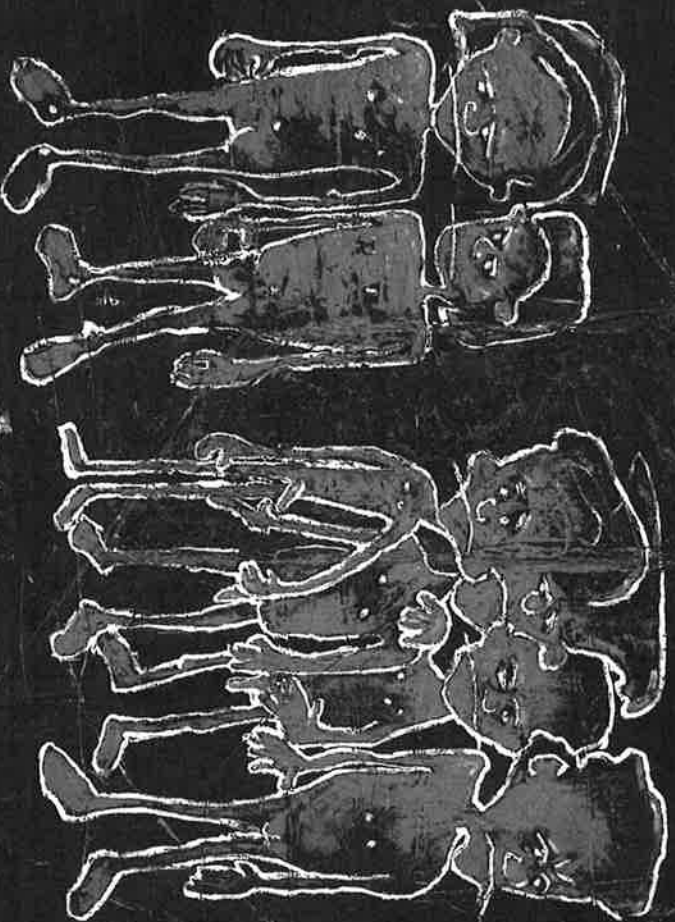


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THE
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ELIZABETH A. POVINELLI



TOWARD A THEORY OF INTIMACY, GENEALOGY, AND CARNALITY



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The Empire of Love

Toward a Theory of Intimacy, Genealogy, and Carnality

Elizabeth A. Povinelli

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For Stacey Marie D'Erasmio

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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.

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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-

tication 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

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

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.

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.

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.

Two

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 socioeconomic 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).”

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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.

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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 (*gamaparrking*, “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 fleshed 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.

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

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

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?

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

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 archaeological, 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

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*

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.

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

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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

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

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