Between the Pen and the Paperwork

A Native Ethnography of Learning to Govern Indigenous Health in the Northern Territory

T. S. Lea
PhD
2002
The University of Sydney

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*"Thesis' includes 'treatise', dissertation and other similar productions.
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T.S. Lea
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Abstract

Drawing on over four years of participant-observation of government bureaucrats in the health department of the Northern Territory of Australia, this thesis is primarily about the work and passions of bureau-professionals who dream of solutions to the problems of Aboriginal health, and secondarily about what it takes to be a bureaucrat, together with what it takes to become one.

It is organised in two main parts, covering firstly the institutional setting, and secondly the activities of bureau-professionals as they learn about and then attempt to execute their assigned tasks. The argument, in brief, is that while the issues surrounding poor Aboriginal health are undeniably real, how bureau-professionals formulate this as a dominant problematic is undeniably cultural. As part of my exploration of how health professionals enact the organisation and wider welfare logics in their disembodied encounters with Aboriginal people, I explore a number of specific issues: the physical or emotional discomforts, satisfactions or distastes associated with visiting communities or dealing with Aboriginal people; what counts as a good and bad reputation within the health organisation; the manifold ways in which institutional practices perforce re-elaborate themselves; and how the task of ordering the health behaviours desired of Aboriginal people in line with Euro-Australian specifications is reformulated as Aboriginal self-determination and community desire.

In all this, I am centrally concerned with exploring what makes bureaucratic formulations so compelling as systems of thought and action. Where the anthropology of organisations ordinarily looks to meta-social explanations to theorise the expansion of bureaucratic culture into everyday affairs, here I insist on looking inwards, at the practices of bureau-professionals themselves, to delve into the magical, fantastical dynamics of a series of institutional practices which are largely unacknowledged and untheorised by all but a handful of anthropologists.
Thesis submitted as a requirement in fulfillment of the degree of Doctor of Philosophy in the Department of Anthropology, the University of Sydney.
Big Space

He said you stand in your own shoes
I said I'd rather stand in someone else's
He said you look from your direction
I said I'd like to keep perspective.

Close to the middle of the network
It seems we're looking for a center
What if it turns out to be hollow?
We could be fixing what is broken.

Between the pen and the paperwork
There must be passion in the language
Between the muscle and the brain work
There must be feeling in the pipeline

Beyond the duty and the discipline
I'm sure there's anger in a cold place
All feelings fall into the big space
Swept up like garbage on the weekend

Between the pen and the paperwork
There must be passion in the language
Between the muscle and the brain work
There must be feeling in the pipeline

All feeling
Falls into the big space
All feeling
Swept into the
Avenues of angles

Between the pen and the paperwork
I know there's passion in the language
Between the muscle and the brain work
I know there's feeling in the pipeline

"Big Space"
from the album Days of Open Hand
Lyrics: Suzanne Vega;
Music: Suzanne Vega and Anton Sanko.
1990 A&M Records, Inc.
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Preface and Acknowledgements

This project began as an insider ethnography of the Northern Territory’s principal health organisation, Territory Health Services,¹ the key institution orchestrating government-funded health services to Aboriginal and other residents in the Northern Territory of Australia. It turned into a testimony on the constant slippage between story telling and fact creating, the inseparability of critical analysis from institutional reproduction, and the intensity of forms of bureaucratic nostalgia and desire. In the end, it is an exploration of what I call, for want of a better term, the magic of intervention, being the way in which bureau-professionals work to achieve the effect of a needy world that must improve but can not without their particular full-bodied and committed faith, logical formulations and involvement.

It is drawn from my work as policy adviser to two successive Chief Executive Officers of the health department over the 1995 - 1997 period; from 18 months full-time formal fieldwork with remote area staff (1998-1999 and again in 2000) when my identity as an anthropological researcher became more explicit; from my ongoing role as a consultant policy analyst for both the health and education agencies; and lately, in the end stages of writing up, from working directly for the newly appointed Health and Community Services Minister.

Adopting the more classic guise as disconnected researcher during my periods of formal fieldwork, I participated in the department’s newcomer induction program and shadowed those public health officers who commute in and out of Aboriginal communities as expert advisors from their home bases in the Northern Territory townships of Katherine, Darwin and Nhulunbuy. I tracked nutritionists and environmental health officers, inspected latrines, sat in on meetings, conducted interviews, attended seminars and workshops, gophered within small work groups, travel-talked in small aircraft and four-wheel drives, hooked into the corporate electronic mail network, lingered with people in their offices, workstations and tearooms, bunked in people’s houses, stayed on for drinks and assisted at such out-of-hours events as public hearings and community consultations.

¹ It should be noted that as of November 2001, Territory Health Services has been renamed as the Northern Territory Department of Health and Community Services (in fact, its previous name), reflecting the stamp of a new Labor Government. As the organisation was called Territory Health Services during my entire fieldwork period, this is the name I have elected to use in this thesis. A discussion of the representational footprint surrounding the original name change from Health and Community Services to Territory Health Services in the first place can be found in Chapter Three.
Throughout the process I also gathered a deluge of contingent material: endless in-house and external reports and summaries, memos and flyers, on-line newsletters and bulletins, discussion papers and funding submissions, journal articles and communiques, file notes and computer print outs. The density of forms was matched by an interactional abundance: in the place of central locations and clear observation platforms were infinite encounters taking place between people on a multi-layered and fragmentary yet ongoing basis. In the midst of these proliferating forms of information and encounter, all claims to complete knowledge—my own included—came to seem increasingly fraudulent (cf. Fortun 1999: 213). Techniques of community study were of no use here, for this ‘field’ had no neat landscape. And posing as an anthropologist when many people knew me as a fellow bureaucrat simply prompted ironic humour—which in the end, was a more successful means of helping busy professionals take me seriously as a genuine scholar than any carefully worded appeals to ethical research conduct.

Coming in not as an insider or outsider but from the outset as a hybrid, I gained access to the inner sanctums of policy because I had relevant experience; I gained access to the travel routes of remote area health workers by admitting my head office ignorance of their worlds; and, as I turned my hand to preparing overhead transparencies, I gained access to the multitudinous workshops and seminars omnipresent in every office environment within the Territory Health Services network by sympathising with facilitators as they agonised over the right ways of ‘taking the group through a process’.

But this teleological representation of initiation, access and eventual acceptance belies a more haphazard, still unresolved, process. For what drove me to anthropology was a puzzlement that has never really left. In encountering the work of health professionals at first hand, I was, and remain, repeatedly struck by the sophistication and substantiability of their practical theorising and the heartache of their reflexivity as they trawl for answers about their felt failure to confer good health upon Aboriginal people, still regarded as the most stricken of all ‘fourth world’ peoples. Professional strategies and bodies were constantly exhausted, yet always there would be a rallying, and the effort would continue on. Trying their best to do the best.

I wanted to understand what motivated people to work in fields which, internally, are as likely to be represented as dishearteningly futile and ultimately impossible as they will be considered surmountable with well-aimed intervention, grit and determination. And I wanted to explore what made it so easy to become utterly captivated by the complexity of the issues, so completely bewitched by the problematising and the enactments of doing.
I wanted to explore, in other words, why I fell so easily into the collective agonising and ever-present practitioner analysing, why I also endured the stress and lack of sleep, or pushed myself to the 'limits of wit and energy' (cf. Brenneis 1994: 30) to get a project funded, to see through a report or position paper, to write a good governmental speech, to travel the road making too-short visits to too many communities, knowing in my anthropological heart the profound regressiveness of zipping in and zapping out for a day of superficial consulting yet doing it anyway, compelled by an urgency that couldn’t be denied. Whose urgency was this? Why so irresistible, so resolute in the face of so much complexity and so many good and valid reasons for acting differently?

More than this, I wanted to understand how it was that representations of both Aboriginal people and the self could be so imbued with contradiction; simultaneously multi-layered and reductionist, full of detail about the infinite and intricate diversity of local practices, personalities, events, yet so readily codifiable into simplistic and universalising character traits: Aboriginal people/we are like this, they/we don’t like that, they/we used to be such and such. What kind of exchange was this, that could give rise to elaborate and sophisticated verbal exegesis, yet always the written products (program outlines, policies, historical precis, evaluations, funding proposals, project assessments, official correspondence of countless variety and theme) spawned simplicity, homogeneity, predictability? How to explain my own pleasure in being able to perform these twin modalities well, swapping from erudite deconstruction and critical analysis of surrounding practices in one moment to a more recognisably bureaucratic analytic (programmatic, formulaic) stance in the next? I wanted to use anthropology not as the superior register against which to highlight the inferior bureaucratic knowledge of the other, but as an approach which because of its ‘look, look again and consider yourself looking’ methodological impulses, seeing the self in the synoptic and making patterns out of particularity, would force against-the-grain insights.

Yet, in bringing these questions into view through fieldwork, I eventually came to realise that the notion of swapping between modalities introduced a false alternative: that rather than thoughtful musing and capacity to entertain particularity and complexity somehow being in contradiction to the categorising inherent within institutional documents and official talk, both were modes of and implied the other. That they are different forms of institutional practice is not in question. In fact, I found it almost impossible to sustain an active engagement in administrative meetings, debates, projects, and in that same moment maintain critical distance as this might be understood anthropologically. But, and this is
my point, simplification is not a moronic or robotic poor cousin of a smarter academic epistemology but is a parallel discursive activity, fed by the same ability to comprehend detail and render it according to the discursive demands of the interactional present. Turning it into ‘bite sized chunks,’ bureaucrats might say; or containing it into ethnographic case studies, anthropologists might also say (cf. Strathern 1991).

And therein lies the tension underlying this ethnography, confronted again and again to constitute its own theme. In the work that follows, I repeatedly encounter doublings or replications between forms of bureaucratic analysis and the concerns of academic theory. An argument running throughout this thesis is that sociological academic analyses share fundamental forms of moral reasoning with their bureaucratic counterparts. Despite or perhaps because of this shared epistemology, academic discourse often places itself on a higher plane, claiming an analytical and moral superiority with which to encompass and overwhelm bureaucratic expertise. And so, no matter how hard I tried, no matter what representational stunts I pulled, I could not evoke bureaucratic worlds in all their complexity, their rich excessive brew of selfishness and bad faith, self-consolation and complicity, earnestness and generosity, sincerity and compassion, nuanced and jock talk, passion and ennui, sympathy and insight, creativity and redundancy, without inviting a sardonic academic response. “How”, I was asked in astonishment, “can these people take themselves so seriously?” “They’re just trying to be anthropologists – bad ones!” dismissed another.

The ancient othering impulse embedded within anthropology, traced by so many, eradicated by so few, seemed to anticipate my every representational move. I wished I could just assert institutional actors are not dolts and leave it at that.

Initially, I reciprocated the admonishments, consoling myself that anthropologists are enchanted only by the disenfranchised, caught in a nostalgia for spaces and places where middle class professionals are not ensnared in bureaucratised worlds. Partly right, perhaps. But making the counterpoint a stamping foot insistence that ‘bureaucrats have culture too!’ forces my task into one of hectoring in order to rectify. And again, here is a move shared already, for health professionals are constantly trying to correct the misinterpretations of ‘their’ subjects as well: Aboriginal people do not get more funding than they deserve - in point of fact they are under-funded dollar-for-dollar per capita in primary health care; Aboriginal people are not all drunks - statistically, there are more total abstainers among Aboriginal than non-Aboriginal people; Aboriginal people are not all the same, every community is different...
Even struggling to get my evocations to force the 'right' interpretation from my straw model anthropological protestor was a powerful and impossible impulse, itself part of the world of conventions to be understood.

In the end, in the pages following, there is no synoptic vision, no insistent conclusion declaring this is how 'the system' really is, but more a set of vignettes and fragments, tracing knowledge practices and visceral experiences, snatches of analysis and accounts of learning. Instead I have attempted to create a sense of what it is like to operate in such a place, to be structured by these particular pulls on the imagination, to share these longings and agonies, these abstractions and these in-your-face experiences, without losing sight of the fact that all such modes of bureaucratic-being-in-the-world are transacted within definable frameworks of governance and normativity. As I build to a concept of the magic of intervention, I pay particular attention to how the art of bureaucratic imagining lies in the projection of institutionalised hopes and longings onto subject groups whilst disclaiming their institutional derivation.

But incomplete acts of description of the inhabited spaces 'between the pen and the paperwork'—between that is, the reproduction of bureaucratic logic by institutional actors and their serial encoding in institutional artefacts—fail to satisfy the bureaucratic hunger for prescription.

“What is the point of describing the modes of our doing without telling us how we can improve?” I was asked.

“I hope this thesis of yours is going to do more than point out the problems.”

It is a limp, unacceptably passive defence to argue in the face of bureaucratic intentionality—in the face of so much sickness and so many things to do be done—to argue this is a study of the will to prescribe, its modes of delivery, and how we learn to adopt and act out its forms. Equally, it seems an act of abhorrent complicity and bad faith to refuse the twin social scientific urge to correct and displace “the highly partial and interested interventions” of institutional players suspected of disguising their own investments in creating problems to remedy (Ferguson 1990: 280).

So what in the end do I say? The focus here is really on what bureaucrats have to say and do, how they get to say and do it and what is available for them to say and do. To put this in a more academic register, I look at what matters to THS bureaucrats and health professionals, by paying close attention to what they dedicated their energies to arguing, promoting, making or doing, and the ways in which these are internally described; that is, to the institutional aesthetic and
make-believes these practices reveal (cf. Riles 2000: 125-133). It is not designed to be read as a specific community study or as a statement about 'organisational culture.' Nor is it a study of the encounter between THS actors as dominators and Aboriginal people as dominated, so much as a study of the expert knowledge practices which would pre-frame black and white encounters with post-colonial inequality as the abject understanding of the power relations at hand. Equally, I do not take any one particular body of theory and religiously apply or debunk it, but have found myself mixing genres to give some sense of THS as a cultural system (one that in fact can go by the name 'the system'), to show its fixity and its disorderliness, its flux and its inertia, its local and its global, its magical workings and its political consequences (cf. Stewart 1996: 20).

I have drawn upon the literatures of the anthropology of home, organisational and institutional ethnography, development anthropology, medical anthropology, the anthropology of policy, of audit, of health and the bio-sciences, of post-coloniality and identity hybridity. I have enlisted sociolinguistics, performance theory, ethnomethodology, Foucauldian discourse analysis, phenomenology and more importantly, the ethnographic work of those who take the mixing of genres to new edges. I am particularly indebted to the work of Kathleen Stewart for her writerly attention to issues of ethnographic intensification and the importance of 'just talk', Michael Taussig for his powerful analyses of magic and mimesis in spaces where multinational capital and modern statecraft press into colonial relationships, Allen Feldman for his refusal to freeze violence into a pathology for which analysis becomes the prophylactic, Annelise Riles and Marilyn Strathern for their intense 'cubist' curiosity about bureaucratic aesthetics and anthropological practices, flattening out hidden planes to re-reveal them in fresh light; and to Joseph Dumit for his work on the dizzying uses of science across contested and newly organising fields.

My more practical debts in this pursuit are many. For encouraging me to think through these issues, for even giving me the space to do so, and for teaching me anything that I might know about bureaucracies, I have many people to thank and many debts to repay. It pains me that I cannot properly name the managers, the fieldworkers, trainers and policy staff who let me spend time with them as part of my fieldwork. Knowing that they were exposing themselves to something unusual, the gaze of an anthropologist, they tolerated my endless note-taking, and even fudged explanations for my presence if they suspected it might be unsettling for others. Their openness says something about their integrity as individuals genuinely wanting to do their work well and of their hopes that social scientists will help them adjust and improve their approaches. While I insistently denied any such
utilitarian purposes for my work, it was repeatedly put to me that all critique is useful, and further, that sometimes health people are too preoccupied with the bush fire crises to see wider patterns. So, they were generous with their time and thoughts.

In return, I undertook to respect their confidences. While Territory Health Services was the real name of a real organisation, all contributors have been renamed, or if not named, simply identified by their function, unless they are known public figures and appear in that capacity. To the un- or re-named regional officers who took the risk of letting me shadow them, I owe my deepest respect, admiration, and gratitude. I am especially grateful to the woman I call Marlena, for taking a risk on a person she didn’t know, on a project that sounded vague, and at a time when she was also in the thick of having to sort out her own new beginnings. Her willingness to experiment opened other doors by establishing a precedent others could refer to.

For the people I can acknowledge by proper name, I would like to thank Bob Collins and Ken Davies, and in the beginning, Trish Angus, David Ashbridge, Shirley Hendy, Rose Rhodes and Graham Symons for their initial encouragement, support and advice. Of all my bureaucratic mentors, I would like to especially single out Peter Plummer and Katherine Henderson who provided permission, infrastructure, critical input, support, clarifying questions and a taken for granted assumption that I would finish, a faith I could not bear to disappoint.

For their encouragement, interest in my topic and scholarly insights, I also thank Ghassan Hage, Andrew Lattas, Neil MacLean, Yadran Mimica, Barry Morris, Gary Robinson, and Yao Souchou. For mates-rates help with transcriptions, I also owe Prudy O’Loughlin. I benefited as well from the assistance and interest of scholars outside Australia. For a short-term but critical overseas lifeline as I researched and wrote from Darwin, in complete isolation from readily accessible academic support, I am especially beholden to Joseph Dumit—whose incredible generosity with insightful commentary on a total stranger’s early work made a deep impression, both intellectually and ethically. Likewise, for their encouragement during my briefest of encounters with them, I extend my thanks to Fred Myers and Donald Brenneis, who both impressed upon me the possibility of combining committed scholarship with approachability and decency, in writing as well as manner.

I pursued this entire study from Darwin, since, operating for the lion’s share as a single parent, I did not want to wrench my then very young children away from kith and kin for the indefensible sake of a thesis. Which made my brief and
all too infrequent sojourns to Sydney for intellectual and emotional stimulus all
the more vital. For hospitality, affection, bodily and conceptual sustenance I am
indebted to Franca Tamisari, Gillian Cowlishaw and Hal Wootten. Apart from great
practical help and hospitality, Hal always provided thoughtful perspective and a
much-needed sombre engagement to force some sharpening in my thinking, often
at critical (down) times in my own levels of enthusiasm or clarity. I owe Gillian my
deepest gratitude for first encouraging my initial interest in anthropology all those
years ago, for her sustained if gentle badgering which returned me to academia,
for her confidence building and ever pertinent feedback—and ironically, for her
deep and provocative suspicion of governmental values. My heartfelt admiration
also goes to Franca for spiralling my thoughts in always productive directions, for
exposing me to new ways of conceiving the relation between self and world, and
for her fundamentally compassionate approach to the task of scholarship. To both
my brilliant supervisors for showing me how intertwined thinking and caring really
are, my deepest thanks. They tolerated my practical circumstances and gave me
great freedom and essential scaffolding. I could not ask for more.

This work was fundamentally sustained by the love and concern of my family: to
Bobbie Lea, Gregory Moo and my generous, creative, wise and loving children,
Daniel and Elise, I thank with all my heart.

Finally, a note on the various methods and transcription devices at use in this thesis.
As a means of approaching the vast topic of how public health professionals enact
both the organisation and wider welfare logics in their embodied encounters with
Aboriginal people, I set out to join work teams in regional offices and travel with
them as they moved in and out of communities. As far as possible, I tried to become
a worker in these teams, not by feigning specialist health qualifications, but by
being adept in mundane office routines. I interspersed this work in the regions
with fieldwork in central office policy settings and by providing secretariat support
for a senior steering committee looking at environmental health and remote area
infrastructure issues, a committee which met every three to four months.

Given that the senior managers on the committee hailed from all parts of the
THS office network (that is, Darwin, Alice Springs, Katherine and Nhulunbuy), our
meetings were usually held by teleconference and at the Department's request,
were officially taped by Telstra.²

² At the time of my fieldwork, Telstra was the dominant telecommunications carrier within the Northern Territory.
This meant that in addition to having the highly consequential responsibility of translating committee talk into written records (Brenneis 1999: 140), I also had the opportunity to transcribe over two years of verbatim committee deliberations (in and out of session) on the problems of tending to community overcrowding, poor hygiene and the need to create good housekeepers out of Aboriginal people through better education and infrastructure supply. The news I brought back from these meetings also provided valuable exchange material in the information hungry regional offices, which meant people initiated contact with me as much as I with them, and more importantly, that I held a good vantage point when the corporate planning activities of the department led senior managers to consider privatising the management of all the public hospitals in the Northern Territory. It was through being thus placed that I was asked to draft a key note address on the privatisation proposal for the then Minister for Health, which in turn became a case study in how bureaucrats usher new policies into being (Chapter Two).

Within all these encounters, I used a mix of interview, conversation, participation, observation, note-taking (during and following public and private encounters), archival and document research together with artefact analysis to gain a rich sense of THS practices. Where the empirical material comes from mechanically taped conversations, I note this by calling attention to it as a transcript, while events under the heading ‘fieldnotes’ refer to manually documented material. While I originally adopted a modified Jeffersonian method to actually transcribe recorded information (Jefferson 1978, 1990), in the end I found the hieroglyphic transcription devices, even when simplified, ultimately too distracting upon later reading to give the sensual feel of speech, which rather ironically is their notational function. In the main I have omitted such notations, except where they unobtrusively lend sense to the placement of emphases as these were originally made.

