move, feed, and nurture more than the most necessary people for any land-related issue. These tasks are said to reside properly within the indigenous family, clan, or community even as these families, clans, and communities are themselves struggling to find the means to pay for rent, food, and schooling.

Even as these incoherencies are written into the everyday fabric of indigenous life, other bodies and voices are being made articulate as they move across institutional spaces. They are not articulate; they are made articulate. Take me, for instance. I have discussed all of the above ways of thinking about bodies and their social and material conditions with the doctors and lawyers I have worked with over the last twenty-odd years. In these conversations I am addressed as an expert on cultural belief and its rational groundings. I am invited to speculate with them on the possibility, for instance, that flu epidemics and streptococcal infections may have been the vector of the deaths and illness that these women described, and perhaps also the cultural initialization of Maliya, *munggarra*, and other active ancestral sites. In these conversations, I can insist that these places and events have no need of radical translation and that they must simply be addressed on their own terms. I do not, however, become indigenous at this moment. I become "over-identified" with my indigenous friends and family or I become "belligerent" and "unreasonable." Or, more interestingly, I risk losing my status as an expert and someone interesting to talk with. Whatever I become, this becoming usually does not affect the diagnosis and government of my diseased body. I can say anything and receive care in a

form that seems to fit my life because the institutions of care had "me" in mind.

All of which is to say little more than that the treatment of my sore is not dependent on the ontological presence or absence of Maliya, my existential encounter with Maliya, or my belief in Maliya. In fact, I live in the same complex, multiply structured world that my indigenous friends do. I, too, must decide whether sharing a life with my indigenous friends is more important than being exposed to low levels of infection. I, too, must decide whether I will inhabit a life-world in which sharing a sore is a necessary precondition of being together, side-by-side, one cup, food that travels from mouth to mouth. But I share this necessity differently even as I share it. I can produce myself as a stranger to it, as a self-governing subject of it, passively or actively—just being quiet in the doctor's office and letting him assume what he is likely to assume so that I can get my medicine quickly—without disrupting other distribution networks that make up the broad nervous system in which my body is produced. I will be made autological everywhere I go, qualified by the obvious difference of my sex and sexuality, but autological all the same. This is not so for my friends and colleagues in Australia. And it is exactly the irrelevance of Maliya to my clinic experience that suggests how autology and genealogy, and their carnal anchors, function most tenaciously, steering the course of action and the shape of discourse by functioning most invisibly in situations in which nothing more remarkable is going on than deciding which part of one's life is relevant to a doctor changing one's bandage.

privilege, bodied difference

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The author's
as well, it's
not

Of course, none of this is true. None of these institutions of care has been formed with me in mind, but only with "me" in mind, insofar as "I" am closer or further from the regulatory norm and the normal body. To reach toward this norm, I, too, must contort my voice and body to fit its shifting horizon.

Four

58 The rendition of care, curiosity, and calamity that I provided the Chicago and Montreal doctors was anything but complete, even leaving aside the beliefs and practices of friends living along the northwest coast of Australia. As the physicians probed me about the source of my sore and about how it was usually treated, I left out another set of social worlds I regularly inhabit. I did not tell the Montreal doctor that, the night before coming to the public clinic, my friend and colleague Michael Warner, also at the conference, had agreed to change the bandage on my shoulder so that we could attend the last day of Divers/Cité, Montreal's lesbian, gay, bisexual, and transgendered PRIDE celebrations. Michael wanted to see the featured performer that evening, Mado Lamotte. It was a difficult job, changing my bandage. Michael struggled to distinguish which part of my shoulder was the wick, which was rotted flesh, and which was alive. He eventually gave up and carefully re-bandaged the entire mess. I don't remember if I told him the medication I was on. But we both would have known that Septrim was widely prescribed for the prevention of PCP (Pneumocystis pneumonia) in people with HIV/AIDS.

After the conference I was off to a date with an old friend

*intersection of
these worlds with queer,
and ones*

of Michael's. And so, as he and I worked on re-bandaging my shoulder for our night out, we discussed the ethics of dating with a sore as hideous looking and as fundamentally undiagnosed as mine, stumbling around for a genre into which we could insert and make sense of my sore and sexuality. We were, as Cindy Patton has put it, "thinking without a proper name."²² Not surprisingly, given the sexual discourses and worlds we shared, we fairly rapidly made recourse to a language of sex-positive safe sex—the ethical and medical imperative to disclose one's health status to actual and potential sexual partners. We discussed this ethic in the casual way that so many people of a certain age do in the United States. Our conversation was not groundbreaking or world-shattering by any means, just two people engaged in a mundane review of the importance of taking individual responsibility for the transmission of disease in a society structured by stranger sociality. (Which, parenthetically, may well be what irks many on the religious right—the casualness of this way of thinking ethically in the domain of sex.) Casual or profound, our conversation cross-hatched elements from the various social worlds that we were a part of, and in the process sutured together, if only for a moment, a new bodily matrix. Sores acquired from one social world entered into another, and as they did so, they were refigured by local discourses.

Although Michael and I spoke of my sore in the everyday language of safe sex, the sociomedical history of the sore rattled the intelligibility of this discursive move—no less in its presuppositions about individual disclosure and stranger publics than in its biomedical nature. What, after all, was I

supposed to disclose to the woman I was dating? I wasn't even sure what the source or agent of these sores was, what risk I was exposing her to. I *could* tell her I was likely to continue to have these sores periodically because my life seemed inseparable from the lives of my indigenous friends and family in northern Australia and because their lives were likely to remain mired in the poverty and racism that helped cause these sores. But this explanatory frame—that poverty and racism are the cause if not the agent of these sores (not so different an explanation from that given to me by the Darwin physician) and that my health was now linked to their health via deeply felt kinship obligations—strains the flesh of the body that Michael and I inhabited. It stretches its skin and internal organs away from the biomedical and bioethical discourse of safe sex and the world of stranger sociality it presupposes, and re-grafts it onto geophysics of a different sort, a geophysics of thick ties of kinship, friendship, and ritual as well as the thick transfers of wealth, health, and power that these thick social worlds make possible and inhibit. In other words, a different supra-organic body is built when the inequalities of white and black, North and South, settler and indigenous are the primary axis of the body that exists between me and my indigenous family and friends. My sore stops being only a biological agent that needs to be treated and begins being also a social relation that needs to be addressed. It is this transnational body that Thabo Mbeki has controversially evoked in his HIV/AIDS policy, that Aboriginal artists have evoked in several well-known HIV/AIDS awareness posters, and that the Canadian Aboriginal AIDS Network has evoked in its harms-

reduction approach to the epidemic.²³ It is also the body that indigenous friends evoke when they describe the difference between indigenous and white people as resting on the relative value of the skin and sociality—that whites care more about the smoothness of their skin (“clean skin”) than the condition of their social relations. They would rather sleep far away from each other than risk getting lice, sores, and scabies.

Still, why wouldn't I tell the Montreal physician about the previous night's tampering of my bandage? What discursive forces were with me in that public clinic that helped shape and direct my language? One set of social vectors pressing onto this scene was a portrait with HIV/AIDS emerging at the intersection of two different portraits of social pathology. On the one hand, HIV/AIDS has been portrayed as the pathological product of genealogical sociability. Early medical bulletins, circulated across world health organizations, warned about the spread of HIV in indigenous communities through sexual laxity, ritual culture, and addiction; in other words, through either the continuity of customary kinship obligations or their breakdown. On the other hand, HIV/AIDS has long been portrayed as the pathological product of the autological subject at the extreme end of stranger sociality. Because I sit at the intersection of these two possibilities, the Montreal physician was less likely to dissect the intercommunal body that Michael and I had built than to tether it together more tightly with the two ends of the same pathological rope—too much genealogy, too much autology, too many kin, too many strangers. And so, if he wasn't thinking about the perverse sexual body, I wasn't going to help him waste our time by going down

what I considered to be a misguided diagnostic path. True, I wanted this sore to go away and, given my upcoming date, I wanted a medically authorized judgment that these kinds of sores were not communicable. But I didn't want to get into a discussion about gay and indigenous sexual cultures. All of these motivations were part of the forces that shut my mouth and kept me silent. And all of these silences are part of the delicate apparatus by which the discourses of autology and genealogy are maintained in liberal worlds. In the effort to get the sore cleaned up and re-bandaged quickly so that I could get back to the conference, I, too, treated my sexuality, Maliya, and my Australian friends and family as irrelevant to the diagnosis and governance of my body. I managed, without anyone asking me to do so, a set of possible alignments between perverse "pathological" cultures—the ritual pathology of Aboriginality and the sexual pathology of undomesticated gay stranger sociality. Friends in indigenous Australia manage other alignments—creating, or not, genealogical spaces and times that do not disturb autological ideologies.

Adelaide, Australia (AP)—Because of ceremonial sharing of blood, as well as a general absence of safe sex practices, Australian aborigines are at high risk of devastation by AIDS, according to the findings of a state inquiry. HIV is spreading rapidly, and some aborigines have already died from the disease, said the report by South Australian Parliament's Social Development Committee. Alcohol abuse and the lack of "cultural sanctions against multiple sex partners" contribute to unsafe sex

and transmission of the virus, stated the report. Also, in many rituals, aborigines cut themselves with a stick or rock and risk spreading the disease by sharing the cutting object, the report concluded.²⁴

I am not cavalier about the danger that HIV/AIDS poses to indigenous people and communities. HIV/AIDS prevention in Australia has been far more aggressive than in the United States. The 1980s and 1990s saw a massive safe-sex campaign addressed to the general public and to gay and indigenous communities that helped to reduce the spread of HIV/AIDS in Australia. Face-to-face encounters were one of the textual means by which information about HIV/AIDS circulated through indigenous worlds. Aboriginal and non-Aboriginal video directors and screenwriters such as Ruth Carr, Catherine Adams, Mimi Pulka, and Tracey Moffat also produced works about and directed to indigenous communities. Infection rates are, as a consequence, relatively low, and seem to have peaked in the 1980s. In 1999, about one hundred people died of AIDS and about fourteen thousand were living with HIV/AIDS, around 0.15 percent of the adult population.²⁵ However, from 1994 to 2000, according to the CDC, the rate of new cases among urban indigenous Australians was four times higher than the average in the general population.²⁶

These calculations of risk and the comparative epidemiology on which they rest presuppose a certain level of homogeneity within population groups even as, according to Stacy Leigh Pigg, they "promulgate a particular set of ideas about the sexual and reproductive body."²⁷ And yet, these popula-

tions and their discursive and material grounds are quite diverse. In some indigenous social networks, the difference between being and not being Aboriginal is a defining feature of daily interactional space. Because this kind of social distinction lies in the foreground, the struggle to define "Aboriginal"—its explicable and numerable cultural, social, and environmental dimensions—defines local cultural politics. Who is and is not indigenous is the struggle of identity. In other social networks, Aboriginality is the daily backdrop of interactional space—nearly everyone is Aboriginal—and so other regional, ecological, ritual, clan, community, and language identities are more important for defining and navigating everyday life. In many indigenous communities along the northwest coast, for instance, the question is usually not what defines an Aboriginal person but rather what it is to be a coastal rather than an inland person, with all the kinship and ritual ramifications of this ecological distinction. As a result, the dispersion of discourses of safe sex, sexual identity, and sexuality through indigenous worlds varies significantly from urban to suburban to rural spaces, from the heavily populated south to the more sparsely populated north. And when discourses of safe sex, sexual identity, and sexuality circulate in places like the northwest coast, they circulate among, and articulate, already existing life-worlds. The thematics of safe sex, sexual identity, and sexuality meet life-worlds with specific notions about how social goods and harms are distributed across age, gender, and kinship, about where the body is and how it can or cannot extend across physical and mental space.

Take, for instance, a conversation that occurred in 1989.

A group of indigenous women and I were sitting on the north coast of the Cox Peninsula, whiling away the late morning discussing the syntax of Emiyenggal, when a Toyota Land Cruiser filled with strangers drove up. Several women, some white, some indigenous, popped out of the truck, and after a brief introduction began to discuss with us the importance and mechanics of safe sex in the prevention of sexually transmitted diseases and HIV/AIDS. To demonstrate the use of condoms, they pulled a dildo from one of their bags and attached it to a piece of plywood. It was quite an uncanny sight—the white flesh-colored dildo swaying back and forth on the piece of plywood, my linguistic notes flapping in the breeze, the remains of half-eaten fish and bread from our morning breakfast attracting the interest of flies and dogs. Very quickly, as was their way, the women began entertaining each other with a particular coastal ribaldry in a mixture of Emiyenggal and Aboriginal English not parsable to the strangers. The women joked about whether the visitors were suggesting that we not only put the condom on the dildo, but that we then test out the entire contraption on each other.

When the older women joked about strapping on the dildo, they relied on, and entailed, the continuing relevance of the social distinction between what anthropologists term cross-cousins and parallel cousins, and what the women term in Emiyenggal *panen/menggen* and *mane/edje* or in creole husband/wife and brother/sister. Because of the dense kinship networks that compose their lives, every woman on that beach had several *menggen* sitting next to her. Speakers chose specific women as the address of their discursive play (*erere*), not

a *menggen* in general, but a specific *menggen*. These modes of play intensify kinship relations, turning a dead category into a more intimate affair, not an intimacy that punctures kinship, but an intimacy that constitutes retroactively the truth of kinship as a persistent and relevant category of social life. In this way, these modes of address are creative and productive as much as they are normative and disciplinary. They pull immanent desires and alliances into actual social worlds, creating actual affective and discursive dependencies where before there were only potential dependencies. They mobilize kinship, age grades, and gender to sweeten certain same-sex and cross-sex relations through a rough, sexually explicit discursive play (*erere, yedametj*). Is this sexuality? Only in the most reduced and decontextualized sense. These women are not choosing between homosexuality and heterosexuality, or between discourses of alliance and discourses of sexuality. They are instead constituting social dependencies beyond the conjugal couple; reducing harm through the formation of broader social networks; and enjoying each other's wit.