My field research was funded by a grant from the Carlyle Greenwell Bequest and my doctoral candidature through an Australian Research Council postgraduate research scholarship, both auspiced through the University of Sydney. The fieldwork was conducted under a specific research agreement with Territory Health Services (see Appendix One), and received ethical clearance from the Joint Institutional Ethics Committee of the Royal Darwin and the Menzies School of Health Research, Northern Territory Hospital (Appendix Two). A less developed version of Chapter Five appeared as “A Benign Arithmetic: Taking Up Facts About Indigenous Health” in The UTS Review: Cultural Studies and New Writing 7 (1), May 2001: 59-73.
Part One
The Setting

Between the Pen
and the Paperwork
Chapter One

Introduction

Between the Pen and the Paperwork
Chapter One

Introduction

Soft, sulphurous mud creeps up our bare legs to the mid-point of greatest width before the calf muscles taper into the knee, creating itchy grey socks where minutes before exposed white skin had been. Only one of our party of neophyte government health employees is able to retrieve the camouflaged mud crabs from the soft, dark silt in this dense tangle of mangrove roots and stalagmite suckers, and even then only after the tell-tale signs are pointed out by Pat Gamanangga, our Aboriginal teacher-guide. She points again: ‘This one now—you see im?’ and we truly want to see the distinction of this particular hole out of what appears to us as serial pockmarks cratering our dappled tidal jungle. We are anxious, keen to know how to see, a piece of cross-cultural canniness promised in our listed aims and objectives for this special out-of-office component of a two-week long public health orientation program (see Figure 1).

Figure 2: ‘Bush Trip: Cultural Orientation’ (Territory Health Services 1998b)

‘M-mm-mm’ murmurs Katrina, a medical practitioner released from her day job as resident clinic doctor on Bathurst Island, 90 kilometres north of us here where we are, Shoal Bay, an hour’s drive out of Darwin, itself the smallest capital city in Australia. ‘We got big mob now. I can see ’em roasting on the coals already, ey?’

Through her simulated bush talk, Katrina has already established herself as a connoisseur of bush tucker and thusly, by semantic entailment, as someone at ease and familiar with Aboriginal people. On the bus ride out to this crab-camp we had collected unripe cheeky plums from old trees standing by a petrol station on the highway; astringent face-puckering fruits the size of olives and the shape of nashi pears most of us spat out immediately, repelled by their immature bitterness. Katrina was the exception. ‘Delicious!’ she had declared conclusively, going on to collect more handfuls, accepting the eager donations of others.

Primary Aim of Activity

To introduce participants to Aboriginal cultural activities such as: hunting and gathering, the preparation of various mangrove foods, basket weaving and cross cultural communication.

Key Objectives

To achieve this aim the following objectives form the basis of the session:-

1. provide an awareness of the different varieties of mangrove foods and their preparation;
2. introduce participants to the collection (hunting and gathering) of natural foods in the Top End coastal regions;
3. teach participants the processes of collecting raw materials (plants) which are used to produce certain bush crafts;
4. to share with participants the role of Aboriginal men and women in hunting and gathering exercises;
5. to encourage participants to learn from one another and getting to know and understand each other in a relaxed and informal manner;
6. promote and assist participants in ways of survival.

Figure 1
Back at the mud flat, Katrina's enthusiasm for the task of foraging is taken up by others ('it's great, isn't it!'), each participant echoing in turns their appreciation of this unique opportunity to learn about and gather authentic Aboriginal tucker. Our hessian dilly bags weighed down with water bottles, sunscreen ointment, the crabs and long bums³ Pat has secured for us, we set out along the hot sand in return journey to the camp area, some 40 minutes away in the glaring midday sun. The March humidity is oppressive: the monsoonal rains have departed for another year but the south-easterlies are not yet bringing any cooler, dryer air from down south. The air is sticky, still, heavy. The outward tide has left behind a mile-long rippled mudflat. We trudge upon the inch-wide ripples, heat pressing down our tongues until to talk takes too much energy and we march in silence, monitored by the rhythmic slap, slap of shoes agitating out of the hard suction of wet sand. At one stage Kathy, a nurse sojourning in Darwin during a working tour of Australia, stops us and points seaward where, past the harsh silver light glinting off the baking sand ridges, curiously close to the shore in shallow, tepid brine, milky from suspended sediment, a fin appears and disappears, reappears and disappears, over and over again. A dolphin maybe, or perhaps a shark.

The glare and heat quickly evaporates idle speculation and our trudging resumes, small mystery unresolved. Carrying a large water container I am conscious only of its weight, shifting it from my left to right, now up to my shoulder, to my head, back down to my hands again where the wire handle imprints a reddish-pink rivet in the same space in my palm, no matter how I try to hold it. No position remains comfortable for long. We hear distant shouts from the second group straggling in our wake. We turn and squint back at the small figures so far away. They are waving, shouting and pointing, we think perhaps at the mesmerizing fin.

'Yeah, yeah—we've seen it!' we shout back, and, resentful at being forced to pause yet again in the glaring squinting heat, we turn our backs and sand crunch on.

Finally the campsite is discernable amongst the spiky Casuarina trees lining a small saltwater creek; still a long way off but close enough to quicken our desultory pace. Back in the shade at last, over-eager bonhomie soon returns in a loudly appreciative gush of eating hot crabs rolled out of coals as soon as the inner juices splutter out of calcified eye sockets, the indication of cooked readiness. Between gritty mouthfuls of crab and crumbling damper bound by a sand-encrusted, thickly charcoaled rind, Ross, a research doctor in charge of public health programs at the local medical research institute, proclaims 'We should be oriented like this every few months—for stress release!' We laugh agreeably, our mutual assent conscripted by the respectful necessity of

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³ A crustacean (Telescopium telescopium) native to the mudflats of the Indo-Pacific region. Approximately 7 cm in length, 'long bums' have a thick, heavy shell and, unlike the sea-snails they are, feed on organic detritus and surface algae found on exposed tidal mudflats. They are quickly boiled and prodded out for eating. For more information of Pat's role as an Aboriginal Nutritional Teacher, see the Royal Darwin Hospital Patient Information Guide, at www.nt.gov.au/rth/hospital_scy/iso/royaldarwinhospital/ This explains that in the cooler months of the year, Aboriginal and Torres Straight Islander patients are served 'Bush Tucker' most Fridays by Pat, who travels to Shoal Bay every Thursday to gather yams, bush berries, mangrove worms, mussels, mud crabs, clams, periwinkles and long bums. Pat then prepares the food each Friday in the hospital's kitchen and serves it to our Aboriginal patients. Those with difficulty in swallowing don't miss out on bush Tucker either because Pat vitamises it for them. Pat helps patients understand the treatment they are undergoing in the hospital environment and also encourages them to eat properly so that they can then stay strong. She is fluent in eight Aboriginal languages.'
enjoying our time in the scrub learning about Aboriginal bush tucker and the relief of being at the tail end of a mildly arduous event.

‘Wish you’d dropped that bloody water bottle. We were yelling and yelling at you to ‘DROP HIIIIIIIIIIIIII!!!’ the stragglers pant to me as they join us under the trees, collapsing wearily onto the thorny sand.

Entanglements

What surprises many fieldworkers in Australia, including me, is not simply that culture and economy meet, but that they meet in ways that disturb our sense of the boundedness of cultures and of the compatibility of different kinds of cultures.... On fishing trips Dreamings surge from beneath motor-powered dinghies; over a campfire meal heavy-metal music roars. On the dirt tracks that lead to isolated outstations, the Northern Territory government stretches car-count meters to monitor ‘public access’ on and around Aboriginal lands. The meaning of an event that occurs when Belyuen women and men are hunting, fishing and collecting, though interpreted locally, seems at times to be incompatible with Aboriginal economic forms and to be drawn from a bricolage of regional and national political-economic and symbolic systems.

(Pavinelli 1993a: 169).

In Labors Lost: the power, history and culture of Aboriginal action, anthropologist Elizabeth Pavinelli describes her work amongst the people of Belyuen; hunter-gatherers who, as the crow flies, live across the harbour from Darwin, leading the culturally-distinct sorts of lives our mud-trek is designed to clarify.

To give expression to how contemporary Aboriginal life worlds are constructed, betwixt and between the multiple discursive and material constraints of the dominating Australian settler...
population, Povinelli was forced to reject the old binaries of traditionality versus change, culture versus colonialism, subsistence enclave versus penetrated capitalist periphery. To Povinelli, the way Aboriginal women talk, walk, collect food, conduct ceremony, care for land and perform their Aboriginality for western voyeurs captures an entire and mobile order of experience, meaning and power. Her analysis turns on a notion of Aboriginal people as contemporary gatherer-hunters who simultaneously live in a living country and under a Western gaze, both of which they in turn help constitute (see also Povinelli 1995, Tamisari 1998). Working the country, being on it, in it, from it, of it, sweating and noticing, is to make the land productive, to hear and give its stories, and to produce expertise in an ongoing contest for authority in self-other relations.

Povinelli makes a point of critical importance to my ethnography: the dialogical engagement between Aboriginal people and the market state also operates in reverse. Settler Australian understandings of self, knowledge, property and nation have been and continue to be impacted upon and shaped by Aboriginality (see also Merlan 1998). The state, she argues,

is neither in the center nor at the periphery of Aboriginal action and meaning. Rather, as Aboriginal and non-Aboriginal actors and their respective discursive uses of each other move from site to site (courts, groceries, beach side, settlement, classrooms), different articulations of Aboriginal action and meaning arise, as do different understandings each group has of itself and the other (1993a: 242-3).

This two-way interdependency of Aboriginal and non-Aboriginal knowledge and identity is a critical insight, often elided in analyses of Aboriginal cultural formations and altogether forsaken in studies of such non-Aboriginal others as government officials. If these last feature at all in post-colonial analyses, they will likely be represented as subjectivity-less agents of the state, responsible for damaging, thwarting and otherwise interfering in the compulsorily exposed lives of Aboriginal people, but not of forming themselves through their embattled relationships with those they want to help. In Povinelli’s ethnography too, the foregrounding of the situated practices of Belyuen women and men blurs from focus the detail of how state players craft their own positions and understandings in the racially bifurcated administrations of northern Australia. While Povinelli stresses the point of mutual structuring, government agents tend to be silhouetted in the background as undesirable visitations on the community or as abstracted architects of impacting policy and legislative changes.

The faceless authority that is true of state agents in general is truer still of the range of players operating as what we might call, following Mintzberg, “bureau-professionals” operating in the institutional borderlands of Aboriginal health in deliberate, conscientious efforts to breach the black-white divides of Northern Territory life. Subjects like those in this ethnography, the public

5 The term 'bureau-professionals' was introduced by Mintzberg (1993) to capture the simultaneity of professionals trained in personal social services with their location in contemporary welfare programs and government-funded bureaucratic structures. Welfare professionals, as Sue Llewellyn points out, are also 'bureau-professionals' in the second sense that they combine notions of professionalism with bureaucratised ideals of fair administration as the most transparent and fair means of achieving social welfare (Llewellyn 1998: 26). In this ethnography, I build up to using the term to also identify academic anthropologists, but more on that shortly.
health professionals operating within the Territory Government's principal health organisation, Territory Health Services (THS), rarely feature in their own right as full-bodied subjects. While in recent times, Foucauldian critiques have emerged of the public health approach which draw attention to its social engineering aspects (Bunton 1992, 1995, Lupton and Peterson 1996, Peterson 1994, Rosenau 1994, Turner 1996), the subjectivities of the officials involved are not the central focus of the work. Then again, in the expectant turn to anthropological work for complicating analyses on what bureaucracies are, and who are the actors, one finds in the main a sadly undertheorised body of work known as organisational ethnography, or in ethnographies of contemporary Aboriginal cultural formations, a disappointing reproduction of unitary categories of 'the state' or 'government', in which the agency of the participants involved is determined out of the picture. In more recent times, a small but growing number of Australian anthropologists have also involved themselves in the analysis of government policy and its (frequently damaging) effects on Aboriginal people, but even amongst these efforts, few have turned their attention to areas of government which are ostensibly supportive and favouring.

If analysed at all, the good intents and beneficent polemics of welfare-oriented bureau-professionals are seen as just so much deceptive gloss. By Foucauldian definition, such workers are structurally enabled through law, authority and regulation to exert forms of public control in the name of community health and well being. They are vested with the power of managing and codifying post-colonial encounters with a subject population on behalf of the elected government of the Northern Territory, itself infamous in Australia for its iconographically racist politics, reviled by liberal southerners as the antithesis of cosmopolitan grace and multicultural pluralism. Being the penpushers of the north, bureau-professionals represent the 'hostile government' (ibid: 1) who in Povinelli's work constitute the formative sparring partners in Aboriginal efforts to produce themselves and their identities in the small coastal community of Belyuen, so close to the mangroves traversed by public health newcomers in annual rounds of orientational mud crabbing.

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6 Critical readings of specifically Aboriginal health policies and approaches further include: Anderson (1994, 1997); Gray (1990); Kunitz (1994); Peterson (1994); Pholeros et al (1993); Reid (1991); Rowse (1996); Siggers (1991); and Tsey (1997).

7 There is also a large body of work exploring aspects of institutional thinking, including Weber's analysis of the values which imbue the rise of capitalism (Weber 1930) and Foucault's tracking of the ways in which 'the administration of bodies and the calculated management of life' (1984: 140) has come into being. For work which explores policy and governance in general from a Foucauldian perspective, works which anthropologists have frequently drawn upon when analysing such things as 'policy discourse,' see Burchell (Burchell 1991, 1991); Dean (1994); Ewald (1991); Gordon (1991); and Hacking (1991, 1996).

8 A significant exception is the work of Jeff Collmann (1979, 1988), whose ethnographic work on the relationship between bureaucrats and Central Australian Aborigines remains important to anthropological understandings of institutional processes, as he probed the issue of Aboriginal agency within state-mediated interactions. In addition, the more recently available race relations literature in Australia is increasingly concerned to highlight the centrality of the state in all areas of settler and Aboriginal life and there are a growing number of works which focus on the direct interactions between Aboriginal clients and (usually) non-Aboriginal bureaucrats. This work has been vital in highlighting the myriad ways in which Aboriginal people have sustained integrity in fields marked by the hegemonic dominance of colonising others. For wider and varying discussions of the role of the state in contemporary Australian race-relations which emphasises Aboriginal viewpoints see, for example: Cowlishaw (1987b, 1988); Morris (1985, 1988a, 1987); Povinelli (1993a); and Latta (1990, 1997). However, we still know little about the subjecthood of the officials involved, a situation not remedied by pointing to the plethora of texts written by, or about organisational bodies using forms of system analysis, with their over-emphasis on managerial structures and goal attainment, a point to which I shall later return. I should also here note the work of Tim Rowse (1996, 1997) as a possible exception, although again, see later discussion. Tony Bauman's preliminary work on her life as a helper marks a radical departure and showcases the kinds of works that are required to fully interrogate the full-bodied messiness and ambiguity of bureaucratisation of life in post-colonial contexts (Bauman 2001).
Anthropologists Rhys Jones and Betty Meehan typify this tradition of reporting on the northern racist character by disposing of the formerly reigning Country Liberal Party's political philosophy as 'heavily influenced by pastoralist and mining interests and its political track record so far has been hostile to traditional Aboriginal rights' (Jones and Meehan 1991: 100)—a verdict which axiomatically assumes pastoral and mining relations with Aboriginal people were and remain unwaveringly negative and that any questioning of land rights is a denotative signifier of racism (cf. Cowlshaw 1999, 2000). Journalists also trade on the imagery of Australia's Final Frontier, relying on the indictment almost as a prosthetic device in the easy identifying of clear enemies to liberal rationality (see, for instance, Alcorn 1995). As I write, the Northern Territory Parliament has just transformed, with Labor holding majority Government for the first and only time in twenty-six years of self-government. It remains to be seen whether this fundamentally transforms popular depictions of the Northern Territory as the geographic emblem of unreconstructed frontier racism.
Resisting futility

The night time lights emitting electrons from the spread of government buildings and hotels squatting along the skinny peninsula that in turn juts into the drowned river valley system known as Darwin Harbour, twinkle across the dark span of water in full view of the Belyuen lands. It is a closeness which makes the people of Belyuen extra vulnerable to government activity—for the piloting of new programs, say, or convenient consultations with representatives of an authentic Aboriginal viewpoint, when the assumed coarsened knowledge of the growing number of Aboriginal employees working within government agencies won’t suffice. At the same time, the Belyuen mob must actively resist classifications of their Aboriginality which would delegitimise it precisely because of their very accessibility and exposure (see Collmann 1979, 1988; Kapferer 1995).

In seeking to draw out the anthropological issues presented by ethnographic work amongst the helping professionals who operate in such a complex domain, (amongst, that is, those who would initiate such convenient bouts of consulting), it is tempting to tease out the contrasts between the gatherer-hunters of Belyuen and the public servant interlopers at Shoal Bay, one to the west, the other to the east of Darwin. Just as Dreamings surge from underneath aluminium motor-powered dinghies, or Japanese Toyotas transport hunter-gatherers so that they can rub sweat into country, so dot-pointed expectations of cross-cultural pedagogy and new management concepts of respect and teamwork undergird our trek through sand and silt in search of mudcrabs. Both excursions into the technological domain of the other—Aborigines’ use of motorised vehicles, bureaucrats’ use of dilly bags—are entanglements social scientists feel compelled to explain, in the former case in the spirit of defence, in the latter by way of sardonic commentary on the spectacle of pink and reddening bureaucrats knee deep in mud and cultural complexity. Our ineptitude and lack of grace in a clearly foreign environment, our determination to enjoy the procedure and be educated by it, our inability to see the forms out at sea as potent signs of a sentient environment, our polite refusal to admit to our sweaty discomfort or yield to our suppressed desire to quickly return to air-conditioning, could all be used to illustrate contrasting forms of embodied cultural knowledge and etiquette.

Yet I see my task as at once more harsh and more humbly empathetic. In what might be called an ethnography of resisted futility, the major tasks I have set myself are, first, to take health professionals and bureaucrats seriously at their own word as they grapple with their deeply felt senses of urgency and failure, and second, to honour the creativity of their practices, as they imagine how to order the lives of others whilst magically obscuring their own dependencies in the processes involved.

This last point goes to the heart of my research findings. I have come to see the constant imputing of needs and desires onto the people seen as needing ‘our’ help, and the conscious and unconscious acts of judgement and self-disappearance involved, as collectively, the magic of intervention (see also discussion below). By ‘magic of intervention,’ I mean to refer to the faith,
and all that sustains it, in the power of institutionally-produced logic to fix pre-defined problems of the other through further acts of institutional expansion, in the moment of denying the existence of any such expansive desire. Now, immediately upon defining interventionary magic in such heavily structural terms, a form of perceptual magic is in fact being effected. As I will show, interventionary logic depends precisely on its ability to displace the mythology and symbolism, the human energy and modes of feeling, that are necessarily involved in its perpetuation. To say, for example, that institutional actors start from the taken for granted premise that Aborigines need improving, and from that premise build an imputed need for ‘our’ kind of expert help, whilst true enough, also implies a cause-effect explanation which interventionary logic thrives upon and through which its fabulations are able to slide. All too often standardised analyses of governmental effects transfix on the heady moral conundrums at play: in trying to fix others, are contemporary welfare agencies doing more harm than good? Whose interests are truly being served? Yet, ironically, this kind of formulation beats at the heart of the magic of intervention and is how the magic inherent in state rationality is obscured from itself. In other words, interventionary logic relies on the discourse of rationalism and means-ends calculations to deflect attention away from the intricate cultural efforts involved in transforming the chaotic flux of life itself, into a problematic world that can be corrected with enlightened analysis and action.

But before moving to explore all this in more detail, it would help at this point to give a better sense of the institutional actors involved and the issues they grapple with, together with some preliminary examples of the magic of intervention as I see it operating in THS.

The subjects

The health professionals I have spent time amongst within Territory Health Services, whilst difficult to easily characterise, are bound by a fervent sense of wanting to make a difference in a domain marked by repeat failures to reach assigned objectives. For the people whose task it is to focus on Aboriginal health, either as policy officers, cross-cultural trainers or field workers, Aboriginal people are sick, and getting sicker, despite committed professional effort and the investment of vast sums of time and money. Nationally, Aborigines have the lowest life expectancy of any defined group in Australia (56.7 years for males and 61.1 for females), dying twenty years earlier than their non-Aboriginal counterparts. They are burdened by long term chronic diseases, and in all age groups, suffer from most diseases at a greater rate and with more complications than anyone else. Even worse, the health profile of Aborigines in the Territory has deteriorated, rather than improved, over the last two decades.10

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10 Many studies exist which outline the dimensions of Aboriginal morbidity and mortality patterns. A key Territory Health Services’ reference is Northern Territory Health Outcomes, Morbidity and Mortality 1979–1991 (Plant, Condon, and Dueling 1995), which presents an epidemiological analysis of Aboriginal and non-Aboriginal illness and death ratios categorised in terms of leading causes (see also Bhatia and Anderson 1995, and Cunningham and Condon 1996). Collections which emphasise the socio-political aetiology of Aboriginal ill-health include Gray’s A Matter of Life and Death: Contemporary Aboriginal Mortality (1990); Sagers and Gray’s Aboriginal Health And Society: The Traditional And Contemporary Aboriginal Struggle For Better Health (1991); and field and Tromp’s The Health of Aboriginal Australia (1991). The National Aboriginal Health Strategy Working Party report, A National Aboriginal Health Strategy (1989), remains a key articulation of the rationale for the emphasis on public health intersectoral effort and community control that have become orthodoxies within Territory Health Services. The creation and deployment of these forms of knowledge by health professionals and policy officers is explored in greater detail in subsequent chapters.
Admittedly, Territory Health Services, the Northern Territory Government’s principal health agency, is but one of a panoply of organisations and individuals concerned with shaping Aboriginal lives for ‘the better’. As might be imagined, there are many, many organisations and authorities involved in the governance of the health and welfare of Aboriginal people, at every conceivable concentric sphere: local, regional, national and international (cf. Friedman 1998). These not only include government bodies but a wide range of non-profit community and social services, some Aboriginal-controlled, which are often funded by the government to ‘independently’ deliver governmental objectives—an issue I discuss briefly in the following chapter.