These women cannot hermetically seal off their practices of sociality from discourses of hetero- and homosexuality and stranger sociality, however, even if they wanted to. After all, discourses of sexuality were already within the languages and practices of safe sex circulating across countless beaches and community clinics as well as in newspapers and on television, radio, and Internet sites by the time we were discussing the syntax of Emiyenggal. An incident with two girls, each about ten in 1989, suggests some of the ways these discourses are coordinated, contested, and absorbed locally. One day,

as we were fishing along a creek, one of the girls, Anna, declared to the other, and to everyone gathered around, that when she grew up she was going to marry her cross-cousin (*I gana marry you menggen when I get bigger*). A mother of Anna—who was about twenty at the time—corrected her daughter, saying that girls marry boys, not other girls, to which Anna replied, turning to her grandmother, “Neh, I can marry her. I call her wife. I can marry her. Eh Nana?” Anna’s grandmother, who was sitting nearby, agreed, saying, “That her wife, that her proper *menggen*, finished, you can’t make im different.” The older women’s statement did not end the argument, for Anna’s mother retorted, “wulgamen you no more sebi, that different, that not *menggen* that lesbian.” For Anna’s grandmother, these were absolutely different social skins, but not the way her daughter had suggested: “No, no, don’t say that, you wrong yourself, you say *menggen*, you say wife, that girl can play with that other girl, that not lesbian that *menggen*.”

It would be easy to claim that Anna’s grandmother constituted the separation between *menggen* and lesbian on the basis of the difference between kinship and stranger socialities and that, as she did so, Anna’s grandmother was constituting the continual relevance of local modes of desire and association in the face of the globalization of the hetero-homo binary.²⁸ But the separation that Anna’s grandmother made was supported by much more than the mere distinction between kin and strangers. It rested on an entire set of presuppositions about the body and its possible extensions—on a more general way of thinking about the body as a material

extension into and out of the physical and social world *as that world is now organized*.

68 For some the tensile nature of kinship mediates social life. Kinship wires the deep recesses of the body. A complex coordination of muscles, organs, and joints signal the wellbeing of various kin, sacred ancestral sites, and ritual events. For others, the body extends more generally across quotidian materiality. For instance, in 1989, one of my brothers, Anthony Bilbil, who was about fifteen at the time, got furious with his older brother. Anthony claimed his brother cut his foot. The proximate cause of his injury was a piece of glass he accidentally stepped on. But what really caused his injury, according to Anthony, was that his older brother had touched his sleeping blanket, violating the bodily separation of siblings. These kinds of extensions of the body affect women and men. But once into their maturity, men and women tend to face these extensions in different ways. Men are usually the victims of social predators such as *munggul*—men who use young pretty women from other areas as bait to capture local men, removing their kidney fat and filling the void with dry grass. The victims have hollow backs, like large mudcrabs, light and without any beef inside, liable to death from the slightest wound. Women are more likely to be the victims of *tjukpiya*—the use of ritually imbued spit to cause traumatic deafness. Women warn men against traveling to certain places after reports of *munggul*, or socializing and sexualizing with women with “different faces.” Men tell women not to take certain roads to hunt or to visit relatives lest they interrupt male ceremonies and become a victim of *tjukpiya* or worse.

Of course, these kinds of accounts of the body and its difference are just the kinds of things that medical and legal regimes of recognition wish to support, perhaps through copyright.²⁹ When culture/custom is considered to have positive social or moral values, then *demanding this determination* is seen as merely recognizing facts on the ground. Take, for example, two exchanges in a land claim between Betty Bilawag, Ester Barradjap, and their respective lawyers on the subject of kinship and marriage.

Mr. Keely: Which mob do you belong to, Betty?

Betty Bilawag: Marriamu, my tribe.

Mr. Keely: When you got married to that old man Mosec, was that a promised marriage or not?

Betty Bilawag: Yes, that my promised husband.

Mr. Keely: He was promised by whom?

Betty Bilawag: By my father promised to Mosec.³⁰

Mr. Young: Okay, good. Was that marriage between Agnes Lippo and Tom Lippo, was that a promised marriage?

Ester Barradjap: Yes.

Mr. Young: And what about your marriage to Tom?

Ester Barradjap: It promised, same.

Mr. Young: Promised marriage, same. Now, is there—who arranged your marriage to Tom?

Ester Barradjap: My father.³¹

Note the various levels of genealogical discourse indexed in this exchange—the law of paternity, the law of custom, and the law of obligation. Other women, who did not marry

promised husbands, or for whom no promised husband was arranged for various reasons (not least because of the social chaos of the colonial period and its aftermaths in the post-colony), are not equally “good subjects” of the law of recognition. In an exploratory discussion for this claim another woman was asked if her husband was promised. She replied that he wasn’t but qualified this reply with the statement that he was nevertheless her proper cousin, i.e., lawful according to the custom of kinship and marriage. This form of address is found not only in this particular land claim, or in land claims in particular. It is a field of address in which a regime of recognition demands a regime of genealogical determination as the condition for authenticity.

It is precisely here that we need to remember that all of these bodily extensions into the physical and social world occur within the actual worlds where people live, not in some other world—not some counter-factual world of an enchanted Dreamtime. And we need to remember that all of these languages and practices of kinship, the body, and desire are also interpreted with regard to how indigenous men and women imagine settler subjects apprehending them and with regard to the power they have in shaping these imaginaries. Indigenous women and men have sharply critical positions on how they are inserted into discourses of the genealogical society and the proper indigenous subject. A few years ago, I was engaged in a conversation about “proper marriage forms” with a middle-aged mother of mine, Marjorie Bilbil, who had refused her own arranged marriage. We were discussing among which language groups it had been “proper” (also “right

way”) for younger women to marry their mother’s father’s brother and why it was proper for women to marry certain men in their grandparents’ generation but not for men to do the same (“women go up, men go down”). At the very moment that I created a knot between traditional marriage and modern sexism, Marjorie Bilbil—whom I had known closely for eighteen years at that point—observed, without much of a transition, “White people marry anyone, like dog really, eh Bet.” I qualified this statement by saying that, properly, they married anyone except members of their immediate family; they were qualified dogs. She responded that this was true, that white people were “back to front” in almost every conceivable way. Given the local emphasis on indirect forms of social critique, “white people” included anyone asking these kinds of questions—including me.

In short, when the group of women argued about the meaning of marriage, kinship, and sexuality, they did so on the edge of a creek that spilled into all of these local and translocal discourses—the sexual proclivity of various ancestral sites, the ongoing drama of *Will and Grace* broadcast on the local television channels, the coverage of white pedophiles in the local Murdoch-owned newspaper, the drinking parties that crisscross Aboriginal communities in which reggae, hip hop, and *wangga* are combined. The ubiquitous nature of the mass media and the longstanding social relations across indigenous and settler personal and institutional spaces have long ago invaginated kinship with other organizations of social life, desire, the body, and stranger intimacy. In these ways, local bodies are not merely open to kin, ances-

meeting
western/indigenous
distance; homophobia + gay
ident. front iddig
(P)

tral sites, and ritual events. They are also open to the drama of Western sexuality with its antagonisms and phobias, opportunities and exasperations. The binary opposition between heterosexuality and homosexuality, and the presumptions of stranger sociality that subtend them both, enter through very local discourses and practices, thickening one set of social relays, thinning others, displacing and unhinging the binary of hetero- and homosexuality itself. The multiplicity of discourses of sexuality provides the occasion for discursive contradictions, contractions, conflicts, and creative invaginations as well as new forms of the social skin, new social phobias, and new social aspirations.