But Territory Health Services’ represents an organisational space where the topic of Aboriginal health is given a particular urgency, keenly felt by those involved, with Aboriginal ill-health being constructed by many differently positioned protagonists as a political and moral scandal that governments can ill afford to ignore. This is in fact unique amongst Australian state government health agencies in having Aboriginal health at the forefront of its core activities. Where, in other jurisdictions, Indigenous issues are peripheral to the central concerns of the generic public sector agencies (appearing as part of the litany of add-ons which merit special if only occasional consideration, such as people-from-non-English-speaking-backgrounds, the homeless, or people with disabilities), in the Territory, Aboriginal affairs are a major administrative focus even within bureaucracies that are concerned with general population issues. If for no other reason, the fiscal impact alone makes Aboriginal pathology the subject of intense government concern. Health professionals will tell you that while Indigenous people form approximately 30% of the population, expenditure on Aboriginal morbidity and mortality accounts for 70% of the health care budget, with most of that going to acute care (coping with the already afflicted) rather than into health promotion and illness prevention, where it is felt there is more chance that calamity might be nipped in the bud or avoided completely.

Now, the way in which Aboriginal ill-health forms a powerful and contradictory metaphorical complex is explored at greater length throughout this ethnography. But let me take this opportunity to highlight an instance lurking here and now of how narratives of woe obscure other presences and absences, of how administrators move themselves and their own dependencies into the shadows (where anthropology is content to keep them), as we all pour our attention into the problems faced by Aboriginal people. It goes something like this. At the same time that the burden of Aboriginal health care and the immense resources thus consumed are lamented, the Northern Territory Government receives a disproportionate share of national revenue in order to maintain most of its services, predominately 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, forms a key part of arguments for extra funding beyond what would ordinarily be distributed under strict per capita allocations.

11 30% and 70%, whilst roughly correct, are clearly anecdotal weightings. Having said that, it is also the case that health expenditure data are in a constant state of revision and speculative interpretation. The Australian Institute of Health and Welfare’s journal publication, Health Expenditure Bulletin, is the source most frequently used by governments for reliable cross-jurisdictional comparisons and is recommended for those interested in tracking financial attributions.
Despite constituting only 1% of the total Australian population, the Northern Territory receives nearly 5% of the total sum of federal revenue, with the level of economically defined ‘disability’ carried by the population as a whole figuring largely in the estimations of extra subsidisation required by the Northern Territory Government so that it can theoretically provide ‘average’ levels of service (CGC 2001). We are not talking exclusively about supplementary funding here either—a massive 80% of total NT Government revenue comes by way of federal injection, and while this support includes provision of services to the non-Aboriginal population, it does indicate the high level of dependency the Northern Territory has on federal revenue, and, in a round-about way, on the continuing service dependency of Aboriginal people.

I will argue this sort of instance of an unsaid dependency on those we would prefer to call dependent is not a deliberate conspiracy but part of the magic of intervention. This magic depends in turn for its effects on intricate and repeated enactments of hand-wringing concern where the anxieties of bureaucrats form the unnoticed background to a foregrounded Aboriginal burden. Indeed, far from wanting health problems to continue for the sake of additional funding, the progressives of THS instead dream of improved outcomes and genuinely desire urgent change within the lives and conduct of Aboriginal people, for they are unacceptably sick. They are, in the words of one remote area doctor, ‘dying like flies,’¹² and in desperate need of remedy, funding and assistance. Contemporary health professionals are also concerned to act in ways which are sensitive to and respectful of cultural alterity. As worried as they may be, they do not want to impose their will on an already subject population. They see Aboriginal subjecthood and the scarring of colonial history as key determinants of present day illness and social disintegration, and attempt valiantly to confer the means of empowerment and cultural reclamation seen as necessary pre-requisites for health and well-being, carefully attempting not to further bludgeon Aboriginal preferences in the process (see also Chapter Three).

Encountered here are health professionals who have set themselves a thorny dilemma indeed. Their formulations are multiple and finely laced, as later chapters will testify. But in essence, and summarising greatly, health professionals ask: can the good health that arises out of the historical symbiosis of capitalism, colonialism and neo-liberal democracy in the modern era be generalised across colonised spaces without imposing its own structuring (Indigenous-culture-destroying) social and historical inheritance? Can professionals act but not interfere, help but not direct, improve but not alter? As anthropologist Tim Rowse puts it, ‘a crucial question in welfare colonial theory and practice [is]: how can the state deliver human services which are congruent with, rather than destructive of, the most valued features of Aboriginal social organisation?’ (Rowse, 1996: xv).

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¹² His full lament goes like this: ‘Let me tell you a story. The Governor General was up here just a while ago to highlight the problems in Aboriginal health and he graciously went around to meet the people in the field while he was out in Arnhem Land. And he met this person, a PhD linguist, who told him he was studying the health of Aboriginal languages. I could tell the Governor General was stunned. I mean, the people are dying like flies all around, and this guy is studying the health of languages?!’ (fieldnotes, July 1997).
The problems bureau-professionals confront are considerable. Aboriginal people are seen to endure unacceptable conditions of hunger, malnutrition, illiteracy, preventable disease, violence (self-inflicted and homicidal), suicide, sexual assault, substance abuse, overcrowding, unemployment and incarceration. Transforming these conditions includes creating income-generating opportunities that meet the local needs of the people, eradicating welfare dependency and associated poverty cycles, building people's capacities to realise their own self-determination in all areas, developing better amenities in all remote communities, applying best practice health management and treatment regimens and increasing Indigenous literacy levels, especially amongst women, so that, amongst other things, families will increase their use of preventative techniques for better health.¹³

The evaluative question of whether or not health professionals can achieve what they are setting out to do is not specifically pursued in this study. Rather, it is the agonising that formulates this problematic that is of key interest to me, assuming centre stage in nearly every chapter. This is not because I view participant proclamations as unmediated insights into a priori realities, but rather, because I believe it is through the highly specific and situated articulations of bureaucratic actors that the complex apparatus of governance is both organised and its multi-layered and complex effects made apparent (Boden 1994, Brenneis 1994, Czarniawska 1997). Thus, while this thesis may be broadly registered as an ethnography of a government health organisation, it is not about the organisation as an abstraction of systems theory, or as a policy and program body responsible for health actions to be assessed in terms of their efficacy (see below). Rather, it is concerned with the people inside the organisation, and their varied perceptions about what they should and must, can and can't do as they deal with others in the institutionally-constrained circumstances in which they find themselves—and which they help (re)constitute.

A dual and related interest is how do people learn what they need to know in order to undertake their activities. That is, how does one learn the language and forms, the content and conduct, of (progressive) health governance, and how is mastery of the forms manifested? This states things rather more blandly than I intend, given that a third major concern of this ethnography is to understand what motivates, what compels people to do what they do. By this I do not mean to account for the biographical journeys which led individuals to THS. Rather, fieldwork for me brought into view a collective and intensely occupied anxiety which seems to beset health endeavours, no matter what the specific program area. Practitioners periodically feel that what they are doing is ultimately futile, going nowhere, the same as what's been attempted before. They often lapse into a despair that there is no defensible grounds for further intrusion in Aboriginal lives and that anyway, community disarray is too complex and deeply embedded to overturn without an impossible-to-realise return to pre-colonial freedom. Reflecting on their practices through theories of post-coloniality and (echoing anthropologists) a melancholic sense of the utter interpenetration of western culture within Aboriginal lifeworlds, health professionals periodically leave themselves few spaces from which to drum the utopianism essential to their task.

¹³ This last finding draws from a body of theory that is very influential in shaping public health practitioners' consciousness of different national epidemiological histories in relation to health improvements. Known as the 'health transition literature', the belief that maternal literacy is the key indicator of population health (Caldwell et al. 1996; compare Ewald and Boughton 2002, and Johansson 1991).
And yet, with closer investigation, I came to see these same arguments (the apocalyptic laments about the sheer impossibility of it all) being redeployed in an ongoing task of creating new points of insertion for professional activity. The compulsion to act flowers at the very point where the ability to act seems annihilated. In THIS, futility and optimism operate as a hologram, ultimately being one and the same thing, depending on the angle at which it is held and looked at. To extend the metaphor, we might see the work of the many tutors in THIS (the trainers, managers, and policy writers) as trying to hold the hologram up first to show sheer crisis out there, impossible and endless work to be done, then—wait for it, a twist, a rallying through deft re-angling to shine new light on the same message of doom which magically transforms problems into something to be acted upon with renewed determination.

This deft movement between critique and its refusal, or rather, its recuperation, can be analysed at a number of levels. To begin with, and returning to the question of insider compulsion, I see critiques of ‘the system’ as a key mechanism through which Aboriginal health is created as an unarguable site for urgent intervention. Perplexity, rebellion and complaint play active social roles in the perpetuation of interventionary magic and the sense of compulsion involved. This is a complex argument, which at this still early stage is better explained by way of brief diversion into illustration.

The appeal of statistics is a particularly interesting example to consider for this purpose. Strung together in the proper sequence, Aboriginal health statistics tell a tale of ongoing decline, which in a strictly rationalist universe might be used to indict current practices. Instead, as later pages will reveal, they are used to augment and extend standardised operations (see, in particular, Chapter Five). Statistical decline is not evidence of a need to reverse dominant assumptions about the need for intervention per se but are used to preface every new case made for continuing, ‘strengthening’ or expanding existing approaches. The repeat identification of failure is thus conscripted to the task of institutional reinvention and extension. Further, while ‘acting on the data’ is a deeply felt personal ambition for many health professionals, it seems that the data have exerted counter-magic on them, to the point where professionals seem incapable of separating their own rationalisations and alienations from what they project to be Aboriginal desires, fears and points of ignorance.

As public health practitioners work to attend to high levels of morbidity and mortality by better understanding the dimensions of the problems and the cultural habits of the people who are suffering, an obsessional endpoint becomes the need to share their information and ‘capacity-build’, so that Aboriginal people can themselves transform their own pathology to health-giving end. What happens next is truly fantastic. The underlying theory is relatively simple: if Aboriginal people knew exactly how sick they are, and what causes it, they would want to work on themselves with greater vigour and determination. If they could understand the true import of the alarming data that professionals have to hand, they would readily commit to appropriate lifestyle changes. As one health bulletin recently put it, information sharing is critical because ‘how can people be expected to manage their disease if they do not understand it?’ (Glover 2001: 1). The unstated corollary is: they could not possibly live as they do knowingly.
Yet, as I see it, the full-bodied identification between bureaucrats and their institutionally produced data sees the highly symbolic character of what are quintessentially abstract information forms erased, or rather, substituted, by a sense of data as having their own independent and highly potent ability to change peoples’ behaviours. Our worry for them is embedded in the data we collect. It is a small move to then see data itself as inherently powerful, to the point where information becomes what it takes to politicise individuals en masse and thus mobilise (positive, health-affirming) lifestyle change. Put another way, professional anxieties pass into the information which is strictly said to represent the health state of others, and the informational depiction of a pathologised reality is itself imputed a magical ability to influence what it is (theoretically) merely a copy of. What are in essence projections of professional anxiety are then granted expert legitimization as factual material indexing the veracity and extent of disease and death, material which in turn must be re-mobilised in the empowering interests of information sharing.

I will stop here, knowing these issues demand—and in fact later receive—detailed elaboration, by simply noting that, in this ethnography, the health professional’s ability to reanimate that which has been deanimated into things that exert magical effects is explored in terms of the psychological and visceral impacts of data on the bureaucrats themselves. This reflects my interest in the affective and aesthetic dimensions of health work, which I see as key to understanding the intensely inhabited nature of bureaucratic compulsions. Yet, paradoxically, it is precisely these dimensions (the bodily and the sensuous) which become obscured within the great majority of analyses of government activity. Such analyses tend to focus on either the end products of bureaucratic work (their texts and formal policies) or on what are understood to be the distinctions of this or that type of organisation, structurally defined.

Simply put, there is much less work on the embodied production of bureaucratic action, on the feeling and the craftwork or the doing of it, which is the key theoretical difference I offer in the approach to be adopted here.

**Seeing is believing: the magic of intervention**

I began this ethnography with a description of new bureaucrats ploughing through mangroves in search of mudcrabs. We were learning then something of how to inhabit our bureaucratic selves in relation to the people we are intending to assist. The sensuousity of this inhabitation is essential to my ethnographic analysis. It should go without saying, and yet does not, that bureaucrats are flesh and blood too. The way they embody and inhabit their world, the meanings they attribute to things, the emotional texture of their daily experiences, all matter to how people engage with each other and with their others. Flesh and blood means being human, means being in the presence of humans who create and sustain cultural practices. In THIS it means being in the presence of people who weave an intricate web of belief and practice, sustaining their faith in the magic of intervention, harnessing failures, skepticism and critique to both prove the need and internally generate the energy for a reinstatement of greater repeat effort. A key argument of
this thesis, and what marks it as an anthropological study, is that people’s whole selves are involved, not just a set of beliefs, or an ideology that operates at the level of intellectual reckoning alone. The opening about mud-crabs thus marks my concern to give emotional and corporeal depth to bureaucratic agents, even if my eventual emphasis is on how institutional actors reproduce established moral and political logics by reframing familiar approaches as alternately Indigenously authored or brand new, a chimerical reinvention process that is aided and abetted by the deceptive appearance of constantly changing and even ‘innovating’ managerial frameworks.14

As following chapters will increasingly detail, several interpretations of the operation of interventionary magic are possible. At its most basic, bureau-professionals act as if the problem of sick Aborigines (deemed to result from the ongoing playing out of an original tragedy of their being colonised) pre-exist acts of interventionist perception. Quite simply, their problems (illness, poverty and so on) are the facts of the matter, the issues ‘out there’ requiring solution, the preceding real, and not a construction thereof. Those who want to make amends merely identify and label what are a priori qualities of the world. That is, the external reality of Aboriginal pathology is irreducible. The professional expert simply confirms and gives name to that which pre-exists her gaze, and tries to fix what s/he thus (sympathetically) discovers as problematic with policies, programs and well-aimed strategies. This then becomes the basis for understanding and inhabiting institutional practice, and it is at this point of reckoning that the first spell on perception has already been cast.

Beyond the acts of judgement which would pre-define Aboriginality in terms of lack, the bureaucratic responses that are devised, and the ‘products’ (institutional documents of one sort or other) that articulate the actions proposed or already taken to fix the a priori problematic world of Aboriginal pathology, are animated with a meaning and power which reveals just how closely institutional actors are grafted into their work. Others might register institutional artefacts (flow charts, statements of policy intent, strategic plans, strategies and so forth) with an indifferent glance, seeing only banality and ‘feel-good statements’ or more critically, displays of state rationality at work. But, as I will show, for the one who has incorporated the corporation, these artefacts exert a particular magic. They are already the representations that will amend the problematised world, they are already the actions that ‘make a difference on the ground,’ that will ‘ensure’ improvements, better outcomes and so on.

14 Let me quickly clarify this last point, as the picture of regular organisational metamorphosis seems to be one of the more certain features of contemporary institutions in a globalised context (see also Chapter Two). Public health, as with all program areas in both THS and more broadly within the Northern Territory Government, is subject to regular review, either of an audit or a restructuring variety. This may lead to position changes, mergers, staff relocations and the retitling of organisations, functions and programs but in the main, the systems of governance through which public health activities are enacted have not significantly altered. Thus, in THS, the key public health activities of nutrition, alcohol and other drugs, health promotion and environmental health have a long program presence, even while their titles, emphases, vocabulary and numbers of personnel involved may vacillate. The lesser point to be made is that the more radically life-transforming shifts in government policy are more likely to come at Aboriginal people from the Commonwealth than the state government (for instance, in the formal shift from a policy of assimilation to one of self-determination (cf. Cowlishaw 1998), as the Commonwealth has constitutional authority for directing Aboriginal and Torres Strait Islander affairs throughout Australia. As a jurisdiction with state-like functions, the Northern Territory Government’s scope of activities focuses more on the delivery of state services that have been nationally pre-mandated (eg health, education, public works).
Just how this faith in the magical power of representations to recompose the world in the direction of system-led improvements develops, and becomes naturalised and inhabited by institutional actors, is the exact subject of this thesis. As I will show, institutional apperception so thoroughly transforms one's interpretation of the surrounding world, the world beyond the bureaucracy appears as something that not only should and can be acted upon through well-worded policies and strategies, but in fact calls for such interventions to be made. This is not a stable world: the life of the work of bureau-professionals, and therefore the reality of the need for their intervention, depends upon the social reproduction of much conflict and contest between variously positioned protagonists about what is to be done, how, who does it best, so on and so forth. Antagonism is the crucible of bureau-professional reproduction, a point I will examine in later detail. Yet, as an overall effect, the internally contradicting stories and the discordant ways Aboriginal people (and others 'in need') variously answer back is unswervingly interpreted in light of the need suggested for more intervention. In other words, the perceived world is repeatedly modified to fit a pre-conceived interventionary slot, but—and this is partly what makes it a magical sort of phenomenon—the repeated acts of perceptual modification involved in registering the world this way are not explicitly sensed by institutional actors as they are being executed. Instead, it seems that bureaucratic forms take hold of intervenors so completely and so demandingly, so compellingly, that the institutionally derived projections one is making onto the world, replete with expectations of logic and fairness and strategic outcomes, are seen as belonging to the world itself, and not to the perceptual acts of the bureaucratically encultured self.

Compounding the invisibility of these stealthy acts of perceptual magic, I will also argue, is the insistent secularism of modern statecraft, which tends to override its own mythical, symbolic and sensuous elements to provide a vocabulary of rationality to explain and evaluate institutional acts within the bounds of its own logical criteria. Further, through what John von Sturmer has called the 'great circularity' of notions of remedialism (von Sturmer 1995: 113), the logical explanations and evaluative analyses of interventionary success and failure made by bureaucrats/academics (for me they are one and the same) help funnel understanding away from the wondrous acts involved in the workings of bureaucratic magic. As I will further claim, the chaos-into-rational-order depictions that are produced by and about the bureaucracy by practitioners and 'outsider' critics alike, writes out the fullness of the actors' lives, and thus repeats the occlusions that sustain the magical transformations in the first instance. The practices that bring about bureaucratic understandings of the world are disavowed, or rather, are inexplicable to institutionalised apperception, having instead attained the unarguable imprimatur of urgently-required remedialism.

15 It has been my assumption throughout this work that much of what stands for critical thought (alternatively: analysis, scholarship, social scientific theory) is inseparable from much of what stands for bureaucratic thought. However, for the sake of convenience, I have tended to (misleadingly) keep the nouns distinct, and have tried to explain and illustrate the continuities and interdependencies along the way.
A simpler way of putting all this would be to say that the very expectation of program logic and redistributional fairness that drives so much of bureau-academic make-believe, together with academic writings which mirror back governmental thinking, belongs to an order of rationality which is itself culturally, and institutionally, reproduced (cf. Baudrillard 1988). Michel de Certeau’s description of historical discourse could well be a description both of the magic of intervention and of analytic critiques which attribute a purely instrumental function to governmental activity. Historical discourse, he says,

> gives itself credibility in the name of the reality which it is supposed to represent, but this authorized appearance of the ‘real’ serves precisely to camouflage the practice which in fact determines it. Representation thus disguises the praxis that organizes it. (de Certeau 1986: 203)

But I use the metaphorical term ‘magic’ in favour of more academically hard-bitten notions of structuration, representation, complicity, governmentality or power, for it draws attention to the operation of fantasy as well as emotions (cf. Sartre 1971); to the fact of being affected and affecting others; to the unspoken dynamics of interpersonal relationships; and to the web of humanly practices—wicked and good, realist and symbolic, repetitive and novel—which sustain bureaucratic effects. Finally, I use it precisely because ‘bureaucratic magic’ is at first blush oxymoronic. It is not what is expected at the heart of state rationality. Being counter-intuitive, I hope it provokes a means of bypassing the moral judgements and instinct to evaluate bureaucratic acts in terms of their efficacy that otherwise seems to drive conventional analyses of matters governmental.

**Being t/here**

As well, the opening shows clearly that I am frequently involved in the events I describe, that these are my practices too, both as a bureaucrat and as an anthropologist. Indeed, there is a definite pronominal tension in this work, which finds me shifting between ‘they’ and ‘we’ when describing THS players and social scientists, which, in the interests of clarity, should be briefly explained here (but see also Chapter Eight). I first came to be involved with THS as an employee (as a researcher, policy analyst, planner and project manager). For myself, I consider this an important prerequisite for my fieldwork, an essential means of immersing into and developing an understanding of the official and virtual hierarchies that had to be negotiated to formally gain unfettered access to the organisation.¹⁶

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¹⁶ As part of my re-entry as an ethnographer, I developed a research agreement with the Executive Board of Territory Health Services (see Appendix One) which basically established formal permission to do fieldwork with officers in the department who were prepared to give me their permission to hang around them. Establishing connection with particular people was then left entirely up to me.
This was definitely a native ethnography: I was born in the Northern Territory, and I am a practicing bureaucrat. Subsequently, within some of the head office environments where I conducted parts of my fieldwork, I was already known. Importantly, while I was determinedly ‘ethical’ about my new positioning as an ethnographer, inserting a notepad and consent forms into interactions to mark the distinction, it was clear, (Ethics Committee anxieties aside\(^{17}\)), that my former central office colleagues did not really care. I was already resolutely inscribed as a fellow bureaucrat. Even moving outside the policy arenas, where my work with THS trainers and public health fieldworkers drew me into contact with people I had no former connection with, the assumption that my research would help fieldworkers better reflect on their own practices proved its own passport, overriding my own protests that inventories of how to do things better were what I wanted to analyse, not reproduce over again.