It is within these thick possibilities that homophobia reappears as a powerful affective and discursive disciplinary tool and is as present in urban and rural indigenous spaces as sexualities per se. Along with the emergence of the identity of heterosexuality and homosexuality as a thing one can be and can be independent of kinship has come homophobia as a thing one can also be, creating a separation between people. Along with this sexual difference has come a thing that must remain hidden or demand visibility: discourse about loss, gain, and ethics, about the gay international and the politics of human rights, and about the difference between strangers and kin. In the face of the weak citizenship foundation of homosexuality and the strongly negative affective foundation, many urban-based self-identified gay indigenes, both men and women, struggle to reconcile their sexual identity with the notion of traditional Aboriginality.³²

All of this is to make a simple point: indigenous men and

women are not the passive subjects of these discourses. They constantly disturb settler discourses of the body and its conditions of desire, integrity, and viability as these discourses circulate through their lives. And they disturb the people who are carrying these discourses, such as me. They disturb me not merely because they are homophobic but because I find retrospectively that being bound to my friends and family along the coast means that I can neither be with them nor with myself easily. I can tell my date that I am likely to continue to get these sores because I am likely to continue to return year after year to people whom I have known longer and more intimately than many in my biological family. But I also return there on the condition that I leave some aspects of my sexuality behind.

As a result, this deeply personal relation has made me personally implausible, my political allegiances awkward. If I locate myself within a world of stranger sociality and the sexuality it entails, then I have separated myself from them. But I also separate myself from myself because at this point who I am is unimaginable outside these twenty-one years of being in this family. All of which is to say little more than what Judith Butler said before—that all identities are risible, are disturbed by the play of citationality.³³ But in so saying we have only just begun. We have merely chalked the starting line of our social analysis. While it is certainly true that “I” am as disturbed by the discourses and expectations of autology and genealogy as my Belyuen friends and family, I am disturbed differently, and the effects of this disturbance are different. We are all vulnerable, but not equally so.

A Belyuen
disturbed by
difference

Part of what produces these different vulnerabilities is the intersection of discourses of genealogy and autology and the actual materialities of social life. I mentioned one intersection earlier—the legal prejudice for old people, old knowledge, and old practice in the context of a low life expectancy. But there are much less formal ways in which these discourses touch material life. My sore is not mine in any sense that really matters, after all. It belongs to a cascading set of social harms and attitudes toward these harms that have emerged in the wake of settler colonialism. Noel Pearson, an Aboriginal activist, has famously and forcefully argued that state welfare, when applied to indigenous peoples, is a technique of numbing indigenous and non-indigenous people to the radical “state of dysfunction” in Aboriginal communities.

Imagine if the average life expectancy of the town of Gatton was only 50 years and sliding. Imagine if the population of Cairns was in prison to the same proportion as the people of Hopevale or Arrakun or Lockhart River. Imagine if over 38 per cent of the 15-10-40-year-olds in the town of Atherton had a sexually transmitted disease. Imagine if kidney or liver failures or heart disease were proportionally the same for Gympie as it is for Cape York. Would we be as numb and complacent about the statistics as we are when faced with the reality of the social disaster of aboriginal society on Cape York Peninsula? No. There would be nothing less than a state of emergency, with government initiatives that had pre-

vailed and failed being fundamentally questioned and radically revisited.³⁴

Pearson's proposals for solving this numbing are controversial in large part because he claims that the malevolence of social welfare will stop only when social welfare itself ends. As a result, Pearson has joined forces with the conservative Liberal-National Party to declare self-determination a failed social experiment and to advance “shared responsibility agreements” between state bureaucracies and indigenous communities.³⁵ These packages condition the receipt of such essential governmental services as remote education and housing on the maintenance of personal hygiene and school attendance. Clearly, these packages smack of an earlier, paternalistic attitude toward indigenous self-governance. And it is unclear how these packages can be “mutual” in any sense given the extreme social, political, and economic inequalities that exist between indigenous and non-indigenous people. When it comes to non-indigenous health and mortality, indigenous Australians inhabit turn-of-the-century Australia, when the life expectancy of a European newborn boy was 55.2 years, and a newborn girl 58.8 years. These remained the high end of the life expectancies of indigenous men and women in 2004, even as that of their non-indigenous co-citizens climbed to 75.9 and 81.5, respectively.³⁶ These statistics of life and death, though neatly fitting the epistemology of the body count, barely capture life at the margins of markets, the bad faith of liberal capitalism's trickle-down economy, and the failure of cultural recognition to evolve an ethics of mutual life.

social welfare

Pearson notwithstanding, the social welfare net has not been shredded in Australia, at least not yet. In rural indigenous communities, social welfare is managed through a variety of programs, including those for aged pensioners, women with children, the unemployed, and community development projects. The Community Development Employment Project (CDEP) is a work plan established in 1977. As Jon Altman and M.C. Gray note, CDEP has been described as "a labor market program, an alternative income support scheme, and a community development scheme," but whatever it is, CDEP has raised the personal income of rural indigenous men and women.³⁷ Even so, the standard measurements of social wellbeing—employment, income, housing, health, education—indicate that indigenous men and women inhabit by far the lowest rung of Australian society.³⁸ The CDEP was run by the Aboriginal and Torres Strait Islander Commission (ATSIC) until 2005, when the Liberal-National government under John Howard dissolved ATSIC. Since its founding, ATSIC had been roiled by a number of funding scandals, though whether these scandals evidence more or less corruption than non-indigenous government is an open question. ATSIC was hailed as the primary place where indigenous issues would be resolved through self-management and was disparaged as riddled with mismanagement and corruption. It is not clear whether the problem ATSIC faced was one of overfunding or underfunding, one of too much or too little self-management. On the one hand, under the Labor government of Paul Keating, responsibilities that initially rested in ATSIC were transferred to other departments, notably control over health care.

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On the other hand, a large majority of funding within ATSIC was non-discretionary spending on programs that the Commonwealth government had determined and shaped, such as CDEP.³⁹

In the shadow of these statistics Pearson's rage is understandable. All of the physicians with whom I spoke as I traveled from Belyuen to Chicago to Montreal to Darwin and then back to Belyuen assured me I shouldn't worry about getting sores because they would go away when I returned to the colder North American climate and a sanitary environment, or, if necessary, after a round of antibiotics. If it were staphylococcus, or a bit of streptococcus, so what?

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To say that in 2003 I discovered that Group A streptococcus can lead to serious, sometimes fatal, health conditions is a sad commentary on my research skills. But sadder still is the fact that I fell for one of the oldest tricks of the capitalist organization of global medicine—ghoul health. Ghoul health refers to the global organization of the biomedical establishment, and its imaginary, around the idea that the big scary bug, the new plague, is the real threat that haunts the contemporary global division, distribution, and circulation of health, that it will decisively render the distribution of *jus vitae ac necris*, and that this big scary bug will track empire back to its source in an end-game of geophysical bad faith. Ghoul health plays on the real fear that the material distribution of life and death arising from the structural impoverishment of post-colonial and settler colonial worlds may have accidentally or purposefully brewed an unstoppable bio-virulence from the bad faith of liberal capital and its multiple geophysical-tac-

"ghoul health"
— cure of
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tics and partners. Even if the Chicago doctor who took the time to treat my shoulder, and whom I have repaid unfairly by pillorying him internationally, was not thinking about the Andromeda strain or Ebola so much as the more mundane possibility that my shoulder harbored a new strain of flesh-eating streptococcus, someone like me remains the worry of ghoulish health—the innocent bystander, the casual traveler, back from the inter-space of empire, the tourist as biological means of transit, stopping here and there on the way to and from, with no certain origin and no certain end. The density of human circulation has created a new biosocial space and time, and it seems that opportunistic infections can strike anyone, anywhere, anytime.