Yet, not only was I already in THS, I was in it at the outset of the task of empathy-objectification which anthropology demands, and which I argue encapsulates the analytic logics which health professionals also bring to the work of explaining their own and Aboriginal acts. It is truly remarkable how small the distance is between the explanatory models of the utilitarian and improving social sciences and that of administrators. Both reify the power of analysis to overturn delusional practices; both share the same utopian belief that betterment can be achieved through ever-refined acts of interpretation; and both share the same assumptions about the deterministic role of key events as explanations for current behaviour. In the humanitarian social sciences, as in the helping bureaucracies, one diagnoses pathology as irrational surface symptom of deeper underlying causes (which assumes that today’s problems have singular origins, a start point and thus by implication an end point, which rational analysis can discern and so prescribe solutions for).\(^{18}\)

\(^{17}\) Like many anthropologists, I am dubious about the ethics of formal ethics procedures as these have been established by such bodies as the National Health and Medical Research Council. (For a recent discussion of the intrusion of the NH&MRC in anthropological studies, see member bulletins of the Australian Anthropology Society throughout 1999 and 2000; for a discussion from a European academic perspective, see Pels (2000).) However, being concerned to ‘do as the Romans do,’ I attained ethical clearance from the local body for scrutinising health and medical research, the Joint Institutional Ethics Committee of the Royal Darwin Hospital and the Menzies School of Health Research, Northern Territory (see copy, Appendix Two). In my application I made the mistake of deconstructing the fiction of anonymous representation, pointing out that even though I would of course change names, it would be hard to disguise individual personalities from the detective work of anyone truly determined to work out who’s really who, given how the relatively tiny THS regional offices draw from mostly well-known and interlocking pools of trained personnel. I further argued that consent could never be settled at a single point and that the researcher must be prepared to negotiate recursively, with the complete expectation that agreement reached at one level or for one occasion is no guarantee of continued permission at all levels and for all occasions (for a discussion of this point, see also Van Maanen 1978a). Such clever honesty meant my project was almost rejected on the grounds that ‘management’ might use my work to spy on lower level staff. In the mean time, proposals to give Aboriginal babies full regimens of anti-biotics in their first six months of life to pre-empt infections were passed with barely a murmur (Ethics Committee member, personal communication). Consent forms have become obligatory symbols in ethics committee rites of passage (see, for example, NH&MRC 1985)—in abidance with the Committee’s anxious wishes, I produced and guaranteed to use them, and thus finally gained full clearance.

\(^{18}\) Marilyn Strathern has further written of two major continuities confronted between anthropologists and the people being studied in anthropologies of ‘home.’ A first characterisation of what she calls ‘auto-anthropology’ lies in how it renders back, ‘to the culture or society from which it comes, the culture’s central concepts, such as “relationship”, “role”, or more particularly the concept of “culture” itself’ (Strathern 1987: 27). When anthropologists study cultures which have themselves produced the notion of ‘culture’ (ibid.: fn.14), our analysis becomes another version of an existing body of knowledge, which, as a version, can be rejected for felicity or relished for glimpses of the self. Such a valuation itself bespeaks the second major continuity. Where I talk of the shared assumption of the power of elucidation to correct processes, Strathern further mentions the proper fit of understanding of knowledge as a commodity which can be exploited or debased as itself belonging to a sense of valuation and ownership that is embedded in western cosmology. It is a very western sense of self that claims representations can displace individuals and which assumes that techniques of theorising have universally common grounds (see esp. pp. 30-32).
More specifically in comparison with certain instrumental forms of anthropology, there are additional overlaps in the spirited defence of Indigenous knowledge over the intrusions of state planners, the calls to develop policy from the grass roots, and in the community advocacy role assumed by anthropologists and committed health professionals alike. Modified ethnographic research processes are readily used within THS, particularly within public health, as a means of better exploring both practitioner biases and service provision shortfalls. Even more widespread, senior management members have had saturation exposure to corporatised formulations about 'organisational culture', many of which claim to draw upon anthropological theories of organisational forms and social change. In this last type of work, 'culture' constitutes an amalgam of values, behaviours and image, an outlook that is internal to the organisation and which must be nurtured, documented and intentionally worked on by individuals, work groups, managers, and the corporation as an entity. In THS, senior managers will host a range of corporate activities aimed at engendering team spirit, or a project management approach, a concern for costs and benefits, or a commitment to core values, and regularly take themselves/are taken to training

19 An entire other study could be made of the uses to which ethnographic techniques are put in the knowledge and advocacy contests of bureaucratic research. Within the evaluation arena, for instance, proponents of what is called participant evaluation invoke anthropological techniques of participant observation and insider-diagnosis as radical methodological interventions sustaining a breakdown of the objectification processes involved in audits and evaluations, (see, for example, Feuerstein 1986, Hawe, Degeling, and Hall 1991, Patton 1987). There are a small number of examples of work conducted by anthropologists in the interests of informing Northern Territory health administration, including the pioneering early work of Janice Reid (1978, 1983), later followed by Maggie Brady, Jeannie Devitt, Tim Rowse and Marie Brandl (Brady 1992, Brandl and Tilley 1981, 1995, Devitt and McMasters 1996, Rowse, Srimgeor, and Lucas 1997). There have also been meetings and conferences hosted by the health department in which anthropological expertise on matters Aboriginal has been sought, including a special workshop which brought together anthropologists and health department bureaucrats in a special policy meeting following the 'Hunter Gather Conference' held in Darwin in 1984 (Gillian Cowlishaw, personal communication; see also Marcus 1990: 10). Much of this work assumes the mantle of 'applied' anthropology, in terms of addressing the social policy issues seen to be associated with Aboriginal management. In addition to these works, a collaborative work using modified ethnographic techniques, titled Forgetting Compliance—Aboriginal Health and Medical Culture (Humphrey, Weeramanthri, and Fitz 2001) pursues the troublesome issue of biomedical dominance in the design and delivery of patient care in the Territory. The recommended methods for challenging biomedical practices are also ethnographically derived (for instance, in the call to improve providers’ communication and cross cultural skills and to refashion decision-making around the goals and values of the patient, not the provider).

20 The amount of material that promotes internal attention to organisational culture is immense—even in the humanities sections of libraries which, being accidental destination points, represent a mere sliver of the massive volume of culture-fix literature circulating between management schools, consultancy outfits, and public/private sector organisations in Australia and internationally (see, for example, Alvesson 1993, Jones, Moore, and Snyder 1988, Kilmann, Saxton, and Serpa 1985, Martin 1982, Sackmann 1981, Trice and Beyer 1984, Trice and Beyer 1993). Early researchers of organisations were excited by the 'striking parallels between the rites and rituals of so-called 'primitive' people or folk societies studied by anthropologists in the past, and the symbolic behaviour in organisations in contemporary American society' (Jones, Moore, and Snyder 1988: 16). An excruciating but not atypical example from Australia, notable for its overt espousal of anthropology, is Wendy Bell's An Anthropological View of How Organisations Think (Bell 1997). Here Bell takes up Mary Douglas' group-grid schema to identify the four different 'cultural biases' or 'predictable world views' (held by fatalists, hierarchists, individualists and egalitarians) present in modern organisations, in order that their respective energies can be collectively harnessed to achieve greater performance economies. The depth to which anthropology is plumbed in organisational literature is variable, although in the selection of texts cited here, Clifford Geertz and Mary Douglas are frequent references, with Sherry Ortner's now classic essay overviewing anthropological theory from the 1960s (Ortner 1984) also a lead reference item. In much of this work, organisational life is cultural in one moment and acultural the next, with 'culture' being one among a number of variables to be tweaked—alongside, say, fiscal management—in the interests of increasing productivity, reducing interpersonal conflict and/or emulating the success of other organisations. According to Schulz, it is this last concern, particularly the once common desire to emulate the so-called 'tiger economies' of South-East Asia, which prompted the turn to culture in organisational studies since the 1980s (Schultz 1995). In more recent times the conceptualisation of organisational theory's cross-fertilisation with anthropology has become more complex, a process tracked by George Marcus in his collection Corporate Futures: The Diffusion of the Culturally Sensitive Corporate Form (1998, see also Rabinow 1996). There are no a number of useful summaries available which review recent work by organisational scholars influenced by anthropology or which give a history to anthropology's belated interest in the field (see Burawoy 1979, Hamada 1994, Handelman 1981, Nash 1981, Rew 1985, Shore and Wright 1996, Shore and Wright 1997, Van Maanen 2001, Wright 1994a, Wright 1994b). Rather than reproduce these here, my discussion focuses on the flexible deployment of cultural metaphors in THS.
sessions and retreats where intense analysis of their own cultural management techniques and personal attributes take place. Company slogans, pamphlets and newsletters which encourage employees to feel valued, or to blend business attitudes with a compassionate attitude toward clients, capture some of this concern with 'corporate culture'.

In the words of one organisational ethnographer, studying the work of those people in organisations for whom the notion of culture is itself such an active subject of intervention leads to:

ethnography with a twist: not just a study of culture as a distant and overarching social scientific concept, but an examination of practical, scientifically informed, self-conscious attempts to design and manage culture. It is an ethnography, as it were, of lay ethnographers, an attempt to document and interpret the culture of culture management.

(Kunda 1992: 23)

Let me extend the analogy of lay ethnography still further to another arena in which THS has an explicit self-consciousness about the notion of culture. For those people working on Aboriginal health, culture also has an outside referent to that of the organisation; here it is about the differences between 'us' and 'them'. That is, not only do THS employees candidly work on themselves as cultural (read organisational) subjects, they are also constantly seeking to understand Aboriginal people, with an all-encompassing logic that, as health permeates every aspect of how people live their lives, every aspect of those lives therefore matters.

Aboriginal bodies and minds are the subject of endless discussion, research, probing, and documentation, and much effort has gone into creating the right internal conditions to better serve Aboriginal people. Accredited training courses and orientation manuals on Aboriginal culture have been developed, and employees are formally encouraged to educate themselves to work professionally (like anthropologists) in the interests of Aboriginal people—and, like anthropologists, are ceded an authority to make pronouncements based on their exposures to, and expert speculations about, cultural difference (see also Chapter Four).

Paradoxically, in this more anthropologically-familiar zone where culture refers to life-worlds, the culture of non-Aboriginal people is discursively eclipsed: it belongs to black bodies, not white, and resides in a set of differences which are uncomfortably mediated by a newly emergent class of Aboriginal professionals within the bureaucracy, and by those people who can draw on the 'being there' expertise of their field experiences. The doubled-over emphasis on culture as a set of attributes Aborigines have (some more than others) but white workers do not (not to the same extent anyways), and as something the organisation manipulates in a determined

21 These processes are examined more closely in Chapters Four and Five, which specifically focus on the work of corporate ideologists in shaping employee beliefs as this co-elaborates with the self-work of employees.
effort to inculcate employees with the right attitudes and values—about, amongst other things, Aborigines—offers a complex field in which to explore the intersection of anthropology, bureaucracy and the governance of Aboriginal health.

Given the intertwining of all these epistemological, methodological and historical commonalities, an immediate problem raises its head. How does one navigate a cultural domain which offers few conceptual footholds for a distinctively anthropological analysis? My short answer, already hinted, is that I do not believe such a pure distinction is possible to maintain, for the intersections that I will continue to uncover throughout this ethnography evidence inextricably shared metaphysical assumptions. In fact, one of my key attempts as an ethnographer is to abandon the familiar and comforting trope of state-as-powerful-regulatory-system-that-imposes-order, to think instead 'I have met the state, and the state is me' or as Colin Gordon puts it, that 'the state has no essence' (Gordon 1991: 4). As such, I see my ethnographic challenge as one of re-feeling and describing anew the textures and insistences of the institutional spaces (conceptual and material) I am always already immersed within, without expectation of being able to analytically teleport out of the mire. Dan Rose puts this another way, when he found he could not understand the economic marginalisation of American blacks without better understanding the society from which they were mostly unincorporated. In his quest to uncover 'the organizational features of the bustling affluent middle class and the more hidden upper strata of the very rich' (Rose 1989: 7), Rose also had to confront what was obscuring his vision as an anthropologist. He found that:

One of the reasons that American culture remains enigmatic to us is that it has inherited on a massive scale the corporation as a colonizing form, that ethnographic practice grew up in this colonizing milieu and is one of its intellectual products and that our ethnographic inquiry is conducted from within institutions. Ethnographers are rewarded by persons like themselves who spend most of their working lives inside relatively large nonprofit corporations such as the university and the scholarly association, to mention two. The social forms that cage our intellectual activities remain all too invisible to us (Rose 1989: 12).

But there are some tentative distinctions I would like to mark in order to stake a space for looking in, within, up, down and around (cf. Nader 1972), more as a colonised inmate than as a putative outsider, and it is to these that I now turn.

**Marking the not**

It should be clear by now that a key insistence of this thesis is a focus on the people who generate the agonising about Aboriginal health more than it is on the subject-objects they are agonising about. How the diverse categories of Aboriginal people take up the bureaucratic meanings assigned to them is definitely touched upon, but the present study does not try to arbitrate whether the ways health professionals interpret their interactivity with Aboriginal people reconciles with the judgements Aborigines may have of the same matter. The related question of how the bureaucracy's policy and program discourse on Aboriginal health is received, interpreted and put to use by Aboriginal people, whilst clearly a substantial issue, likewise remains in the
background of this thesis, a possible pursuit for later work. To put this differently, my interest is not so much in how Aborigines cope with 'the system' but with how 'the system' copes with Aborigines.

How can such an excision possibly be defended in the era of holistic, multi-sited ethnography (cf. Marcus 1995)? Well, I could argue, without fabrication, that the restricted focus is strictly determined by methodological concerns. Given my concern to know how bureau-professionals come to know what they know, obeying the tacit rules about who not to talk to circumscribed my ambit. In an interactional environment founded upon alliances and cliques, and in dedication to the anthropological methods of immersion and critical empathy, I needed to emulate how bureau-professionals form knowledges about their publics, by using the same orchestrated and fragmented cues and assignment of meanings sustained by bureaucrats through conversations amongst themselves. My full participation in the world of bureau-professionals entailed full participation in their self-imposed forms of isolation too.

Allen Feldman for instance, argues precisely this case in restricting who he interacted with in the course of conducting fieldwork amongst Irish resistance and paramilitary groups. He writes:

> My 'access' to certain restricted circuits of paramilitary discourse and culture depended on my recognition of the thresholds of secrecy. This recognition had to be visibly displayed by me in dialogue and in everyday interactions. ... in order to know I had to become expert in demonstrating that there were things, places and people I did not want to know. (Feldman 1991: 11-12)

In my case, I knew from past experience that if I appeared to be a scrutinizer contesting forms of insider expertise with Aboriginal viewpoints, I risked provoking either a combative or submissive response from the health professionals whose naturalism and trust I so utterly depended on. Especially within the interpersonally competitive arenas of public health, my assumed knowledge of otherness—indeed the very suggestion of greater familiarity with individual Aboriginal men and women—would be targeted as social capital to be bested or quarried, or both.

As following chapters will show, public health professionals will enlist any and all ethnographic clues in an ongoing and highly competitive quest to establish the superior extent of their own sympathetic and textured experiences of, and knowledge about, Aboriginal cultural difference. They are constantly winnowing out of every encounter (their own and vicariously, that of others) scraps with which to craft and display forms of greater anthropological expertise. I therefore needed to demonstrate that my interest was exclusively and authentically the domain of their interests, and moreover, that I was keen not to correct, second guess or show up but to instead be taught by those with greater professional cross-cultural knowledge than myself. And I was rewarded. It was through adhering closely to professionals, and being sensitive to the sources of their interpersonal envy, for instance, that I came to see how Aboriginal cultural alterity is imagined and interpreted in ways which seem remote from embodied Aboriginal subjects, even when those subjects may be physically near (see especially Chapter Six).
Yet, while this methodological picture of tactical complicity is certainly very accurate, it is far too narrow to adequately represent the theoretical issues this study confronts. To put my argument bluntly, the first point of departure from many other modes of analysing bureaucratic activity is that this is an *anthropological* work. For me, this means that the evaluative imperative toward triangulation, which would have me compare and contrast Aboriginal perceptions of bureaucracy with insider perceptions of the same, is more an impulse to be explained than an analytic logic to be reproduced.

This distinction is perhaps best expanded by way of an unlikely comparison with the late Alfred Gell's (1998) concerns regarding the anthropology of art. After considering a large body of anthropological literature in *Art and Agency: An Anthropological Theory*, Gell concludes the corpus is not distinctively anthropological at all but is dominated by 'imported' analytical categories. Borrowings from art theory are especially paramount, ushering in a conceptualisation of art as objects or products (containers of meaning) that can be appreciated for their aesthetic qualities or technical virtuosity when, for Gell, it is the realm of biographically-situated interpersonal transactions, or praxis, that should be the analytical starting point for anthropology. Rejecting the notion that anthropology is a task of adjudication, Gell argues that 'evaluative schemes, of whatever kind, are only of anthropological interest in so far as they play a part in social processes of interaction, through which they are generated and sustained' (Gell 1998: 3).

Gell's definition of what anthropological analyses must achieve is equally insistent:

*The aim of anthropological theory is to make sense of behaviour in the context of social relations. Correspondingly, the objective of the anthropological theory of art is to account for the production and circulation of art objects as a function of this relational context.* (Ibid: 11)

His task then, is to specify the network of social relationships in the vicinity of art objects, not in order to make art works a derivative symptom of institutional politics, but to consider them as mediational indices, as part of an unfolding phenomenal arena.  

What does this have to do with a study of actors within a health bureaucracy? Well, if the social scientific work which examines contemporary Aboriginal issues in relation to government is to

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22 A similar point has been made by A.E Robertson, pondering why the challenge issued in the early 1970s by Roger Bastide for anthropologists to analyse development plans and activities as they might tackle such topics as kinship, economic and political institutions or spontaneous processes of change, has not been responded to. Robertson comments it is 'probably because we have found it more convenient to work with the analytical categories of other disciplines in dealing with `development`' (Robertson 1984: 2).

23 It is important to note that Gell is making more than a simple critique of the decontextualisation of art from its conditions of production. His work is also the beginnings of a critique of Bourdieu's theories of praxis, which for all its attention to the inventiveness of quotidian practices, of subjective actions which have 'neither meaning or function' (Bourdieu 1990: 18), remains profoundly structuralist. Like Michael Jackson, Gell argues that Bourdieu diminishes subjectivity with his overemphasis on impersonal structural forces, thereby depriving us of the very site where life is lived, meanings are made, will is exercised, reflections take place, consciousness finds expression, determinations take effect, and habits are formed or broken' (Jackson 1996: 22).
be believed, the key task of critical analysis is to expose the damaging policy effects, intellectual gaps, or self-serving discursive manoeuvres of government work. The life-worlds of the people involved in government work, their doing of it, are rarely brought into the picture. In the omission of human labourings, a greater rationality is tacitly assumed: bureaucrats are simply conveyors of more absolute configurations, which may be adjudged truthful or not, effective or otherwise, and so on. Like art work that is isolated from the praxis which organises it, evaluative anthropology risks subsuming professional activity to referential material, material that can be alternately falsified or used to buttress further truth claims. Yet, as I hope to show, learning to govern in Territory Health Services is achieved through symbolic, material and narrative practices that operate as much between the pen and the paperwork as in formal documents and other types of governmental declaration. Paraphrasing Gell, an anthropological approach is concerned with how institutional practices are lived; an evaluative approach with how effective they might be in achieving their own truth claims. Some further examples might better illustrate this distinction.

Creating distance

Tim Rowse, an anthropologist and political scientist who has written extensively on the interface between the Northern Territory Government and ‘the Aboriginal domain,’ has devoted specific attention to the health and welfare professionals operating within the network of organisations focused on improving Aboriginal health in his work Traditions for Health: Studies in Aboriginal Reconstruction (1996), and, almost uniquely within anthropology, has shared my interest in the health professionals operating out of Territory Health Services.

Writing of his former role as resident medical anthropologist at the Menzies School of Health Research in Alice Springs, Rowse found no problem tracking the discursive concerns of the surrounding health professionals. Like me, Rowse found the public health policy and program areas of Territory Health Services to be an ethical and practical testing ground for the individuals concerned, in which a great deal of the ubiquitous talk work concerned the construction of fairness, ethno-sensitivity and health equity, counterpoised against the perceived hostilities of narrow-minded clinical staff or a racist general public (cf. Brennies 1994). Earnest epistemological discussions about the nature of Aboriginality and the methodological complexities of government work were ever present and on the surface—presenting, in fact, problems for the anthropologist seeking an outside space from which to critically analyse the scene. Admits Rowse:

It can be uncomfortable to detach oneself analytically from the process of constructing Aboriginality: those with whom one is working are likely fervently to believe in their representations of what they are doing as 'the Aboriginal way.' Government subsidies may be at stake in maintaining such representations, as will colleagues' deeply felt senses of identity and of common purpose in difficult enterprises (Rowse 1996: 5).

But this simultaneously obscures too much and goes to the heart of the issue. What precisely are these 'deeply felt senses of identity and common purpose'? How do they come to be formed, in what ways are they captivating, how are they enacted?
To achieve his desired distance, Rowse resorts to a familiar social scientific tactic vis-à-vis governmental activities and artefacts: different programs and statements of intent are carefully deconstructed for their effect and effectiveness. For the implicit audience of administrators and other helping social scientists appealed to through such a critique, there is no question of the usefulness of this approach. By chiding administrators for inadvertently failing their clients, by correcting their errors and misconstructions, Rowse clearly hopes his work will help the helpers see through their own mystifications, so that the damaging effects of governmental interventions are mitigated, and the potential benefits of well-directed public spending realised.

In this way his work, and corrective work like it, is propelled by an essentially governmental ethic: the task is to recommend what ought to be done, under the foundational assumption that what governments do or do not do are paramount indices of how life should be and thereby is lived. By foundational, I mean that explanations and starting prepositions about the ongoing need for government intervention would in many cases be unthinkable but for the taken for granted assumption that very little of value occurs independently of government policy and associated academic formulating. (I have elsewhere called this the magic of intervention). This foundational faith creates another common ground between bureaucrats and those academics who authorise and reinforce it by seeking to point out the ways in which government policy has failed in, and could improve on, its social betterment objectives. By privileging policy texts as the key site of meaning and treating formal government policies as the main causal variables in human social change, Rowse essentially produces a (managerially familiar) breakdown of the gaps and occlusions within government acts targeting Aboriginal health in Central Australia. Here, then, we see the shared epistemological basis I’ve alluded to above: a faith in goodwill analysis resolutely guiding anthropology in critiques of aberrations so as to leave a more principled edifice as remainder, with the starting assumption of the need for public intervention left intact.24

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24 It is a concern that is saturated with contradictions, since anthropologists are just as likely to distance anthropology from any interventionist role as they are to express dismay at the damage which is frequently inflicted on different peoples when anthropological insights are missing from cross-cultural encounters. Again, while I do not mean to isolate him for especial critique, Tim Rowse provides an exemplifying illustration. When Rowse was positioned as the resident medical anthropologist at the Menzies School of Health Research in Alice Springs, he was troubled by the administrative expectation that he would be able 'to put forward generalising models of the cultural logic of Aboriginal behaviour' (Rowse 1996: ix). His source of disquiet was twofold. Firstly, he was worried his knowledge repertoire and ethnographic command would be inadequate to such a grand task; and secondly, he felt that fulfilling the desire to know more for better governance ran the danger of displacing specifically Aboriginal representations of what Aboriginal people want, need or desire for good health (ibid: 10-11). Yet, in the orienting remarks to his earlier critique of self determination policies, The Aboriginal Domain and the Bureaucratic Imagination, he urges administrators to better sensitise their work to cultural issues by becoming 'further informed by ethnographic perspectives on remote Aboriginal concerns and styles of collectivity' (1992: viii). In a similar vein, Patrick Sullivan asserts that the Australian state exhibits 'an almost culpable inability ... to base policy on adequate assumptions' about Aboriginal society (1996, 16), and challenges anthropologists to pursue 'a far more active and instrumental role' in Aboriginal administration (ibid: 17, see also Maddock 1989). While there would be many who would find talk of intervention collusively abhorrent, such explicit accounts place into sharp relief prevailing assumptions about the anthropological enterprise as that which is simultaneously not for the state yet privy to insights the state should heed in the design of more effective and socially just interventions (eg New 1985). For a review which surfaces similar issues within British anthropology, see Wright (1995). Historical overviews of 'applied versus pure' debates can be found in Gell (1984) and Shore and Wright (1986). For contemporary discussions which problematise the cliched applied/pure distinction, see Gupta and Ferguson (1997) and Ahmed and Shove (1995).
At the same time, Rowse's work, like much of the anthropological literature I have discussed, assumes the phenomenal world of bureaucrats to be already known, to in fact be so taken-for-granted it becomes paradoxically less available for anthropological analysis (Rose 1989:6). In another common analytic move, Rowse further assumes a fundamental naïveté on the part of practitioners, by implying they will have no sense that their iconising representations of Aboriginal customary traditions may be fictive or problematic (see also Sutton, 2001). Yet, in my experience, THS actors can hold alternative or contradictory views about such issues in quick succession. A more troublesome challenge for anthropological analysis is to comprehend the slippery movement between pragmatic insider appreciation of the ironies of claiming fixity in such matters as cultural identity, and the creative, tactical deployments of such simplifications in pursuit of different institutional agendas. As Rowse notes, government funding might be dependent on just such a denial of complexity.

Tracking these shifting deployments is a far trickier business indeed, for which the familiar forms of superior social scientific critique give little traction. As I will argue, practitioner movements between reification and deconstruction, critique and reinstatement, faith and scepticism, simplification and complication, are deft discursive operations which dynamically coalesce to form shared bodies of knowledge, of which the anthropologist's corrective inserts are simply a part (cf. Riles 2000: 4-6).

Finally, it is the treatment of bureaucratic players as second-rate academics whose faulty texts and directives must be rectified, when such evaluative analyses are the very stuff of the everyday institutional practices to be comprehended, that leads me to draw a line, echoing Gell, distinguishing an anthropological approach from that which adopts a political science, or what we might call an administrative analysis of governmentality (see also Ferguson 1990). I need this distinction to be very clear. The functionalist concern to assess the efficacy of bureaucratic actions, exhibited by many social scientists, reproduces rather than apprehends the analytic logic of bureaucrats.

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25 The easy assumption that the familiar is already known is taken up by Rosaldo, who argues that there is a hierarchy of cultural visibility in anthropology, with those closest to university-educated professionals having the least culture, following a logic which conflates culture with difference (Rosaldo 1989: 202; see also Appadurai 1986b; Gupta and Ferguson 1992, and Hamner 1986, 1988).

26 In his critique of the instrumentalism inherent with acts of academic criticism which try to expel racism from ideological practice without understanding the in-world self-evidences that such practices might serve, Ghassan Hage similarly identifies what he calls 'governmental anti-racist sociology' (Hage 1995: 71). 'I do not necessarily mean by this a sociology that toes a governmental line, or even one that criticises government policy in order to 'improve it', although both of these are examples of governmental sociology ... What defines it as governmental is its practical orientation. This means that it is both prescriptive and always written from the perspective of a (sometimes vaguely defined) practical subject that is seen as capable of implementing the prescription. This is often the government, but it can also be a trade union or an anti-racist group or those who are perceived as victims of racist practices, or even the sociologists/politicians themselves' (ibid.).
The irrepressible desire for decontaminated meaning

Ironically, as it turns out, I agree with Rowe that it is difficult, if not impossible, to detach oneself analytically, without sharing his assumption that a stable truth lies beneath concealed intentions awaiting the ethnographer's critical revelations. As I’ve hinted above, taking bureaucrats seriously at their own word brings one face to face with a challenging and reflexive discursive realm where the critical concerns of the analyst are anticipated in unexpected and striking ways. As George Marcus notes of corporate interlocutors, the individuals operating in contemporary organisations are ‘engaged in acts of reconceptualizing their circumstances that shares kinship with our own predicaments as distanced, professional analysts of changing contemporary social and cultural realities’ (Marcus 1998: 2). In other words, bureau-professionals are highly intellectual, inventive and self-analytical subjects; able, willing and in fact well-tutored in reflecting on the ambiguities and contradictions of their own domains, deploying vocabularies saturated with the critical knowledges (psychoanalytic, sociological, political-economic, quantum, material, anthropological) of the contemporary era. Dealing with people who by training and habit have opinions on their opinions, or as Giddens frames it, have available to them the techniques of personal-knowing and self-structure reflexivity ‘as a hermeneutic medium of reflection’ (Giddens 1994), undermines the anthropologists’ attempt to play the God-trick of overall perspective and infinite vision (Haraway 1991: 189).

The challenges this presents are familiar to a number of ethnographers of contemporary institutions, and are powerfully worked by anthropologist Annelise Riles. Riles makes the abundantly meta-analysed practices of the Fijian bureaucrats and activists preparing for and attending the United Nations Fourth World Conference on Women (1995) the very subject of her study. In her ethnography, Riles draws particular attention to what she calls the ‘achingly familiar’ feel of the analytical material she confronts:

This replication of the work of sociologists—an example of what Lash (1994) terms ‘modernization’s doubles’—offers an opportunity, I think, for developing new ways of thinking that do not resort to surprise discoveries, do not uncover hidden generalities, and yet do not treat cultural phenomena as uninteresting or undeserving of analysis because they are already understood, elaborated on, or even critiqued by those who used to provide the raw ‘data’ for our analyses... In such a condition, the anthropologist’s analytical moves are not so much insights as the very elements of the analysis that one seeks to describe (Riles 2000: 4-5).

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27 Scott Lash likewise describes his confrontation with what he calls the ‘haunting doubles’ of enlightenment in the era of organised capital, where in the place of betterment are worsening conditions, where the improvement dreams of socially-minded architects become ‘the prison estates of tower blocks and housing projects’ and where ‘the anti-clerical emancipatory potential of classical physics turn[s] into the nature-destroying science of the late twentieth century’ (Lash 1994: 112; cf. Beck 1992, Scott 1998). Yet, he argues, we can’t disregard modernity’s capacity for reflecting on itself. What happens when modernization, understanding its own excesses and vicious spiral of destructive subjugation (of inner, outer and social nature) begins to take itself as an object of reflection’ (Ibid). When the enhanced information processing abilities of a highly educated workforce turns the framework of problem solving, questioning and the like...into a radical critique of the ‘system itself’ (113). Without sharing Lash’s optimism in the emancipatory potential of critique, I take from his insights a sense that the sophisticated oppositional politics held by such ‘architects of power’ as government agents, removes the comfort of old notions of centre versus periphery, state to citizen, oppressor and oppressed, inside and outside and opens the space for a differently conceptualised political landscape (see also Baudrillard 1988).

28 As Slavoj Žižek points out, the sophistication of modern subjects, their critical detachment on their own activities, upsets critics of ideology in their slick removal of a key platform of critique: ‘We can no longer subject the ideological text to “symptomatic reading”, confronting it with its blank spots, with what it must repress to organize itself, to preserve its consistency—cynical reason takes this distance into account in advance’ (Žižek 1998: 36).
Riles explores forms of institutional aesthetics by using an aesthetic methodology, that of stripping away 'thick' detail to create abstractions that might help show the already well-known from different vantage points, using the forms and designs of her institutional actors (the diagrams and client friendly cartoons, or organisational matrix charts), so much the better to bring into view the modern knowledge practices she wants to demonstrate. It is an immensely important theoretical and methodological advance, and one to which I owe many, many debts, even while we possibly differ in our interpretation of the practical effects of bureaucratic documentation—on which more later.

Encouraged by Riles' innovations, and that of other experimenters studying institutional forms and logics²⁹ this thesis explores what might happen when we don't assume our own superior analytic capacity, if we think of interventionist logic—our own and those whose logics we intimately share—as made and not born, if we see the anthropological challenge instead as how to trace the material and affective history of bureaucratised intellectual habits in interactive practices, as the objects, instruments and subjects of our meditations.

So doing, one quickly confronts the paradox I've repeatedly alluded to above, in that the analysts' trick of promising resolution through the right (methodologically well-wrought) critical analysis stands as yet another instance of the infinite mirrorings taking place in these interstitial spaces between scholarly and bureaucratic performativity. That is to say, health professionals conscript the same instrumental purpose to their task of thinking through mired practices: with the right kind of research and analysis, a breakthrough insight/intervention will emerge. Yet, in THS at least, rather than providing breakthroughs, analyses of 'failures' of effect or uptake—diagnosed as, say, a lack of political will, long-term funding, or poor engagement with Aboriginal people—become devices of reinvention. Not true or untrue, insider critiques of 'the system itself' (cf. Lash 1994: 113) are sophisticated, postmodern and replete with radically ironic insights into the workings and mystifications of operations of power, that are in turn creatively redeployed in the direction and wording of 'new' institutional activities. In other words, bureaucratic thinking has within itself a self-reinforcing faith which corrective critique only serves to re-legitimate.

As Daniel Miller argues, the point of anthropological studies of global-to-local capital, bureaucratised society and post-colonial practises of consumption, 'is not that [they are] good or bad, but merely that it is increasingly the inevitable cultural process in which we find ourselves' (Miller 1995: 11). It is as a result of being fully immersed within 'the inevitable cultural process' in which I find myself, I would argue, that the evaluative commentary that seeps into my work is both

²⁹ It is a difficult task to acknowledge key influences, when, as Van Maanen has recently noted, 'studies of organizational identity and change are often—perhaps most often—ethnographic in character' (Van Maanen 2001: 244), which is another way of saying it is an extremely diverse and rapidly expanding field. Yet, in my search for literature which does justice to the phenomenology of organisational work whilst taking seriously the policy intents of the organisation and its wider social effects, I discovered with Dan Rose that 'there are few inspired examples of what ethnographers can accomplish' (Rose 1989: 12). As a result, it will become obvious that I have drawn heavily upon a small number of what I consider to be key anthropological contributions to institutional study, from which I would single out the work of Donald Brenneis, Joseph Dumit, Allen Feldman, James Ferguson, Emily Martin, Paul Rabinow, Annemarie Riles, Marilyn Strathern and Michael Taussig.
an accurate depiction of the domain and a signal of my (academically-honed) bureaucratised inhabitation. That is, the tone of complaint and muted promise of correction that at times creeps into this present study is simultaneously an essential feature of western institutionalised knowledge and evidence of an epistemological imperative that may be identified but lost in the moment of capture. It sets up a tension in my ethnography, a disavowal of evaluative impulses that can never be maintained, pitted against the constant threat of descent into forms of sociological moralism (cf. Chapter Eight). And by confessing my faithlessness in advance, thereby repeating the expiations of theorists before me, I am also suggesting resolutions are possible when the requisite disclaimers are in place, another move we will find anticipated in the labyrinthine theoretical constructions lacing the knowledge artefacts produced by health bureaucrats as they carve space for their data models and program logics (see especially Chapter Five).

The reader will not find solutions to these problems of re-representation offered here, but rather will find them identified in the ongoing moments of their intrusion, as partly a matter of engagement and part that of unavoidable mimesis. As Kathleen Stewart argues, there is a case to be made for admitting the impossibility of a complete expulsion of known problems through our perfect scripts, for acknowledging imperfectability, rather than attempting to emulate ‘problem-solving absolute knowledge’ in our authoritative analyses or self-proclaimed methodological innovations (Stewart 1996: 23). It could be, she speculates,

that the ‘new ethnography,’ ...could make a space for such inevitable failures rather than rush to contain them in a discipline of correctives and asides that dreams, once again, the old dream of the perfect text in new textual solutions such as author positionings, formally dialogic presentations, ironic distance and self-reflection. Without such a space for imagining the inevitable failures of representation, new claims of textual solutions to the political problems of subject and object, meaning, difference, and cause take on the gray tint of a new positivism. (Ibid: 24)

Furthermore, when failure is its own aesthetic (Riles 2000), identifying shortcomings simply re-presents the transcendent critiques of participants, when the anthropological quest, it seems to me, is to evoke, however imperfectly, the moral order which frames and enables such denunciations to occur. Or, more precisely, the task is to render the specific characteristics of living in, learning, upholding, reinventing, modifying, and giving shape and content to cultural life. In this case, to bureaucratic life in a rapidly transforming yet remarkably consistent (or perhaps better, circular and spiralling, ever returning to same points with new amendments) post-colonial democratic capitalist context. It is not enough to foreground one's own participation, because the ethnographer is always already 'inside'. And since, as de Certeau reminds us, paraphrasing Wittgenstein,

one does not 'leave' this language, since one cannot find another place from which to interpret it, since there are therefore no separate groups of false interpretations and true interpretations, but only illusory interpretations, since in short there is no way out, the fact remains that we are foreigners on the inside— but there is no outside. Thus we must constantly 'run up against the limits' of ordinary language... (de Certeau 1988: 13-14, original emphases).
Approaching policy

Curiously enough, not all ethnographic studies of organisations consciously run up against the limits of what I am identifying as issues of historical and epistemological replication and entrapment. To take the newly emerging genre collapsed under the category 'the anthropology of policy' at its word, the task is quite clearly to take government logic beyond its own ideal or meta-accounts to instead expose what public officials seem to deliberately obscure from themselves and others. A recent example, entitled *Anthropology of Policy: Critical Perspectives on Governance and Power*, edited by Chris Shore and Susan Wright, clearly announces its detached critical intent:

We ask: how do policies 'work' as instruments of governance, and why do they sometimes fail to function as intended? What are the mobilizing metaphors and linguistic devices that cloak policy with the symbols and trappings of political legitimacy? How do policies construct their subjects as objects of power and what new kinds of subjectivity or identity are being created in the modern world? (Shore and Wright 1997: 3).

By 'problematising 'policy' the authors hope to reveal its inherent interest as anthropological phenomena (which) can be read by anthropologists in a number of ways: as cultural texts, as classificatory devices with various meanings, as narratives that serve to justify or condemn the present, or as rhetorical devices and discursive formations that function to empower some people and silence others. (ibid.: 7, emphasis in original).

Approached as texts, the focus centres on the language of governmental policy as written 'thing.' The object, as Peter Beilharz has separately put it, is that of 'seeking to understand policy better than its authors, to locate and identify the meanings in the text, in its language or perspective rather than in its (often instrumental) intentions' (1987: 393, see also Iannantuono and Eyeles 1997).

Now, provided that institutional actors themselves are not completely confused with their textual emanations, a focus on policy texts and critical readings of the same is not necessarily a problem, particularly since an unavoidable feature of contemporary government bureaucracies is the enormous volume of textual media produced therein. Yet what tends to happen is that the interactivity which produce the countless forms of institutional documentation that are deconstructed for signs of governmentality, itself remains incidental, and not central, to anthropological analysis. Bureaucratic performance and agency are merged with and substituted by—in being regarded as a derivative symptom of—completed and published textual products. Such a disavowal of physical presence, by the way, is one which bureaucrats also reproduce in their own disembodied and sanitised representations of what they produce and how they get to do so. It is all truly fairy work, products untouched by human hands. Yet, as this thesis will argue, a significant volume of seriously elaborate and intensely personal cultural work pours into creating and sustaining impersonal and de-authored institutional products. As Bruno Latour notes of technical articles, far from being impersonal 'the authors are everywhere, built into the text' (Latour 1987: 54).

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30 Examples of relevance to the issues pursued in this thesis include Bell (1997); Burawoy (1979); Foner (1995); Gill (1995); Kidd (1997); Peterson (1994); Reynolds (1981, 1987); Rowse (1992); Schwartzman, (1993); Shore (1996); and Wright (1994a).
My objection to ignoring the surrounding life that sustains bureaucratic artefacts is more than methodological, as these last points also make clear. Anthropological analyses which are primarily acts of critical reading can impose a subject-object divide which, in the very act of privileging the printed artefacts that are produced by policy formulators, separates texts from their conditions of production. In a strange substitution, policy objects are endowed with an affective dimension denied the formulators; policies act, they have political effects, they transform and transfigure, they are well- or ill-regarded, they use words strategically and intentionally with a view to regulating and circumscribing the options of others. We might say the objects are subjects and the subjects objects in anthropological analyses of governmentality, or, to restate this another way, of policy animism. The intents of bureaucrats are lifted from their documents, and out of the world of their daily practice and action, with resulting magisterial attributions aligning rhetoric with agency, semiotics with epistemology. And anthropologists assume a place alongside other political commentators as informed outsiders bringing the political effects to light.

Again, I need to be clear. I am not suggesting that the semiotic density of policy texts should be discounted. On the contrary, bureaucratic writings are condensed sites of meaning; they are, after all, explicitly interventionist and intentionally persuasive (Apthorpe 1997, Beilharz 1987, Davis-Floyd 1998), and this certainly needs to be accounted for in renditions of institutional action. As they operate at the government level, official policy formulation processes are also heavily procedural, oftentimes involving parliamentary assent; and always involving inter-departmental negotiations, the presence of advocates and dissenters; the contested dispensation of budgetary allocations; and so forth (Barret and Fudge 1981, Hogwood and Gunn 1984, Lindblom 1980). But I am arguing that the rhetorical weightiness and recognisability of government documents emerges out of the dramatised, embodied interactions of multiple authors who are adept in designing the condensed and multiple meanings that analysts later delight in decoding. It is these actions which are paradoxically put to one side in analyses which focus on texts alone as the distillation of state power, or alternately, as purely aesthetic devices without practical effect (compare Riles 1998).

So, is this an ethnography of policy? Yes—and no. Generally speaking, policy is what bureaucracies do. Interpreted broadly, 'policy' includes statements and directions by ministers, departmental policies, operating rules, regulations, guidelines, procedures, and industrial awards where these dictate or shape accepted ways of doing or at least explaining things. The THS members described here all operate within policy frameworks. At times they invoke the policies they are affected by and charged with implementing as if these control them. At other times, especially when they are invited to participate in policy discussions, they talk as if they are the ones doing the controlling.

Yet, in this ethnography I do not so much want to re-invert the subject-object divide of policy to give all agency to players and none to texts, or vice versa, but to adapt from Alfred Gell the

31 See also Fischer (1996) and Majone (1989) for a full discussion of literature which treats policy rhetoric as a subject in its own right.
notion of policy texts as transactional indices, to consider policy as a relational practice, with an emphasis on its ‘being-in-the-world.’ By this I mean to unbound the concept of policy from its key place as a sign to instead focus on it as a site of experience, where elements of adhocery, serendipity, routine and formula are merged, like ritual events the world over, blending new fashioning and spontaneity with past practices and known rules for performance (cf. Fabian 1990). These issues are taken up and explored ethnographically in the following chapter, where, by using a case study of policy ‘in flight’ (specifically, efforts by the Northern Territory Government to outsource the management of all five of its public hospitals in 1998–99), I explore the liminal and routine modalities of policy creation as these are enacted by practitioners.