The temporality of ghoulish health stands in stark contrast to the state of health crises at the seams of global capitalism. There, sores and diarrhea mark the timing of life and death—an exceedingly slow, hard to quantify, cumulatively acting health collapse. Sore after sore, bronchial flu after bronchial flu, broken toilet after broken toilet wear down the body's immune system and help account for the quantifiable difference in life expectancy between Aboriginal and non-Aboriginal Australians and the less easily quantified difference in quality of life. Diseases of poverty are not usually medical rarities; they demand neither high technology nor new movies to apprehend them. Rather they demand choices about wealth and resource distribution and political sensitivity to a different kind of corporeality.

In short, ghoulish health is ideological in the sense that Althusser used this term: the imaginary relationship of peo-

ple to their real conditions of existence. The material backdrops of these imaginary relations are multiple, the patterns of structural impoverishment many. The withdrawal of capital from regions after the severe extraction of resources and the resulting pollution of the environment—such as seen in Papuan mining regions, the Brazilian rainforest, and Nigerian oil fields—has left over-crowding, incipient starvation, environmental harm, and appalling sanitation.⁴⁰ The encouragement of a region to enter capitalist development quickly, bypassing the economic “drag” of social services such as health care that would threaten or stifle the sufficient bottom line (as if profit operated according to the limit of sufficiency in capital accumulation), has also led to a steep curve in health failures, such as we have seen in China and the post-Soviet world.⁴¹ In still other regions, such as the interior lining of First World settler colonies, the continuing state of carnal collapse has led to calls for new strategies and experiments in life.

In other words, Pearson's rage, as an echo of the carnal collapse in indigenous worlds, is not alone and does not register the only intersection of callous prejudice and ghoulish health. We heard a similar outrage in Greg Bordowitz's film, *Fast Trip Long Drop*, which explores his response to ACT-UP's inability to stem the tide of death before so many of his friends and lovers had died. The film is a cry of a failed dream and a waking nightmare in which he cannot depend on having the normal stages of a normal life: birth, childhood, adolescence, middle age, and old age. He no longer has the privilege of a certain kind of youthful amnesia around the transitory nature

"carnal collapse" of
life worlds,
capitalist

outing of
vs indigenous
AIDS
health

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of life. He lives within a deathscape, and no one cares. And yet, the sheer volume of Bordowitz's outrage is also a subtle sign of just how thoroughly life is distributed in the liberal diaspora—not life in a simple numerical, demographic sense; but life as an experiential state. His justified shock signals a certain privilege—that many people consider life as something that can be counted on, at least for a certain length of time, for long enough to be able to forget about its limited nature. This amnesia does not infect many others. If you are an indigenous person in Australia, you know you are likely to die fifteen to twenty years earlier than your white counterpart; that your household income probably will never rise above the poverty level; that you probably will be sent to prison (though they account for only 2.2 percent of the population, indigenous people make up 20 percent of the prison population); that you and your children probably will have life-imperiling addictions; and that you probably will have sky-rocketing levels of diabetes, renal failure, and Group A streptococcus that will cause you or your children to suffer from rheumatic fever and heart failure.

In short, the cause of ghoulish health and its solutions telescope a certain tension between international poverty and profit, statesmanship, robber capitalism, liberal capitalism, gangster capitalism, and socialism, and they increase the pressure on subjects of these value regimes to conform or risk being left behind in a vastly reduced, nearly uninhabitable landscape. In the language of a post-recognition politics of shared responsibility: Wash your face or funding for your school will vanish. As progressive health programs chal-

what health is normal

lenge the normalizing routines of ghoulish health, the ways in which ghoulish health fixes certain populations into a normative geophysics consolidates the distinctions between ordinary and exceptional bodies, providing different expectations about which forms of remedial care are likely to work for whom, and why. This routinization of public expectations, mediated by government, NGOs, and public reports about the persistence of a set of negative biostatistics, creates a normative expectation about where it would be normal to see a sore such as the one on my shoulder, and where not—what Allan Feldman has described as a discourse of “in place and out of place bodies.”⁴² After all, part of the disturbing nature of the sore on my shoulder was where it was seen and on what kind of body—in Chicago/Montreal and on a highly educated white woman. One aspect of the disturbing nature of Aboriginal health is also its location—a biosocial fold of the Third World within the imaginary healthy body of the First World. Unless, of course, what I had was a symptom of HIV/AIDS, in which case I would cease being an effect of a biosocial fold and start being a cause.

Ghoulish health does not characterize the world-views or practices of all world health activists—nor of most indigenous health workers and activists in Australia. A host of competing national and international state agencies and NGOs have built a set of interlocking, more or less functional institutions and protocols for rapidly apprehending actual and possible infectious types and trajectories, both to forestall pending epidemics and to address the cultural and material inequalities that help foster them. But they build these programs within

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a context of limited and unevenly distributed resources dedicated to national and international health. As indigenous families and friends of mine in the northwest coastal regime negotiate their lives in landscapes of sores, the extralocal institutions meant to remedy their situation are skimming surplus value off their ill health. In a study of the Aboriginal health care system in the Northern Territory under the conservative Country Liberal Party, Tess Lea has noted that even as it denounces the immense sum of resources consumed by Aboriginal health, "the Northern Territory Government receives a disproportionate share of national revenue in order to maintain most of its services, predominantly on the basis of the cost burden of supporting Aboriginal people. That is, the parlous state of Aboriginal people and the role of the nation in bearing responsibility for that sorry state form a key part of arguments for extra funding beyond what would ordinarily be distributed under strict per capita allocations."⁴³ The Northern Territory Government is, to use the social imaginary of my friends, a *munggul*, a person who feeds on other people's kidney fat. The state's extraction of wealth from indigenous ill-health is not the only game in town. Vaccines for Group A streptococcus, tested out in the laboratory of indigenous communities, may ultimately generate profits for large corporations, just as the results of bio-prospecting in Mexico generate profits for pharmaceutical companies far away from home.⁴⁴ The HIV/AIDS pandemic has already become a "lifestyle" illness for many in the First World, providing a permanent flow of cash to the pharmaceutical companies treating it. Power itself speaks this truth—potential, if deferred,

profit is seen as the necessary incentive for companies to invest in biomedical research on so-called marginal diseases in the first place.