Admittedly, it is an unusual case study with which to open an ethnography professing to be about professionals embroiled in the furtherance of Aboriginal public health. An extended description of how corporate plans and hospital policies are co-produced may not seem directly related. But the very selection of this case study reflects the major challenge of this thesis, which is to strike a balance between what might be glossed as a structural approach (that is, one that is concerned with sociological, historical and political-economy issues), with a phenomenological approach; or between a macro and a micro analysis. To explain briefly, in the doing of bureaucracy, peaks and troughs of attention and crisis are an exact description of how policy concerns come to be experienced. For the senior managers and policy analysts involved in orchestrating the movement of endorsed or formal ideas through the organisation, Aboriginal health, like issues of hospital management and corporate planning, violence against nurses or organisational restructures—erupt as the issue that matters most on a recurrent but intermittent basis—jostling for attention with other, equally insistent concerns, taking over as the paramount issue for one moment, reducing to a simmer in the next.

It is by pursuing the pressing topics of the day as they are picked up by Territory Health Service players, by tracking the details of policy formulation in their very mode of transaction, that the ordinariness of what feel at the time to be unique and dramatic events becomes clear, and the importance of bodily interaction to the creation of formal documents can be revealed. The way policy events sweep people into intense and yet essentially repetitious involvement itself expresses an essential characteristic of institutional work. By capturing policy dynamism before and as the plans and strategies harden into a residual policy record, by entering the embryonic turbulence of the space ‘between the pen and the paperwork,’ where the distinction between writing and speaking is suspended and the texts that are clearly marked for symbolic elaboration in a public and legislative arena have not yet attained the insistent presence of formal historical documents, I hope to create something of the sense of the everyday world of bureaucrats as they, and I, came to experience it. The sense to be taken from this is how the players involved adjudicate the momentarily paramount, how they surf the seemingly capricious eruptions of their workday worlds, to be swept up in the all-consuming, adrenaline-surging, momentous issues of the moment, to nonetheless reliably issue invariably predictable products which reinstate familiar logics (cf. Ferguson 1990: 55–73).
A key to understanding what motivates returns to the fray, to what I call the dynamic inertia of institutional activity, is that within the essentially repetitive work of creating bureaucratic forms is a re-conjuring of novelty, in both the sound of the content and the social feel of the enactment. This will turn out to be one of the key features of THS knowledge production, and it would be a mistake to consider it unique to Aboriginal health subject areas alone or conversely, to issues as grand as organisational restructuring and hospital corporatisation attempts.

The motif of failure also makes it first appearance in the following chapter, operating in its common guise within policy discourse as the necessary construction of a problem— a deficiency, an inadequacy, a redundancy—that requires a solution in order to validate the ‘change’ directions being proposed. As Niklas Rose and Peter Miller describe it, ‘The ideals of government are intrinsically linked to the problems around which it circulates, the failings it seeks to rectify, the ills it seeks to cure’ (Rose and Miller 1992: 181). The articulation of difficulty and failure, inadequacy and underdevelopment, of issues requiring resolution, even the delimiting of resolutions possible, form the programmatic task of policies, always to be posed in terms of their own indispensability. In the case presented in the following chapter, the public hospitals, and more broadly still, THS’ historical overemphasis on direct service delivery, are identified as pressing problems which only a complete reorganisation of the department along corporatist lines can remedy.

Chapter Three picks up the thread of failure in its more historicised guise and also establishes something of the ethnographic setting in its historical, geographic and structural entirety. Here I look to the uses that are made of history in the everyday registers of program talk, and its mixed mode of application in attributing responsibility for failure and gain in the Aboriginal health arena. I argue that in THS, Aboriginal people are not so much people without history (cf. Wolf 1982), as people burdened by too much history, while health professionals are configured as those empowered by history to remove the negative imprint of their colonial forebears from burdened Aboriginal bodies. The antagonisms of intergroup transactions and efforts at coordination within THS are also briefly described, the better to establish the ethnographic context of my study. At the same time, I attempt to explain the impossibility of such contextualising devices when these very same devices are used within the narrative frames of institutional actors to contextualise their ethnographic others too.

In Part Two of this ethnography, entitled ‘Absorbing and Delivering,’ I develop different models to explain the structured character of people’s expectations and formulations, in the turbulent midst of individual experience and everyday affect. Throughout this section of the thesis, my aim is to explore the contingency of the irresistible to ask what makes public health approaches in Aboriginal health not only thinkable but intellectually irrefutable, even in the discordant midst of practice? To put this differently, how do dominant typifications of self and other emerge in highly intellectualised, dynamic and reflexive environments which are supremely sensitive to issues of personal independence and difference? Specifically, Chapters Four and Five are concerned with the kinds of things people say repeatedly about the problem and solution of Aboriginal health, and with the resilience of diagnosis and prescriptions for remediation.
Here I attempt to trace the mechanisms through which the knowledges of public health, or as Emily Martin puts it, the 'underlying grammar of what people bring to a discussion' (Martin 1994: 14), are absorbed, without losing sight of the fundamental diversity of individual elaborations through which these underlying modes percolate, and the tensions involved in their articulation. As I will show, when health professionals probe and reflect on their experiences of attempting to help Aboriginal people, they simultaneously revise, debate and through contestation reaffirm already accepted social knowledges. Chapter Five looks to the social life of health facts (cf. Appadurai 1986a), at how they are picked up and reformulated into prescriptions about what Aboriginal people need to know in order to be healthy, in turn revealing the tremendous ability of the (modern) bureaucratic mind to reinvest that which has been abstracted from its social basis with magical properties (cf. Taussig 1999).

In the final chapters of this ethnography, the focus moves to embodied arenas of racialised encounter within 'the field.' Where earlier I argue that statistical abstractions transfix bureaucrats, in Chapters Six and Seven I suggest that the surplus of symbolic images about Aborigines have acted upon the health professionals, to the point where they are incorporated and carried into 'intercultural' encounters, encounters which typically have both a surface normality and a surreal lack of engagement. As I will demonstrate, there is a style of operating in THS public health practice that is at once intensely engaged with the question of Aboriginal peculiarity and yet disengaged and strangely uncurious about key aspects of everyday life. This disengagement continues even when health professionals are within close physical proximity of Aboriginal agents and earnestly desiring that elusive community development pre-requisite, 'the good relationship.' To explain how this may occur, I draw upon phenomenologically-informed concepts of embodiment and perception to argue that professionals retreat into corporatised body postures in zones of cultural (in)difference.

The chapters which follow from this one thus look at what might be thought of as sites of policy response and uptake in the work of regional officers, or the research concerns of epidemiologists and statisticians; sites which, as Ball reminds us, must also be viewed as arenas of creative social action (Ball 1993: 13). Yet though the emphasis in the following is on policy as it is conjured into being by its formulators, and while the enactment of policies is a major theme of later chapters, it should be noted I have not attempted to follow the detail of any one particular project through all its stages of conceptualisation, planning and implementation.32 This is a deliberately resisted representational strategy, for, despite having assembled longitudinal data on the ebbs and flows of a number of different projects and programs, what has struck me most about how people learn to operate within Territory Health Services is the fluid and rapidly changing processes and connections that constitute what are simultaneously densely repetitive fields of activity.

32. But see James Ferguson's seminal study of development discourse for a highly effective example of such an approach (Ferguson 1990).
In the attempt to channel attention to how policy facts, or better, how institutional knowledge forms, are embodied, transmitted, interpreted, played with, taken up, rejected, re-represented and otherwise made into seemingly new phenomena within the particularities of local interactions, I have purposely ‘scattered’ the case examples, to give some sense of the manifold filaments that institutional actors must dedicate so much of their effort toward reweaving back into coherent program scripts and activity explanations in order to operate with effect. Operating with effect is itself a subject pursued in this ethnography, for this is also a major focus of attention for institutional players—the interactional performances that spin texts and proclaimed instrumental actions into existence, almost as a by-product of practitioner interaction and power maneuvering, being so all-absorbing they demand constant practitioner, and hence ethnographic, attention. My narrative tactic of disassembly, then, weakly soldered with sufficient contextualising information to lessen confusion, is designed to evoke the knowledge practices of bureau-professionals without falling too far in the direction of prescriptive judgement on the one hand, or suspension of meaning on the other.

It should also be noted at this point that many parts of the organisation are ignored in this thesis, and many questions relating to its organisational structure not taken up.13 I focus in detail on the activities and conceptualisations of people operating in the data and policy, training and public health operational arenas, as these are all sites where the focus on forming and maintaining a progressive organisational identity—whether this be as a liberal social worker or as an astute manager—is most explicit; but this has meant leaving aside many other domains of expertise and practice of equal interest and importance.

The hospital network, for instance, our starting point for a focus on policy-in-the-making, is not examined further in its own right. Moreover, while such factors as the workings of managerial hierarchy, and the changing nature of corporate ideologies have been incorporated into my analysis, this is not a study of the formal or structural properties of Territory Health Services, except, once again, as these are experienced and enacted by inhabitants. Finally, the question of how the administration is ultimately funded, and the political interests it serves, are not really pursued here, except in passing. These relationships form the backdrop to the phenomenal world of THS bureaucrats, the ‘stakeholders’ whom they deal with, the environmental matter they scan in, the ideologies they espouse or reject, and are treated as such here in the spirit of ethnographic intensification.

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13 Briefly, THS formally operates from the ‘centre’ in Darwin through a consortium structure whereby staff employed and paid by THS work in a variety of clinical and community health, corporate support and administrative positions in a variety of settings covering urban and remote areas. Many non-government organisations with a health and/or welfare focus are also funded, promoted and given organisational direction by THS, including remote area clinics that are officially designated as controlled and run by Aboriginal people (cf. Fisher 1997). In its self-defined snapshot business profile on the web, THS gives an idea of its client range as follows: ‘The Northern Territory of Australia is big—1.3 million square kilometres—the size of Italy, France and Spain combined. There are two main urban centres and ninety small communities spread across the state. These communities include small towns, cattle stations, mining communities and Aboriginal settlements’ (http://www.intel.com/in/eng/eBusiness/casestudies/snapshots/ths.htm). For a more detailed description, see also Chapter Three.
Nor have I attempted to develop a coherent theory of why institutional practices perforce re-elaborate themselves, a major theme of this thesis, although a Foucauldian response constantly tugging at the margins is that there is no authorial centre for the institutional ability to distribute self-replicating practices, as it is a dynamic which exceeds individual actors. Describing the development games played out in Lesotho, James Ferguson also suggests that the transparent good of community development ambitions (to improve amenity, save lives, grow food, empower, educate) obscures the extension of governmental power such goals actually facilitate:

By making the intentional blue-prints for ‘development’ so highly visible, a ‘development’ project can end up performing extremely sensitive political operations involving the entrenchment and expansion of institutional state power almost invisibly, under cover of a neutral, technical mission to which no one can object. (Ferguson 1990: 256).

Yet, as I know Ferguson would agree, it is too simplistic a truth to say bureaucrats depend on black impoverishment and ill health for the extension of their own positions (and incomes) as helpers. It is as true to note that the prosperity of the west depends on the poverty of the rest, and leave all explanations of enduring inequality at the door of this indisputable claim. Like evaluations, when we stick to explanations which rest on ultimate functions and cause-effect outcomes, we are left with nothing to say about its human elements and the magic inherent within claims to rationality. While it may be all a form of self-interested governance, it is also—my argument—an epistemology, a faith, a language, an aesthetic, an economy of knowledge and a distillation of the truths of life as they matter to a people in a place and in a time. Pressed to the point I would argue that, like most cultural forms, bureaucratic modes of being in the world are reproduced as if they are the only form of life imaginable, which corrective fine-tuning through critique only serves to affirm.

To summarise the organisation of the remainder of this ethnography in few words: where my first set of concerns is to mark a space for the tactical agency and organisational dynamic of administrative work, and the second is to understand the institutional mechanisms through which public health workers come to know what they need to know to be regarded as fluent within bureaucratic fields, the third is to understand the subjective, symbolic and political effects of that work when people are in ‘implementation’ mode. In conclusion, I start where I began, with a sense of wonder at the creativity and energy that goes into sustaining the emotional intensity, the puzzles, myths and facts, the surges and repetitions which are, to paraphrase Taussig’s description of male initiations, ‘if not the source, then at least the drama by which [THS] reproduces itself through the medium of persons’ (1999: 136). There is magic-making in bureaucratic work, that heavy-handed and falsely pacifying appeals to power, discourse, globalisation, complicity, (obstacles to) democratic participation, rightness or wrongness, cannot hope to give expression to.

All this to say, anyone doing fieldwork amongst bureaucrats has first to deal with the long shadows cast by pre-existing theory about who bureaucrats are and what they represent, if ever they are to grasp the passion ‘between the pen and the paperwork’ and thus recuperate the interactional practices through which the state navigates its products.
To paraphrase Vega,

_Between the pen and the paperwork,_

_There must be passion in the language_  

_Between the muscle and the brain work_  

_There must be feeling in the pipeline._

But in social scientific hands:

_All feeling_

_Falls into the big space_

_All feeling [is]_

_Swept into the_

_Avenues of angles._
Chapter Two

Wording

Between the Pen
and the Paperwork
Chapter Two

Wording

On March 16th 1999, after a whirlwind period of intense bureaucratic activity, the Northern Territory Cabinet convened to decide the management fate of all five of the public hospitals sited in each major township throughout the Territory. Senior THS bureaucrats hovered in their offices, vibrantly tense, like so many stockbrokers fixated on the cue that will tumble the index. Waiting, concentrating, scanning, hardly daring to go out, poised for the first signs of decision to break. Their work—last-minute-meetings, exhausting drafting and collating, corridor dashings and frenetic into-the-small-hours-of-the-night type of work—teeter on the brink. Already at the second stage of the tendering process, rumour has it that the Sisters of Mercy, a Catholic order with an extensive hospital management profile in the southern states, are the favoured applicants in the shortlist of companies to be invited to proceed beyond ‘expressions of interest’ to the ‘best and final offers’ phase of the bidding process.

It is almost a foregone conclusion. The nuns will lend credibility to an otherwise highly controversial attempt to outsource the management of the entire public hospital network. It all computes. But still, schooled in anticipating the unanticipatable, the bureaucrats sit tight, confident that their predictive work will hold true—the hospital management will be outsourced—but even more certain that theirs is a world of incremental adjustments, where nothing is certain until it is retrospective and the unintended can be realigned to an original intentionality. So they project, and they wait.

The next day, March 17th 1999, the official announcements are finally made. With front page headlines of ‘Govt scraps plan to privatise hospitals’ (English 1998), the then Chief Minister of the Northern Territory Government, Dennis Burke, declares his Cabinet has decided against proceeding with their bold outsourcing plan. With this announcement, over a year of bureaucratic activity slide into oblivion. And yet, as opacity smoothly returns to the health bureaucracy with the daily media exposure of the previous months now removed; as policy formulators shift gears back to a less breakneck speed; and near and far stories explaining ‘what really happened’ spin into circulation, ‘stirring the mix of the known with the unknown, moving rumour and ambiguity along the chain of storytelling’ (Taussig 1999: 65-6); steps toward the corporatisation of the health sector continued stealthily apace.

The Uncertainty of Certainty

Between these liminal moments in early 1999 and August of the year preceding, when I first re-entered the world of policy to be swirled up in its turbulent motions as a bureau-anthropologist, what is the outcome of greatest anthropological note? An account of the reasons underlying the eventual ‘failure’ to privatise the management of public hospitals? The actions, conflicts and
rationalisations of public servants faced with such potentially massive organisational change? The public's successful 'resistance', the way they overcame obstacles to citizen participation to overturn unwanted government decision-making (Futrell 1999: 494, cf. Habermas 1989 (1962))? The global context to the ongoing push to have public sector agencies operate according to formulaic market principles? Or, as a related point, the transfer of public services, once thought of as the exclusive responsibility of the state, to profit-making firms (Dean 1994, Wiltshire 1987, Yeatman 1993)?

While this chapter certainly takes in all the above issues, my concern here is with the setting of policy. Not, as I've already been at pains to stress, policy understood as textual artefacts to be deconstructed for their semiotic and referential significance, but rather policy as intersubjective action and embodied process out of which political effects and texts are generated. Thus 'the setting of policy' is here literally about the settings in which policy writing takes place and about the setting or the placing of policy words. I focus on three aspects of the privatisation proposal: the way people were interpreting events as they unfolded, splicing fragments of information into a mobile narrative of accounting; the aesthetic work involved in producing good policy texts; and the related interactional work involved in performing one's involvement in bureaucratic productions.

Before I cut to the policy case study at hand, some further definitional footwork is briefly required. I want to propose some ways of analysing policy which relocates it as a dynamic or interaction between agents, rather than strictly as a discrete product, although clearly it can be seen as both at once. And in that move, I further suggest three main starting points for investigation.

Policy can be analysed first of all as in and of discourse (Apthorpe 1997, Ball 1993, Beilharz 1987, Fischer and Forester 1996, Rose 1993). That is to say, it can be understood as a transmission of state rationality which, as a conceptual field, is inscribed into principles for rationing and assessment, and forms part of the expertise of bureau-professionals and often too of the citizens whom they attempt to regulate. The analytic task here is to examine the justifications used, the conceptualisation of appropriateness and worth, the notions of a proper distribution of risk and choice, and so on. Here, policy language is clearly not only about persuasion and classification, justification and manipulation; it is also performative (Butler 1997).

Second, it is clearly not only language that performs—speakers do too. Focusing in on policy's performative elements, it soon becomes clear that practices of reading and deconstructing, and embedding an excess of meanings and sources within texts, is what policy practitioners actually strive to do. That is, in making the shift in perspective from products to their human production,

34 It should be noted from the outset that while outsourcing proposals certainly represented a new crisis for Northern Territory bureaucrats, it was still one moment in a much older transnational reordering of welfare services in the name of rational efficiency; a reordering which has seen ordinary citizens become shareholders of formerly publicly owned and managed assets (Hancock 1999, Maetzelfeldt 1999, but see also Pierson 1994). Recent examples have seen Australian Governments (state and federal) more or less painlessly and even popularly constraining future welfare program budgets by systematically reducing contemporary revenue sources. This has been achieved via a number of mechanisms: through asset sales (such as the recent partial sale of Telecom, now Telstra, which has inveigled members of the public into the enterprise loop as shareholders); or through such decentralist policies as the defunding of public education by freezing allocations and tagging per capita dollars to students as they shift to the private school sector, without replacing the unit loss in the public system. As this will be felt by a currently unspecifiable and therefore non-coalesced group of future parents, the cuts are simultaneously long in the making and foreclose opportunity for concentrated collective anger.
we also find that the work of textual analysis is, as Riles would put it, work already done. The academic's deconstructive styles are anticipated in what bureaucrats themselves do—albeit with different effects and for different purposes—frustrating nonetheless a key technique of analytic effort, that of lifting layers as if to reveal the concealed. For participants, policy formulation requires close reading strategies as part of both the work of scripting and of performing virtuosity in the co-presence of others. Despite my clear irritation at constructions which over-emphasise the instrumental coherency of discrete policies, as if the task of anthropology is essentially one of reading, deconstructing texts is intrinsic to the ethnographic domain at hand. A close reading of the pro-privatisation argument at the outset will thus help clear a space from which to see how the same content that matters so much to social scientists bent on exposing policy's latent meanings, is likewise a concern for policy analyst—for whom the immediate power of language, to convince, contain, act and do work is subjected to endless scrutiny and dissection.

Close textual readings merged with close ethnographic description are also among the few strategies available for glimpsing the otherwise opaque background of compromises, things that couldn't be said, the negotiations and hard struggles over wording and accent. the other policy trajectories that were present in notional or embryonic form or perhaps even developed to a final stage before being rejected, like so much footage on the cutting room floor. For just as policy wording has much of the imprint of its chaotic conditions of production obscured through its self-presentation as the outcome of an orderly, sequential and historically necessary movement, so too policy players untether their written and formalised products from their own relational activities. They too ascribe agency to what they emit, as their own involvement blurs into the background.

Indeed, as I will show, in THS, it is an artful accomplishment to have policy achieve a naturalistic appearance as emanating unsolicited from the arena of community advocacy, rather than from the administration. A well worded policy will often assert a pre-state, authentic identity originating from a 'real' of historically-based client need, 'discovered' through consultation, rather than its contrived proxy. To the reader, listener, enactor or target of policy, the argument should appear as pre-given, with few alternate narratives available within view. This achievement is not only wrought out of a careful selection of words and a clever choreographing of stakeholder inputs, although both these factors are at play. It is also the result of a retrospective attribution of clear logic, and with that attribution, a denial of what are often extraordinarily chaotic conditions of production. Complicating this further, the work of preparing for retrospective straightenings takes place prospectively. Policy practitioners iteratively prepare themselves for later re-alignments by developing infinitely adjustable interpretations of unfolding events along the way, so that whatever the outcome, it can always be accorded an original intentionality, or at least explained as a loss with a correcting and thus equally vindicatory little homily. I will argue that an ironic disposition is critical to this in-situ preparation for the certainty of uncertainty at every stage.

35 The notion of 'the real' in bureaucratic terms is fluid and contradictory, as often as not a convenience of argument as much as a constructed imaginary, always pointing beyond the circumstances of bureaucratic construction to groups, pressures, ideas that are deemed to have more substance than the here and now. These issues are pursued in more detail in subsequent chapters and discussed specifically in Chapter Eight.
Which leads into the third point, in actuality a combination of the preceding two, which is that policy can be analysed as a space of mundane and dramatic interaction, in which the people involved at the heart of scribing policy determinations, the actors at the epi-centre so to speak, become the main focus. My main ethnographic challenge lies in capturing some sense of how the backstage participants live out the technologies of government, or what Nikolas Rose calls

the complex of mundane programmes, calculations, techniques, apparatuses, documents and procedures through which authorities seek to embody and give effect to governmental ambitions

(Rose and Miller 1992: 175).