Progressive health care workers and advocates face not only the economy of health. They encounter the uneven national terrain in which this health is distributed. Within First World settler colonies such as Australia, the United States, and Canada, the state's organization of health care and the national imaginary of the indigenous subject vary significantly. The United States is alone among these three countries in lacking a universal health care system. I was able to have relatively quick access to the University of Chicago Hospital because of the kind of private health care policy I had. The aggressive diagnosis of the physician I met there may well have been influenced by my ability to pay, his relative unfamiliarity with anything indigenous, and the research quality of the hospital itself. The clinics I visited in Australia and Montreal were both public, and the indigenous subject there occupies a much larger segment of the national and health care imaginary. As a result their doctors displayed more, if varying, degrees of familiarity with the kind of sore that I was carrying, though they differed significantly in their diagnoses of the biological agent of the sore. But the doctor in Darwin, who was the most familiar with these kinds of sores, was also the least aggressive in terms of the treatment. Rather than resolving the triangle of diagnosis, treatment, and eradication, familiarity seems to have bred, if not contempt, then neglect. Indeed, what many medical anthropologists and health workers have long known is that the first order of business in these

"zones of dysfunction" is to interrupt the nervous system of blame and bemusement among doctors ("they leave them on the shelf to rot") and the blasé attitudes among indigenous men and women. These pathologies of the body must be made pathological; they must be made unfamiliar to the subjects most familiar with them. I must begin to lose faith in my indigenous friends. My indigenous friends must lose faith in each other.

In *Notes on a Native Son*, James Baldwin reflected on a problem that he thought all African American parents faced: "How to prepare the child for the day when the child would be despised and how to *create* in the child—by what means?—a stronger antidote to the poison than one had found for oneself."⁴⁵ The ability of indigenous men and women to navigate the various autological and genealogical demands on them depends not merely on mastering a set of discourses. They must also navigate these discourses within the actual worlds in which they live. The speed with which people die, the violence attached to these deaths, or the slowness of a body's decay all present different temporal frameworks—cataclysmic and glacial—for the working out and working through of these different discourses of autology and genealogy. When a funeral occurs once a week or every fortnight in Aboriginal communities stretching across the Top End region of the Northern Territory, the social, monetary and physical stamina required to attend them all, let alone participate in ceremonial aspects of one or several of them, can quickly overwhelm people for whom the average yearly income is \$10,000—and that's if one is able to keep up with the paperwork of welfare. Yet, being absent, no matter what the financial rea-

son, provides the emotional friction of the sort that led to the alleged *mungarra* attack—the intensification of feelings of severe isolation of the person (*gamaparrking*) that leads to biosocial catastrophes. It is within these actual worlds that new experiments in sociality emerge.

In other words, if extreme poverty and extreme sexuality signal the collapse of intimacy and genealogy, they also signal the availability of these states for experimentations in new forms of life. The normal has de-camped, and with it the presuppositions of an ethics of the norm. Another prefabricated ethics of crisis is excreted into the scene: the ethics of the extreme social reduction, and the ethics of living in unlivable conditions. Within these scenes, arguments are made for alternative regularities, in the beginning at least only for "here," where the old regularities make no sense, where they have become incoherent and inconvenient. In the end, who knows where and how these new regularities will migrate?

It should not surprise anyone that many of these experiments emerge in forms and terms that make them hard to digest. These experiments are awkward. They produce discomfort to many not living within these zones. They do not have an obvious redemptive moment. It is not clear—at all—whether they will produce anything that anyone could or would want to live within. So these kinds of experiments don't seem fair, because there is no way to know whether they will produce a good life for anyone. And yet, it is just these kinds of awkward, uncomfortable, off-kilter experiments in life that the carnality of liberalism produces.

We get a glimpse of the heterogeneity of these social experiments and the network of law and economy in which they

"new lives" ^{on the ab.}
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are embedded by looking briefly at how, in 2003, a sister of mine used the \$119,000 that she received in compensation for the accidental traffic death of her husband. He did not die from a sore. At least a sore was not the immediate cause of his death (although, it should be noted that many deaths are attributed to secret sores, inner sores that people who have given up on life are said to hide). Because a car hit him before life could, state resources could be mobilized for compensation. Within a few weeks, some said days, the money had been converted into cash and assets such as trucks, washing machines, and stereos, and then distributed across five different Aboriginal communities. Very quickly, the widow was in virtually the same state of poverty she had been in before she received the compensation.

What may well be interpreted as "waste" in one culture of circulation, however, was viewed as a proper form of sharing in another.⁴⁶ Jealousies and criticisms certainly abounded regarding who was given what and what sorts of things should have gone to what sorts of people. Many people whistled at the sheer speed of the distribution and were not surprised when, within just a few more weeks, the widow reclaimed several of the large assets (trucks and washing machines) and redistributed them along another line of kinship. And people commented on how quickly the widow transitioned from being the author of social ties to being dependent on these same social ties. She herself shrugged at times about this rapid transition, saying, rich or poor, she had kin. No one questioned, however, whether the widow should have disbursed these goods. Instead they questioned the calculus of the closeness of kin-

ship, residence, marriage, previous economic help, and ceremonial connections on which the giving was based. And they adjusted how they thought about the degree and kind of relationship the widow had to various people based on her choices of distribution. The widow, for instance, relied heavily on a network of trained indigenous women, in a variety of indigenous communities, not merely to collect, fill out, and usher the forms necessary for her compensation through the state bureaucracy, but to tell her that such forms of compensation existed in the first place. And these women used the fact that they had activated this epistemological asset for the widow because of their kinship, residential, marriage, or ceremonial closeness as the basis for a claim on the resources that resulted.

This potlatch is matched by countless smaller instances of financial redistribution that create and nurture networks of interdependency and that calibrate and recalibrate types and degrees of social closeness among people. In short, these economic possibilities are part of the extendable, flexible, and absorptive play of kinship relations in a region where an actual relationship is never as settled as modernist accounts of kinship studies suggest. Indeed, in this extreme example we see something profoundly ordinary—the willingness to act on a very different ideology of self in society, an ideology of "enough" and of the "will come." Kinship is not a view from the nowhere of the genealogical chart. Rather, it is made meaningful each and every time someone uses it to manipulate, chase, sweeten, pressure, or ignore specific people. In disbursing the money she had received for her husband's

*gift economy
intersect w bureaucracy*

death, the widow creatively entailed, out of the deformations that composed her life, what might be called a network of trust—trust that provisions will come, that the severe nature of poverty in a capitalist society will not exile the self from the social.

In these biosocial environments, the comforting difference between worlds of fantasy and reality begin to bleed as subjects experiment with the limits of the body in a field of liberal deformation. For indigenous people I know, the relevant question is not what kind of harm is too much for what kind of person, but how does one produce a viable subject within these carnal worlds and mitigate the social numbing they inspire in others. Achille Mbembe pointed to this in his provocative reading of Amos Tutuola's *The Palm Wine Drinkard*.⁴⁷

The ghostly exchange of body parts that Tutuola describes has a real counterpart—the organ trade, the sex trade, and the less publicized profit in accidental maiming and death.⁴⁸

Take, for instance, a front-page story that ran in the Darwin newspaper about a female maintenance worker who received \$100,000 in compensation for the deformation of her hands after twenty-five years of using a floor polisher.⁴⁹ The article presented a picture of the woman's hand and invited its readers to decide whether the amount of the compensation award was justified. The article reflects the logic of tort law. Tort law asks not merely whether this harm is too much to ask of any citizen, but too much to ask of *this particular kind* of citizen doing this particular kind of job. These ordinary assessments rework a point made by the political philosopher Carl Schmitt that, although the liberal state has the right to

demand that its citizens risk death, even die, in a war fought against its enemies, no one, neither state, court, nor business, could demand that anyone sacrifice his life for economic expediency.⁵⁰ The “no one” of Schmitt's abstract citizen is always someone particular in individual compensation claims. As a result the worth of a hand—whether it is really mangled or not that bad—depends on how you look at it. The visual field of judgment, as Sarah Jain has noted, is saturated by social discourses of gender and racial value.⁵¹

But even a lesser compensation payment would be a windfall for indigenous men and women. What surprise, then, that when a group of women and I read the article during a break from turtle hunting it prompted one of the women to note, “When that mob boy fight like today they say ‘hey mate no more fight for chin, poke out the eye one way then everyone split the money.’” In the carnal conditions of contemporary indigenous life, an eye, a limb, or a death caused by “bumping” (being hit by a car) has immense monetary value—and so there are jokes about hanging a limb out into traffic as a way of generating money for a washing machine, or a car, or a coffin. One of the woman said, “that mob kill imself enough cash for one's funeral.” These conversations often prompt laughter, but it is laughter of the abnormal camped within the normal.⁵²

Baldwin reminds us, however, that subjects who can live in and experiment with environments of numbing harm must be made, nurtured, and grown out of the very environments that are poisoning them. The women and men I know constantly reflect on just this fact, how to provide their children

How to make subjects who can stand it

with the self-discipline necessary to survive the "hard facts" of poverty in the context of what they call "hard Aboriginal law." Some of these elements of self-discipline were caught in the rendition of pain and mercy that I provided various doctors in Chicago and Montreal. Often, as part of my standard sore narrative, I describe the proper personal stance toward the pain of treating a sore. "Dig as deep as possible and don't feel sorry for me if it hurts." This short narrative fragment is a truncated version of what actually happened right before I left Belyuen for the conference. A few days before I was set to leave Australia for the United States and Canada, I asked one of my mothers, Binbin, to take a look at my shoulder.

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'What's this on shoulder mine, sore?' I asked.

"That nothing, what do white people call them, pimple," she answered.

"Well killim pimple wulgamen," me.

She did, with her fingernail. But the pimple did not go away, and I was soon pretty sick. So I walked to the house of my cousin, a health clinic worker, and asked her to diagnose my pimple.

"That's not pimple, menggen, that sore."

"Cutimim then. . . . Don't feel sorry for me menggen you cut right down."

And she did. Pus was soon running down my back. My niece (*ngambin*), the health care worker's daughter, finger painted with the pus on my back. "What this auntie?" "X." "What this?" "O."

My decision to have minor surgery on my shoulder engaged the law of autology on its own terms. I was an adult choosing the best possible medical options available to me. No one held me down. I held myself down. I was in pain but the pain was not sovereign, I was. But this adult had a childhood that allowed her to say later, "cut as deep as possible and don't feel sorry for me." This is the question, then, for them and for me: Why can some people hold themselves down sufficiently to get the care they need? What gives someone this discipline? How should parents fashion their children so that they will be capable of taking care of their bodies, not simply in the context of traditional custom and ritual, but in the context of liberal corrosions?

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A few years before this event, a twelve-year-old daughter of mine, Bronwyn Bianamu, had an aggressive sore on her left knee that had spread so deeply she was having trouble bending her leg. Scared of needles, she had run away whenever a doctor visited the community. She was camping at a site called Keldjelwik, a remote outstation with little by way of medical care beyond the bandages and antiseptic her aunt, a nurse, had brought with her. One evening, as her grandmother Binbin, her mother Diane, and I sat by a fire, Binbin told me to entice Bronwyn over with the promise of lollies (candies).

Me: "But I got no lollie, wulgow."

Binbin: "Nuku, then grabbim arm, head."

Diane: "Bronwyn, Bet got lollie!"

Bronwyn: "True, Bet, you got lollie?"

Me: "Might be."

severance as a
different kind of cutting

When Bronwyn came over to get the phantom lollies, Diane grabbed her legs and stretched them straight. I grabbed her arms, which were stronger than I thought. Bronwyn tried to scratch my face to get away. Binbin ripped open the sore on her knee with a sharpened twig, pus and blood bursting everywhere. Diane carried Bronwyn over to her aunt, a nurse, who was also camping at Kedjelwik, to be bandaged. Later, her mother led her to the salt water to soak her leg. In a few days, Bronwyn could straighten her leg and run around with the other kids. When she came into camp for some tea and chips, Binbin said to her, "See Bronwyn, that leg im straight today. You gana think hard. You gana cut that sore yourself next time. Today you run around. Not like yesterday. You're not going to be scared. You gana take care of that sore. You gana cut yourself so that you can walk."

This redemptive narrative—a child crippled by the canalized carnalities of capital's failure to trickle down is healed by the traditional knowledge of her grandmother—can determine the meaning of this scene only if other textures of revulsion and violation are kept outside. These other affective textures include my own panic as I held Bronwyn down, terrified that I was reenacting violent scenes from my own childhood, wondering what is the difference between being held and being held down, between physical pedagogies whose telos is self-discipline and physical pedagogies whose telos is the disorganization of the self. And these other discursive textures include community and public debates about sex and child abuse in indigenous communities. In these debates, all intense physicality, especially practiced on a minor's body, quickly collapses into physical abuse.

This method of disciplining subjects is not the only method that people practice within and across indigenous communities. Many people decide that the right way to nurture and protect their children, siblings, parents, and grandparents is not to constitute them as the kind of subjects who can cut themselves, but to remove them from the conditions that make cutting such an attractive option. They heed the warnings of health care professionals that sores, scabies, and endless flu should not be dismissed as "nothing." They are convinced that they have placed too much trust in their families. They decide that they will never be able to forge a middle-class life within these worlds. They take their children and close relatives away from rural and urban communities and the economic and social demands of kin. They decide that many of the moral and social practices within these worlds are repugnant, and they work for a different life in another kind of world. But when they do this, they must still teach themselves and their children to be able to bear the pain of a different kind of severing, the pain of separation. They must learn to depend on stranger sociality in their everyday lives, to look forward to the pleasures and pains of understanding *ngamaparrking*, and to reflect on their lives in terms of their own individual progress. This, too, takes discipline. It takes a person who can cut herself in a different way.

(parental actology), truth and lies)

- 11 This said, there have been a number of excellent studies of sexuality and transnationalism. See for instance, A. Wilson, *The Intimate Economies of Bangkok*; Manalansan, *Global Divas*; Rafael, *White Love*; Babb, "Out in Nicaragua"; Patton et al., *Queer Diasporas*; Quiroga, *Tropics of Desire*; and Boellstorff, *The Gay Archipelago*.
- 12 See Lewis, "W. E. B. Du Bois," especially 41-44 and 496-553, and Kaplan, "The Anarchy of Empire," especially 171-212.
- 13 Recent studies in diaspora have emphasized exactly the origin-less, or origin-obscuring, nature of diaspora. See, for instance, Axel, "The Diasporic Imaginary"; Roy, "Discovering India"; Edwards, *Morocco Bound*, especially 1-28; and Sharpe, "Is the United States Postcolonial?"
- 14 Social scientists are now examining the methodological implications of the shift from a comparative to a transnational focus. See, for instance, Seigel, "Beyond Compare."