Thus, this chapter looks at the interplay between the performances embedded in policy discourse as discourse, and in the surrounding actions of those producing such discourse. I will argue that while all institutional texts are hard-working, not all texts are created equal. For an institutional product to be adjudged as having the right look and feel, its processes of fermentation and the virtuosity exhibited by its collaborators come into play. A text’s success is also evaluated according to criteria of incontestability. People work hard to create not only a persuasive text, but an unarguable one, a quality which, as I argue below, requires the tactical deployment of hard-working yet ubiquitous words. Finding these words through collective processes of scribing is indescribably exhausting, yet, and this is my key point, there is an excitement to the creation of banality, a deeply personalised aspect to the creation of the impersonal, inoffensive yet rectifying text, which goes to the heart of understanding the addictive and frustrating nature of bureaucratic inhabitation.

To explain something of the compulsion associated with bureaucratic involvement (a much wider theme than this chapter alone), here I confine my attention to the intense emotion that bureaucrats feel when surfing policy events, to the captivation of creating unarguable words, to the seduction and pleasure of being regarded as an instrumental player, however caught in a production chain as a replaceable link an individual may actually be.

One final set of orienting remarks need to be made. The events described below condense activities that took place over a two year period, events which I entered approximately half-way through, pursuing a brief to write a Ministerial Statement.36

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36 In my former role as Executive Adviser to the Chief Executive Officer of TIV, I had been responsible for preparing an earlier Ministerial Statement in 1997. 'Outlook for Health Services' (Seventh Assembly First Session: 22/04/97 Parliamentary Record No.32: http://www.gov.nt.gov.au/lant/hansard/HANSARD7.NSF, warning of the dire consequences the public could anticipate if it did not share the pain of health financing responsibilities. The second Statement was to update this first, along the lines of a 'where have we come from, where are we heading' theme, in readiness for the November Sittings. The 'Sittings' are scheduled occasions when the full house of Parliament meets, and in the Territory occur six times per year, lasting up to two weeks at a time. While the majority priority for the elected Government during these periods is to see its policy legislation passed, the Sittings are also occasions when the Government uses the mechanism of the Ministerial Statement to give particular issues prominence. Ministerial Statements are essentially speech documents which can take up to forty minutes to be read aloud to the Assembly. They are in no way considered routine but rather as extraordinary opportunities for Ministers to have uninterrupted periods of critical parliamentary time to showcase their polemical command of the issues within their particular portfolio/s, and for bureaucrats to have the arguments surrounding key initiatives sounded out in more detail than legislative discussions ordinarly permit, knowing they will circulate to a wide audience of other institutional players—unions, non-government organisations, companies, media outlets, other bureaucracies. If the issues being highlighted are not overly controversial, it is the convention that copies of the Statement will be pre-circulated to members of the Opposition and key advocacy groups to promote engagement and a greater likelihood of publicity. To have a Statement listed for attention is equally no minor matter. A specific-purpose Cabinet Committee adjudicates the appointment of speaking time—matters outside immediate legislative concern must be argued and lobbied for, with more senior Minister’s putting the case for their juniors. The ease or otherwise with which a Minister can command Ministerial Statement time is thus a signifier of his/her standing within Government. In sum, they are not seen as opportunities to be squandered, either by the Minister and his/her staffers, or by the bureaucrats charged with providing material for the performance.
From the outset I received mixed messages about the nature of my task, a natural confusion which I have attempted to render below by breaking up the chronology. But in the interests of clarity, a synopsis of events is as follows.

In 1998 and 1999, the NT Government considered outsourcing the management of its public hospitals, as an abridged form of privatisation. In the end, it didn't happen. Overtime it became clear that the bureaucrats were not in control of doing the leg-work for the hospital project, which was instead in the hands of a private consortium, Hospitals Development International, and a schism developed between the senior managers of the health bureaucracy and the office of the Minister for Health, which deepened to crisis point toward the end of 1998. At the time of my entry as ethnographer-bureaucrat in August 1998, senior health managers and policy officers had only just begun to hear whisper of how seriously the Minister was considering the outsourcing idea. Up to that point, the bureaucrats had been involved in developing what was felt to be a momentous policy shift of their own, a new strategic direction they called 'Strategy 21', which they were expecting the Minister to make a key note address about in the November 1998 Sittings of Parliament.

**Funding Hospitals: A Problem of Good Government**

Turning then to how the Minister first announced the Government's intention to seek expressions of interest from private companies interested in managing the hospitals on the Government's behalf, I begin with a close analysis of his key note address to the November 1998 Sittings of the Northern Territory Parliament, noting ahead of time that it ignores Strategy 21 almost entirely.

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**Part 1—Debates—Tuesday 1 December 1998 Eighth Assembly First 01/12/98—Parliamentary Record No:13**

Mr BURKE (Health, Family and Children's Services): Madam Speaker, I rise to support my colleague, the Treasurer's statement and to give the House a more detailed explanation in regard to the government's proposals on hospital services.....

This government is committed to delivery of ongoing improvement in the health status and wellbeing of all Territorians. As we pursue this aim, 3 key questions are constantly with us: What is it that government should fund but not do?; what should it both fund and do?; and what should it not be in the business of at all?....

Two weeks ago, Cabinet endorsed a plan to test the market and seek expressions of interest from the private sector for the management of public hospital services. The private operator option is conceptually very simple. It operates as a 2-stage process.

Step 1 sees us calling upon a cross-section of hospital providers to enter into an arrangement with government to manage and develop publicly-funded health services under strict contract conditions. This is just the same as getting an obligation-free quote, only in this case we are asking experienced private sector operators, who between them provide close to one-third of all hospital episodes of care in Australia, to submit their assessment of what could be done in the Northern Territory to improve hospital facilities, provide more services, upgrade our medical equipment and provide free public hospital services. This is not privatisation, which involves the selling-off of government assets and no further responsibility on the part of government.

If we move beyond this first stage, the Northern Territory government will still retain overall responsibility for public hospital care. We are not selling off our hospitals. We will know if the private sector is interested and able to meet our full expectations by March next year, when expressions of interest have been fully costed and assessed. Then, in step 2, if the options put to government present a convincing enough case, the public sector will be buying hospital services for the public, just as it currently does, this time using a private rather than a public sector management arrangement. The vision is for a systematic upgrading, redevelopment and refurbishment of all our hospital facilities.

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*Figure 5: Opening remarks, Health Minister's Statement (1/12/1998)*
After a mandatory acknowledgement of the ‘dedicated services of many health workers and support staff’ who are responsible for ‘the huge improvements in the general health status of Territorians that we have witnessed over the past 20 years,’ the tempo quickens. Scrolling down, a rapid accumulation of problems form the rising action:

Firstly, there are the unacceptably high levels of sickness and early death within Aboriginal groups and the extraordinary and upwardly-spiralling costs of end-stage renal failure, injuries and respiratory and heart disease, which are well known to all of us here. Put simply, Aboriginal Territorians have drastically poorer health across virtually all causes of disease. Life expectancy at birth for indigenous men in the Northern Territory is 57 years compared to 77 years for other male Territorians. For indigenous women it is 61 years compared to 83 years for other women.

Aboriginal health disadvantage is further reflected in Territory Health Services gross health service expenditure. Well over half of our total spending is on a quarter of the population, yet there are no incentives in the current system to produce preventative health outcomes beyond the use of more resources and nothing to force practitioners across all fields to tie their activity to underlying causes. ....

Secondly, we continue to have limited remote area access to well-resourced primary level health services, because the federal finance system reimburses the use of pharmacies and general practitioners, but not the use of allied health professionals, Aboriginal health workers or nursing staff....

Thirdly, we have the highest long term growth of any jurisdiction in this country with associated age-specific and whole-of-life health needs....

Finally, at 25%, we have the lowest percentage by far of people with private insurance in Australia, with only 3.6% of these electing to be treated as private patients when they enter the public hospital system. .... When it comes to determining what each state and territory's hospital funding should be, the Commonwealth deducts that quarter of the population who have private insurance from our overall allocation. Then, when this same privately-insured and therefore non-funded group elect public patient status, and they have little choice, the Territory picks up 100% of the tab. The availability of private facilities is low, and this is combined with low numbers of private and correspondingly high numbers of publicly-funded medical staff. There are few choices for either insured patients or those who would pay separately for a specific private service if good options existed. .... From a health financing point of view, it places even more pressure on the Territory taxpayer to assume the brunt of hospital and community care funding. We are spending nearly double the amount per head of population than the average spent across Australia for hospital care, and more than 3 times the amount for community services.

Our ultra-public system, with its limited private providers, has created a massive burden for the public purse. Our physical facilities are in need of radical redesign, and we can anticipate massive capital works expenditure to bring our hospitals into line with modern integrated health care practices and same-day procedures. Our hospitals were designed using post-war notions of ideal hospital layout, which at the time stressed long-stay ward-based care. Yet the current and future trend is for short stays and greater integration of acute, with pre- and post-acute care, rehabilitation and community-based services. In the last 3 years, treatments delivered on a same-day basis increased from 23% to 26%, which just about takes us to our capacity in the present hospital environment....

In the past 5 years the budget for Territory Health Services has increased from $129m in 1993-94 to a projected $179m in 1998-99, growing into the future. In the 3 years since 1993-94, the overall THS budget went from $266m to $385m. And under the current regime, we can accurately predict pumping $500m into health by 2006. As I have made abundantly clear, this escalation cannot be explained away as the inevitable by-product of population growth. It is a high risk situation by anyone’s calculation.

Later pages witness the dramatic entrance of a rescue plot (the introduction of competitive enterprise into the outmoded and welfare-dependent hospital sector); followed by the only real option left standing after a rapid-fire elimination of rhetorically posed counter-arguments. ‘If we can get more out of the system and return it to people in terms of improved services, facilities and outcomes then our ethical mandate is clear,’ the Minister sagely concludes. Offered with simple dignity, the Government is morally bound, as an act of wise stewardship of public monies and electorally-entrusted pastoral responsibility, to carefully explore private sector interest in public hospital management on behalf of the Territory taxpayer.
Narrative framings aside, there are a number of other concepts broached here, laden with twists and pulls on loyalty and belief, which recur throughout the literature surrounding the attempt to introduce quasi-market features into the public sector, which, whilst not the subject of this chapter, deserve brief comment. The idea that the Northern Territory is penalised by unfair distributive mechanisms for allocating health care funding is a repeat claim in THS narratives, calling on particular representations of the economy, nation and populations of need. As the villainous ‘outsiders’ in this story, federal bureaucrats stand accused of bludgeoning the particularities of the Northern Territory’s resource-intensive demographic profile by treating health care as a national phenomenon, with Australia as the basic unit of analysis. The deeply and historically intertwined circuitry of state and federal funding is neatly separated into discrete enmities—Territory taxpayers and Commonwealth financiers—eliminating all forms of structural dependency from view.37

That health care costs are poised to rapidly accelerate is likewise a common trope in health sector discourses, calculated to create a demand (and thereby the justification) for greater fiscal control and debt management which only a wise government can put to effect. The power of uncontrollable cost spiraling to out-maneuver the innumerable previous ultimatums that were likewise aimed at cost containment is not flagged as a sign of administrative deficiency but instead feeds the fetishistic attribution of overwhelming agency to an ephemeral category, ‘costs’, such that they have the power to besiege, be unruly, take off, be out-of-control (cf. Taussig 1980a).

Witness also the appearance of probabilistic quantifications of Aboriginal ill-health as a problem privately-managed public hospitals are best placed to remedy. This is a complex twist on an oft-repeated argument which sees Aboriginal health status reduced to a reflex of health care funding. The argument, stripped to its essence, is that Aboriginal people are more unwell than current profiles are able to show, and more unwell than the current health care system can bear. Without the specialist diagnostic services a privately-run hospital would be able to offer, the true proportionality of Aboriginal pathology will remain unknown and further ability to treat their complex and multiple disorders impeded. In other words, while the Indigenous health report card is sufficiently bad to warrant immediate increases to acute care funding, until these extra services are in place and we are able to collect specialist data, we won’t be in a position to know how truly bad it all is and how underfunded we’ll really turn out to be. The long-standing differential between high Aboriginal illness rates (defined epidemiologically), and low Aboriginal hospital utilisation rates (defined as a bed-stay per diagnostic category or illness type), here becomes evidence of under-servicing,
syllogistically creating proof of more illness to come. At other times, the same sorts of data may be used to argue that Aboriginal people lack, in equal measure, both an understanding of their own illnesses and of how to respond with appropriate levels of recognition (alarm and hospital-oriented action). I shall have more to say about these issues in Chapters Three and Five.

One should also note the assertion of moribund architecture (see also Territory Health Services 1998a), an uncharacteristic disclosure when ordinarily government literature pronounces its asset base to represent wise investments well-maintained. Where only a few months previously great ceremony had attracted to a remodelling of the entranceway to the principal hospital, Royal Darwin—an architectural intervention designed, it was whispered, to sweep from sight the unseemly clusters of blackfellas escaping the high-rise air-conditioning for a smoke and the hailed greetings of countrymen by the front doors (cf. Coulehan 1995, Sansom 1980: chapter 8)—now the same refurbishment is derided. As the Minister put it in his speech, 'Historically, our reluctance to be realistic about the true management issues facing the health and community services arena, has seen us flirting with what are, in fact, relatively minor issues: hospital waiting lists, décor and the like.'

Now RDH is admitted to the realm of the disputable. It is eight stories too high, an ugly brick tower-block in a tropical cyclone-prone city closer to the equator than to any other capital in Australia, a town geologically famous for attracting to its ironstone ridges the highest lightning strike rate in the world. Now the Minister happens to recall that the blueprint for the original hospital design was bequeathed to Darwinites by ignorant Commonwealth bureaucrats, exactly duplicating the Woden Valley Hospital in the cold national capital of Canberra, which in turn reproduced a Canadian hospital from snow-bound Alberta. Now we learn of the abundant problems of ventilation, drainage, fire and flood protection, vermin sealing, water-proofing, electrical safeguarding and temperature control. Air-conditioning alone is said to cost $7000 per day, an expense made more astonishing by the singularly useless presence of snow shields barring the water-condensed, trickling glass windows which the badly-done-by RDH inmates must peer through to glimpse the mangroves basking in the lukewarm tropical mudflats on the horizon beyond.

'No-one can tell me I don't owe it to our staff and patients to try and get them something better. But try putting all 5 hospitals in the public sector capital works program and see how fast we get our new hospitals,' the Minister now says.²⁹

²⁹ The argument mooted here is that, with the right incentives, private operators would replace or refurbish the moribund old public hospitals with client-attracting boutique layouts by deploying the more flexible debt financing capacities of the commercial sector, bypassing the clumsy budgetary processes for major public sector capital works that befuddles and increases the expense of Government purchasing. Within the public sector, major capital works are ordinarily purchased within in moments of electoral largesse, which bureaucrats capitalise on by entering into a game of over-bidding and over-building (that is, of maximising projected usage and therefore the capacity requirements of what is being proposed), knowing it will be a long time before they get another bite at the major works cherry. (For detail on the problems of hospital 'overgrowth and redundancy' for governments, see Nesmith (1995: 8) and O'Brien (1997). On hospital topography and the changing nature of surgery in relation to building styles and the need to exploit health's luxury potential, see also Hamer (1986). Obscuration of costing data in funding bids is a well-known bureaucratic issue, as this financial manager explains, 'The traditional way of doing things is by the seat of your pants. You just need an envelope, preferably a used one, and turn it over and on the back you can do all the calculations you need. Those calculations traditionally forget about a lot of the costs, about half of them, and the second half of the costs we have to worry about some other time. The history of all of Royal Darwin Hospital and indeed every other hospital in Australia, is littered with examples of where we've done great things, we've under-estimated what it is really going to cost, repeatedly to the point where it becomes an expectation, or if you actually put up the real cost of doing things, people will just balk at it and good quality things would never get a Guernsey so we almost create a system where to under-estimate the costs to the future is a necessary evil in order to make progress.' (Transcript, August 1998)
Finally, the Minister reassures worriers, repeatedly castigated in the speech for their anticipated obdurance, (‘people whose allegiance to the status quo is set in concrete’, ‘those whose ideology will not permit them to ever entertain ... new ideas’), that under private management arrangements, there will no nursing or allied health redundancies, no loss of union conditions.

Lest this be seen as fanciful rhetoric, the alchemy is explained in some detail. Shareholder profit will be generated by creating a luxury niche for privately insured fee-paying patients to obtain boutique services (cosmetic and other forms of non-elective surgery); by integrating general practice and other ‘ambulatory’ (outside hospital) services into the hospital complex, thereby reducing the number of ‘coughs and colds and little holes’ appearing in the Accident and Emergency Department (the principal effect being to shift costs back onto the Commonwealth-subsidised Medicare system); and by flattening administrative hierarchies. Only the unenlightened, recalcitrant listener would hear this reasoning as code for eliminating middle manager administrative positions. And of course, the hospitals would continue to provide free acute care services to the uninsured under the strict terms of the Medicare Agreement.

The public would barely know the difference: the successful private operator would, as owner-builders, receive a fee to make the hospital network more con/temporary in the name of profitability, an arrangement which would operate just like any other form of contractual bill-paying in its invisibility to clients. It would be phased in over time, to build in an element of sensible caution (‘we’ll test the market first before proceeding’) and to allow the magnitude of administrative recalibrations to be absorbed over time, less painfully, more judiciously. learning all the while from the mistakes of other jurisdictions.

Irresistible.
Irrefutable.
Only none of it happened.

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40 'Coughs, colds and little holes' is a common diminutive used to describe the non-critical ailments which people present with in casualty wards—‘little holes’ being cuts or small wounds which require simple suturing.

41 Public hospital care in Australia is guaranteed through a universal (non-means-tested), compulsory system of health insurance called Medicare, in place since 1984. Funded through a progressive taxation system, the primary mechanisms ensuring all Australians have access to in-hospital care, regardless of ability to pay, are: 1) the provision of funding to the States/Territories, the levels of which are negotiated through what are known as the Medicare Agreements, under which the States agree to provide public hospital services to persons defined as eligible under the Health Insurance Act 1973 (unless the patient elects to be treated as a private patient); in return for annually indexed funding (Grant & Lapsley 1993: Ch.6). These Agreements are the subject of intense debate, during which various population and growth figures, demographic and disease profile burdens are posed and contested, and old tensions between the Commonwealth and State jurisdictions resurfaced to entrench new rivalries (cf. Duckett 1999); and 2) the provision of medical benefits for services to private in-patients of hospitals or day hospitals or day hospital facilities (other than Medicare hospital patients) who receive benefits...equal to 75% of the Schedule fee (Senate Select Committee 1991).

42 Adhering to strict and expensive building code regulations, hospitals like all those in the Northern Territory, were built for longevity, both in terms of the bricks and mortar, and the expected duration of stay for the bedridden patient. The architectural topography—with double corridor layouts, ensuite toilets located between wards and corridors, barriered nurses’ stations and limited interaction with non-hospital services—was premised on the need to isolate and capture discrete infectious diseases and the associated long recovery periods (Davis and George 1993). With the acceleration in the last decade of quicker recovery, less physically exhausting, but more technologically complex procedures (such as keyhole surgery), patients are not expected to recover in the acute surgery setting itself. Newer facilities thus tend to physically separate the more densely engineered structures surrounding acute surgery and rehabilitation sites from the less expensive constructions required for administration, consultation, diagnosis and lower order treatment and rehabilitation purposes. Further, the architectural models preferred today, made available through cheap construction techniques, lighter building materials and the need to be flexible (that is, expandable, contractable, pull-downable) around the rapidly evolving and hence shorter lifespan clinical technologies, are modelled more on shopping malls than the military style hospital complexes of old. Like consumer markets the world over, the aim now is to compete for ‘brand loyalty’ by marketing—to patients, physicians and nursing staff alike—through attractive forms of con/temporary architecture (see Hamer 1988, Nesmith 1995, O’Brien 1997).
Working Words

The work of producing the Minister's Statement contains within it links to other such works, many, many other such works. An effect of past and future injunctions that are compressed within, but not contained by, any one text—but this one involved me directly. As ethnographer-bureaucrat, I wrote it. Or rather, to be more precise, I was responsible for orchestrating its collation out of multiple inputs, catching the words of others to spin into a collectively acceptable format (see also Riles 1998). The same text that so readily lends itself to deconstructive analysis of the conventions and persuasions invoked, are articulations of rationality and measures of reason that I learnt as a policy analyst to easily deploy, deriving artisan pleasure from carefully crafting, through "techniques of unnoticeable control," the perfectly instrumental text (Nichols 1991: 3-4).

Let me briefly expand on my participation in these events. I had commenced formal fieldwork in early 1998, firstly by being inducted as a remote area work newcomer (see Chapter Four: 'Learning') and then by spending time with the public health professionals who travel in and out of Aboriginal communities to advocate healthier living practices. Originally it had been my intention to conclude my fieldwork with a period spent amongst policy officers in the central office division of THS. But as luck would have it, my opportunity came smack in the middle of my remote area work, with an invitation to ghost write a Ministerial Statement on future directions in health for the November Sittings.

That first day, in August 1998, when I had been called in to meet with the Chief Executive Officer of THS to receive the brief, I had been very nervous, my field notes allow me to recall. I could feel myself gushing, talking too much, laughing too loudly at my own jokes, and being too quick to fill small silences. The CEO knew I had been doing fieldwork with the public health officers, travelling around (shadowing Environmental Health Officers as they inspected remote area latrines, as it turns out), but how much did I know about 'Strategy 21,' the new strategic vision being developed for Territory Health Services?