1: Rotten Worlds

- 1 Michelmore, "Flesh-eating Bug."
- 2 McNeil, "Hundreds of U.S. Troops."
- 3 See, for instance, Jain, *Injury*.
- 4 Gosdsil, "Remedying Environmental Racism"; Westra, *Faces of Environmental Racism*; Park, "An Examination of International Environmental Racism."
- 5 Centers for Disease Control and Prevention, "Anthrax," http://www.cdc.gov/ncidod/dbmd/diseaseinfo/anthrax_g.htm.
- 6 See Pigg, "The Credible and the Credulous"; Cohen, *No Aging in India*; Farmer, *Pathologies of Power*; Kleinman et al., *Social Suffering*; and Rabinow, *Making PCR*.
- 7 For a seminal study of the impact of Western medical epistemologies on indigenous healing see Reid, *Body, Land and Spirit*.
- 8 See also Myers, *Pintupi Country, Pintupi Self*, and Austin-Broos, "Two Laws."

- 9 Watson, "Aboriginal Laws," see especially paragraphs 16 and 29-34.
- 10 A.P. Elkin may have been referring to Maliya when, in his field notes, he assigns "malir" to George Munggulu, whose patrilineal land was Banagiya. Maliya is located off the coast of Banagaiya, Circa 1937, Box 18, Elkin Fieldnotes, Sydney University.
- 11 Maggie Timber self-identified as a Marritjaben woman. She speaks here in Emiyenggal because she considers me an Emi speaker.
- 12 "Sorry business" is a common way of referring to various indigenous mortuary ceremonies.
- 13 Povinelli, *Labor's Lot*, especially chapter 3.
- 14 See, for instance, Fred Myers's classic study, "Burning the Truck."
- 15 Alwin Chong, executive officer, Aboriginal Health Research Ethics Committee of South Australia, http://www.flinders.edu.au/kokotinna/SECT02/ETH_PROC.HTM. See also Terri Janke, "Our Culture: Our Future: Report on Australian Indigenous Cultural and Intellectual Property Rights," issued by the Aboriginal and Torres Strait Islander Commission, http://www.terrijanke.com.au/fs_topics.htm.
- 16 National Health and Medical Research Council, *Values and Ethics*. This replaced *Guidelines on Ethical Matters in Aboriginal and Torres Strait Island Health Research, 1992*. Independent of these new guidelines, but within their general spirit, Melbourne University established a Chair of Indigenous Health in 2004 to which it appointed Ian Anderson, a Koori man and longtime health activist and researcher. For his and others' critical contribution to debates in indigenous health and ethics, see I. Anderson, "Ethical Issues"; Reid et al., *The Health of Aboriginal Australia*; and Kaplan-Myrth, "Hard Yakka."
- 17 National Health and Medical Research Council, *Values and Ethics*, 5.
- 18 Kowal and Paradies, "Ambivalent Helpers and Unhealthy Choices," 1347.
- 19 *Daly River Land Claim*, 79-80.
- 20 Povinelli, "Consuming Geist." See also Cattelino, "Casino Roots."
- 21 For discussions of recent legal innovations in sentencing and juridical process see Auty et al., "Koori Court Victoria."

- 22 Patton, *Globalizing AIDS*, 7.
- 23 Bond et al., *AIDS in Africa and the Caribbean*.
- 24 Associated Press, 15 October 1993. Available on AEGIS (AIDS Education Global Information System) Web site, <http://www.aegis.com/news/ads/1993/AD931874.html>.
- 25 See also, Willis et al., *HIV Futures II*; D. Altman, *Power and Community*; Dowsett, "Alliance Building."
- 26 Nicolle Casella, "Aborigines Leading in Risk of HIV," *Perth Sunday Times* 14 July 2002. Available at The Body Web site, http://www.thebody.com/cdc/news_updates_archive/july18_02/aborigines_hiv.html.
- 27 Pigg, "Globalizing the Facts of Life," 40.
- 28 For a discussion of the globalization of the hetero-homo binary, see Povinelli and Chauncey, "Thinking Sexuality Transnationally."
- 29 See, for instance, J. Anderson, "The Politics of Indigenous Knowledge," and Myers, *Painting Culture*, especially chapter 11.
- 30 Kenbi Transcripts, 5765.
- 31 Kenbi Transcripts, 5880.
- 32 See, for instance, Chapple et al., *Dangerous Liaisons*.
- 33 Butler, *Gender Trouble*.
- 34 Pearson, "Aboriginal Australia at a Crossroad." For quite different approaches to indigenous poverty, see Brock, *Outback Ghettos* and Morris, *Domesticating Resistance*.
- 35 For the economic and health implications of these new shared responsibility agreements, see Collard et al., "Mutual Obligation in Indigenous Health" and Calma, "Implementing New Arrangements."
- 36 See also the most recent Social Trends Report, published by the Australian Bureau of Statistics, on indigenous welfare in remote communities (available at <http://abs.gov.au>) and the Council of Australian Government's report on the social welfare of indigenous people nationwide (<http://www.coag.gov.au/meetings/030605>).
- 37 See J. Altman and Gray, "The Effects of the CDEP."
- 38 B. Hunter has noted, "Indigenous people are about two to three times

- more likely to be impoverished than the non-indigenous population, irrespective of the equivalence scale used." Hunter, "Three Nations, Not One," 6.
- 39 Fifteen percent of the ATSIC budget is discretionary spending, mainly distributed to cultural programs and cultural support. Eighty-five percent of the budget was devoted to non-discretionary spending, such as CDEP. See "The Lead-Up to ATSIC's Establishment" in A. Pratt, "Make or Break?"
- 40 See, for instance, Apter, *The Pan-African Nation*; Kirsch, "Lost Worlds"; and Sawyer, *Crude Chronicles*.
- 41 Sen, *Development as Freedom*. Speaking about the African diaspora, Michael Hanchard has discussed this uneven development as "racial time." Hanchard, "Afro-Modernity," especially 252-257.
- 42 Feldman, "Violence and Vision," 35.
- 43 Lea, *Between the Pen and the Paperwork*, 26.
- 44 Hayden, *When Nature Goes Public*.
- 45 Baldwin, *Notes of a Native Son*, 106.
- 46 See for instance, Peterson, "Demand-sharing"; Schwab, "The Calculus of Reciprocity"; Austin-Broos, "Places, Practices and Things." In a recent policy paper, Schwab has argued that understanding these forms of sharing would critically reshape the approach to poverty alleviation, housing pricing, employment, and welfare organization and distribution in indigenous communities. Schwab, "Principles and Implications."
- 47 Mbembe, "Life, Sovereignty, and Terror," especially 5-12.
- 48 Comaroff and Comaroff, "Occult Economies"; Cohen, "The Other Kidney." For general discussion, see Das and Kleinman, introduction to *Remaking a World*; Scheper-Hughes, "Parts Unknown."
- 49 Maharaj, "\$100,000 Compo."
- 50 Schmitt, *The Concept of the Political*, 48.
- 51 Jain, *Injury*, especially introduction.
- 52 Foucault, *Abnormal*, especially chapter 1.