Pushing documents starkly titled 'DRAFT' and 'CONFIDENTIAL' across the table for my later reading, he told me the Minister had been particularly impressed by the work the Department had done formulating their new corporate strategy, 'Strategy 21', and wanted to showcase it in his next major address to parliament. 'This is big,' he added with great solemnity. 'There's even consideration of outsourcing parts of the hospital.' My pad was out and pencil clicked, ready to write. I asked him what the tone and key themes would be, and listed his advice as he spoke, feeling a tremulous excitement, like a gambler breathing the scent of the race track—here we go again, helter-skelter, fear and adrenaline, the nervous tingle of being back in the pack and 'in the know.' Oh yeah, and I would be able to treat it as fieldwork too.

43 While the whole ethnography is of course premised on my involvement as bureaucrat-ethnographer, my remarks here are confined to contextual descriptions. A more detailed discussion of the doing of native ethnography is elaborated in Chapter Eight: 'Being T/here.'
There was remembrance and tactility operating here, re-entering densely layered webs of management intrigue and conjecture to join other players in the loop of initial action and first-cut flows of information as they looked up and around, sharing in the speculative effort of second-guessing what lay behind the sudden interest in outsourcing. was it all just a bluff to keep staff in line or something more? There was no problem for an ethnographer interested in gathering stories here—it was a case of swimming in a narrational flood tide and co-performing on the run. People button-holed each other in corridors and doorways, took and made constant phone calls, trawled emails, newsletters and other conduits of corporate announcements, tuned into parliamentary broadcasts and worked their personal networks in a vigilant search for snatchs of information. The sheer audacity of the proposal (to outsource management of the entire public network rather than pick off one hospital at a time, the usual, stealthier practice in all other states), was considered by some to be part of an ambitious game plan by the Health Minister, conventionally not the most powerful of Cabinet delegations, to stage a coup for the Chief Ministerial position.44

‘Expect a Cabinet reshuffle’ one manager advised conspiratorially, while another predicted that, this being ‘Burke’s swan-song [as Health Minister], he’ll want to hit them hard’ with the Ministerial Statement I was charged with preparing. Others claimed the Minister had been seduced by a particular consultancy consortium, Hospitals Development International (HDI), on a trip to Djakarta to explore health export opportunities—consultants who were in fact subsequently hired at five grand per day to advise the Minister on how to get the proposal through to realisation. Consultants, it was further rumoured, who shared a Vietnam War defence background with the former Commanding Officer of the Second Calvary Regiment, Colonel Dennis Burke.

Talking to managers to help form pictures of the Statement in my mind’s eye, it was clear that very few believed the officially promulgated story sourcing the outsourcing as to do with financial solicitude. Typical of such rejections are the frank words of this executive manager, himself a key agent within treasury and budget interactions, who after advising me to work information technology, recruitment and retention into the Ministerial Statement, making sure of course, to highlight the good effort of staff in all these areas, reflected:

Exec I mean I, I think the, uh I think the health bureaucrats and the politicians have done a con job on the country, in terms of they keep saying um you know [health] costs are out of control and they aren’t out of control. .... Now I think that’s rubbish. Now you mightn’t want to say that Tess

Tess No::

Exec You mightn’t want to say that but that that they’ve got everyone conned. Treasuries have got populations and politicians conned.

(Transcript, 27 August 1998)

44 Indeed, early in the following year, the Health Minister Dennis Burke was announced Chief Minister, breaking the five year reign of the incumbent, Shane Stone, but not the stranglehold of the Country Liberal Party itself, which had been the ascendent political party since 1974. Burke remained as leader until August 2001 when the Labor Party gained power for the first time.
'It's interesting to me,' said another, 'that the people who promote outsourcing always have some sort of vested interest or are using a model which is inappropriate—i.e. the American model. The only country in the western world with a shit public health system is the country that has the most outsourcing, so you have to ask...' (Transcript, 25 August 1998)

Or here, the hospital manager closest to the heart of constructing the cost imperative for outsourcing, and whose justificatory data on the unconstrainability of acute care costs I was under particular instruction to include:

    Mgr  Well, quite off the record I would caution very strongly against outsourcing. Best way of blowing your budget, a financial disaster.
    Tess It is interesting that you say that. =
    Mgr = That's, hey that's okay, I mean if that's what they want to do, I'm, I'll go do it! ..... I am not yet aware of an example of outsourcing of health care that's worked so I think it is a very brave and noble venture.
    ONE I MIGHT SAY I will be quite happy to take part of but I will be putting on my full metal jacket in the process and getting contractual exemption from any responsibility for things that are undo-unachievable, and there'll be a lot of them.

    If I counted up all the cost saving initiatives at all the conferences I've been to, health ought to be paying us instead of us paying for health 'cause everyone saves the whole culture of health five times over it would certainly appear.

A bit of reality checking probably needs to go on but you've got to be careful talking reality checks with [the Minister]- it's not really ((starts laughing)) it's not that popular. ((shakes head)) Reality.

(Transcript, 24 August 1998)

And yet, however spurious the claims of anticipated private sector beneficence were deemed to be, the possibility of withdrawing from the unfolding drama was not a thought to be thought. Quite the opposite, in fact. Casting ironic opinions on the unfolding events seemed mandatory, no matter whom I was speaking to. Managers would move from critique to contribution and back again, telling me what tone I should strike, the managerial emphases, the good staff initiatives that should be highlighted and then how ridiculous it all was...all in the same breath. Their body postures likewise belied their conformity. People would lean forward conspiratorially to make a wry comment, or stretch their legs and fold their arms pleasurably as they spoke about the project's rejectable premises, but there were no slumped shoulders, nor even the slightest resistance to my requests for their constructive inputs in crafting good words for the Minister. As one manager put it to me,

I make no bones about it Tess. I see this [Ministerial Statement] as an opportunity to lock the Department in to think this way: 'here's what the Minister said, it's what we have to do.' I mean, the public sector is not passive in this process. When you come and talk to me about what he [the Minister] might say and you're writing it, well it's, it's a key mechanism for getting stuff in, then getting it to come back out to staff as [policy] gospel.

(Transcript, 31 August 1998).
Tough conformity

I want to pause here at the apparent discrepancy between what policy people have to say in their seemingly revelatory moments of irreverence and candor, contrasted with their more prosaic suggestions for what I might care to use or leave out of material for a broader public script on the same policy issue. In some analyses, such disjunctions would be used as evidence of what is seen as the complicit and hidden politics of policy work. For example, Gideon Kunda (1992), following Goffman (1961), draws a distinction between the ‘managerially sanctioned and enforced view of employees’ and the various ‘cognitive and emotional distancing’ techniques (irony and humour; self-conscious parody; speech qualifiers and disclaimers etc) deployed by members of an engineering firm, when they more obviously critiqued or challenged prevailing corporate ideologies with ironic asides and acerbic commentary (Kunda 1992: 160). In Kunda’s hands, irreverence and ironic attacks of various kinds are moments of personal autonomy struggling for emergence out of the tough conformity demanded of senior managers as the price of their inclusion.

By choice they (managers) have entered into a contract that is more than economic, one that must contend with overt external claims on self-definition...Although it is not immediately apparent, the price of power is submission: not necessarily to demands concerning one’s behaviour, as is typical of lower status work, but to prescriptions regarding one’s thoughts and feelings, supposedly the most cherished belongings of autonomous beings. ...The organizational self that is formed...is founded on the carefully cultivated ability to control and manage an appropriate and often ambiguous or shifting balance of role embracement and role distancing (ibid: 214-5).

For Kunda, the binary is clear: corporate talk is ideological while ironic talk is an authentic expression of the distinctive personality which must struggle to occasionally distance itself from the otherwise total cognitive takeover orchestrated by the institution. Critical commentary reveals a residue personality that remains resistant to the hegemonic order. As an aside, a similar argument is often made in research which focuses on the role of ‘play’ or humour in organisations (eg. Rodrigues and Collinson 1995). Such actions are seen as forms of allowable subversion which, by disguising threat, become important conduits of subordinate critique or, more functionally, are the means by which employees manage paradox and incongruity (se also Hatch and Ehrlich 1993).

Now, while forms of play can indeed be serious, as Allen Feldman’s work on the use of songs and jokes within the prison regimes of Northern Ireland clearly demonstrates (Feldman 1991), it is the attribution of greater testimonial authenticity to critical language that I want to contest here. The accusation of complicity privileges the referential outer layer of cynical dialogue, leaving aside the role that critical sentiments might play in sustaining institutional interactivity and action. In THS, as I came to understand it, spirited commentary is part of the work of sounding out the politics

45 For a similar critique of the attribution of emotion and private thought as more authentic repositories of the self than other forms of interaction, see also Lutz (1986).
of the policy as it is forming, and not jeopardising moments exposing bureaucrats as suppressing the deeper truths that exist independently of their conformity. Ironically, it was by subjecting what drove my own and others intense commitment to creating forms we could so easily interrogate for their own infidelities that I began to appreciate the intersubjective and constitutive dimension of irony amongst health professionals—and its own ironic provocation of scholarly distrust.

For social scientists who insist on neat lines separating the virtuous from the untrustworthy, ironic asides function as compelling proof of the pretended, treacherous nature of bureaucratic ethics, where political commitment and proper conduct subside to a more duplicious, cynical knowingness. It is the knowingness that causes especial umbrage—knowing ahead of time the duplicities and bad politics involved in our practices, supporting and deriding simultaneously. Whatever skeptical stories we might tell ourselves, the righteous critic would have it, we are nonetheless creating forms of logic which uphold the state bureaucracy and its hegemonic interests which, in all good conscience, should be more demonstrably renounced. Banter is simply bad faith, proof pudding of bureaucratic self-interest. We should be ashamed of ourselves really, especially me, an ethnographer writing bureaucratic speeches and admitting enjoyment. Pointless really, to even try accounting for the pleasure of wry, critical and cynical banter or the delight of ‘stress-induced camaraderie’ (Cullen and Howe 1991: 20), against the cocked eyebrow of deep anthropological suspicion.

Even so, in my experience—to unabashedly invoke the ‘being there’ of ethnographic and native authority—insider-critique gives form to the performance of involvement. That is, it exhibits and makes visible the activity of scanning, monitoring and critical thinking that has been taking place all the while; a sass that artfully marks the speaker as one who is ‘there’ already, involved, quickly knowledgeable and readily able to give intelligent comment. It evidences ongoing interest and participation, informed by the contingent tale swapping and interpretation that zaps through the inner coterie responsible for mobilising early policy formulation. Being ‘in the know’, ‘taking the pulse’, and signalling one’s knowingness, including through a confident ability to cast ironic and deprecating asides, is simultaneously part of the ethos of doing, the anticipatory component of preparing to absorb what comes next, and, seductively, an exhibition of the shrewdness required to be regarded as a ‘good operator’ (see also Munro 1999). They’re instances of how, in the flux of encounters with incalculable and pressing issues that come at policy officers and managers riding the turbulence of major policy shifts, bureaucrats engage in a pragmatic attempt to anticipate and explain in advance the manifold outcomes that may yet unfold, failures and unexpected turns of event included.

46 Linda Hutcheon’s work on the irony of irony draws attention to this double-edgedness. Its pleasure as a social form lies in the joyous, malicious and witty use of shared meanings that can be made out of ‘in addition to and different from what is stated’ (Hutcheon 1984: 11), combined with a mutual disposition, or what she calls an attitude, toward what is said and unsaid: a joint stirring of plural meanings with their critical edge within a discursive community. But therein lies the risk of irony, for, in dabbling with the affective dimension of words (the evocative power of innuendo and plural meaning), irony can as much put people on edge as seduce through its perlocutionary play with socially agreed meanings over and beyond the conventional (Butler 1997: 3). Irony, Hutcheon argues, is always ambiguous and capable of being both subversive and authoritarian, its effects never able to be guaranteed. People will always condemn as much as support its use because of the instability of allegiance its use signifies (Hutcheon 1984: esp.9-36, 44-56).
In gauging what response to fashion, how to perform, what posture to adopt, and importantly, how seriously, if at all, to take any of it, wry or moderating comments *are as procedural* as assenting or optimistic ones, and adeptness in all modalities is critical to the proprietary orientation to issues of the moment managers must manifest to show their policy dexterity, their *flexibility*.47 Bureaucrats call it having ‘ownership’, without which enthusiasm for what I eventually came to see as the essentially repetitive ritual flurry of policy participation cannot be mustered. These observations are also suggested by Robert Jackall in his ethnography of the world of corporate managers in manufacturing corporations, when he observes:

> The premium on alertness to expediency demands... an ability and a readiness to doublethink one's way through the contradictory irrationalities of everyday problems. But standing at the middle of events grappling with exigencies, especially in a hierarchical milieu that requires authorities to display sincere conviction in their actions, seems to foster at least a kind of half belief... in one's efforts to do what has to be done. (Jackall 1988: 188)

To give this more clarity, let me elaborate briefly several characteristics that are common to policy development procedures as I have come to know them, patching in the hospital outsourcing case study in the same fragmentary way practitioners experienced and (cynically) re-pieced it together as it formulated in flight.

**Jostling**

When I re-entered the policy and managerial side of Territory Health Services to prepare the Ministerial Statement, my original brief was not to write about the hospitals specifically at all but rather was to prepare a more uplifting ‘progress report’ on the achievements of the health portfolio since the last general Ministerial Statement (delivered in April the previous year). In particular, I was to build on a series of corporate planning sessions that had already filtered the words of some 600 employees, other agency and non-government organisation representatives, into a small number of feeder documents. Key amongst these was a document that many people urged me to give special attention, ‘Strategy 21’.

It was at first hard to see why Strategy 21 deserved such foregrounding. Coming as I had straight from the more policy afar field of dusty work with health’s own fieldworkers48 to accept this brief, I was a stranger to its production history—and that made all the difference. To my out-of-place eyes, it had the appearance of a ubiquitous government strategy document, a variation on a well-established standard. An astounding eighteen months in the making, it was essentially a five-page corporate strategy miniaturising the ambitions of Territory Health into a ‘Core Business
Focus’ and ‘Stretch Goal Areas’ Comprised of a series of dot-points, it used a series of such bureaucratically unquestionable terms as ‘stretch goals’ ‘strengthening community capacity’ ‘intersectoral collaboration’ ‘leadership and innovation’ and ‘more gain’ to create a tale of evolutionary advance.

**Strategy 21 - Directions 2005**

**STRATEGIC INTENT**

To create and enhance a Territory wide network of services which delivers continuing improvement in the health and well being of all Territorians.

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**STRATEGIC DIRECTIONS**

- Public Health
- Primary Level Health
- Acute and Specialist Care
- Community Services
- Organisational Support

**CORE BUSINESS FOCUS**

- Policy Leader in Health for Territorians
- Funder/Partner of Government Approved Health Services
- A Core Northern Territory Provider of Non Commercial Health Services
- A Catalyst for Total Health Solutions, Achieved Intersectorally

**STRETCH GOAL AREAS**

- Strengthen Community Capacity
- Develop a Robust Health and Community Services Sector in the Northern Territory
- Significantly Increase Aboriginal Involvement in the Health and Community Service Workforce
- Be a Major Contributor to the Northern Territory’s Economic and Social Development
- Enhance our Organisational Capability

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**FURTHER INFORMATION**

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Figure 6: Strategy 21 Front Page

Its recognisability moved beyond layout and phraseology to theme and intent. Strategy 21 distilled a wider ‘new public management’ theme of transforming THS from being an ‘institutionalist’ into a ‘residualist’ welfare organisation (Titsmuss 1974): that is, one which avowedly privileges market mechanisms and prefers state funding of privately-provided services (with ‘private’ here including government-financed community sector organisations) over comprehensive public service provision and delivery. One of a series of attempts mediated through a range of tactics—performance management, contract employment, and the withdrawal of government from direct service provision into a more distant regulatory role—Strategy 21 simultaneously activated

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49 The ‘New Public Management’ is a summary description of the managerial reforms which have swept through western administrations since at least the 1980s. A convenient summary is provided by Linda Hancock, who describes its key features as: similar styles and models of management in the public and private sectors; a shift from process (bureaucratic) accountability to accountability through quantifiable results; an emphasis on generic management skills, devolution of management control under strict rules of reporting, monitoring and accountability; disaggregation of bureaucratic structures around separation of core from peripheral functions, policy advice from service delivery; the preference for privatisation, contracting and contestability; the use of specific, performance-based contracts; further emphasis on private sector management practices, including performance-based pay; corporate image making and new management information systems; the preference for monetary incentives for performance, and stress on cost-cutting, efficiency and cutback management (Hancock 1990: 30, for critical discussions see also Power 1997: esp. ch.3 & 5, and Strathern 2000).
a corporatisation agenda and promoted a competitive enterprise culture within THS. It asked THS staff to embrace the language of outsourcing, to view time as a commercial property, to see themselves as business managers separately responsible for controlling production, purchase and supply, with associated promises of a more transparent return on investments of government capital.

Now, to understand these familiar injunctions as somehow representing radical innovations, it is worth remembering that much health activity (like that of other social service agencies) is conventionally seen as economically opaque. Its expense claims cannot be straightforwardly tracked to direct financial returns or clear social benefit outputs, and the pursuit of administratively rational ends are made suspect by health's emotive claims to greater responsibility for birth, life and death. In the absence of guiding business principles, the argument goes, waste, mismanagement, duplication of effort and inefficiency potentially reign.

In as few words possible, with the funder/purchaser/provider separations advocated within Strategy 21, it was felt THS actors would be forced to clearly identify and distinguish situations in which they were purchasing goods and services from non-public sector organisations (who would be contracted to then provide the said goods and services), from those occasions where they still held primary responsibility for direct service delivery itself, not just the funding. Even when the Government remained the service supplier, different functions would be marked between different units within THS. Where once colleagues negotiated their spending against a given budget with a view to juggling competing interests across their different program areas by simply agreeing to collaborate, now these interdependencies would need to be established more formally. The inherent ambiguity and essential opacity of much welfare work from an evaluative point of view—very little outcome to show for a lot of throughput activity—could be reconfigured through the discipline of costing all activity components and revealing these costs to the 'purchasers' (other departmental officers) who, in mercantilist fashion, would insist on value and effect against the original allocation (cf. Preston, Chua, and Neu 1997). That is, by reformatting the interpersonally negotiated practices through which health professionals ordinarily 'implemented' programs into contractual arrangements which itemised expected outcomes against a given level of expenditure, it was claimed the indeterminacy of much health work would be circumvented.50

The professional employees within THS who are held directly responsible for service delivery as, say, professional nutritionists, infant nurses or social workers, would in turn be responsible for establishing pseudo-markets for their services by negotiating the 'purchase' of their work, either by the Department or by community organisations, with such entities as Aboriginal Health Boards

50 This notion of an exchange of obligations between different functions within THS in turn mimics a plot scenario evoked by governments who assert that government services are not provided free of duty but rather can only work in a context of mutually realised obligations between the state and its citizenry. Usually this argument prefaces demands for greater individual willpower and family authority to be exercised to supplement the state's regulatory efforts. See Muetzelfeldt (1999).
becoming proxy purchasers. These organisations were promised that now they had the discretion to ‘buy’ what they wanted, from whomever they wanted to buy it, without being restricted to THS, introducing competition where before there had been a state service provider monopoly. In reality, there are few competitors for government services in many areas of the Territory, and most of the money non-government organisations have to spend is government derived and tied to restrictive performance agreements anyway (see also Fisher 1997). But the theory can be made to seem liberatory, and that is how I understood my brief. Further, people’s work functions would need to be redefined, there would be the breaking up of former work teams to create new ones, and the organisation would be restructured to reflect the new accountabilities. The anticipation and speculative thought surrounding these impending changes thus fed a tense atmosphere of liminality that found its symbol in the five pages of Strategy 21.

As I initially understood it, my task was to weave a compelling script around the abridged mercantilist logics contained within Strategy 21, to reintroduce narrative detail and homely anecdotes that would in fact create a new version of an ongoing corporate story about health being an enterprise, both as an organisational ethos and as the biographical life project individuals are urged to self-manage. Tellingly, the concluding subscript for Strategy 21 is a metonymic device that cleverly captures the bureaucratic intent to compel precisely these identifications: ‘Health is (you)our business.’ (In PowerPoint presentations, the (y) flashes in and out of visibility, from ‘your’ to ‘our’, highlighting the semantic exchangeability even more powerfully.)

I was familiar with the well-placed quantifications and the tropes of unarguable logic telling a statistically compelling tale that people must assume greater responsibility for their own health, and could even give an aesthetic reading of Strategy 21’s quality. As a genre type, it successfully followed the formula. The right kinds of words had been balanced together in new but recognisable ways, a key requirement of a good policy text. As Annelise Riles notes of documents produced for the United Nations’ sponsored Fourth World Conference on Women (the ‘Beijing Conference’), certain words recognisably fit with each other, a congruence or balance that is immediately discernable to experienced policy practitioners. Language acquires ‘a shape, a rhythm, a feel, not simply a meaning’ (Riles 1998: 386). Writing instructions for policy documents are often to produce aural and visceral as well as specific content effects. For instance, I was asked to write the Statement in a way that was ‘crunchy, punchy, not navel gazing or touchy-feely.’ Words were suggested to me on the basis of their deemed fit. One manager promoted using the terms ‘funder, purchaser, provider’ to describe how outsourcing would work, saying: ‘I think this is (sic) ah, flavourish sorts of words you know, that—it’s sort of business language as well you know?’ (Transcript, 27 August 1998).

Another prompted with: ‘these are nice words for you...Cybersmart GPs. I thought you could work that in. Business words.’ (transcript, 28 August 1998)
Despite its formulaic nature, for those who had been involved in its collective production, Strategy 21 had a profundity not readily visible from its nicely balanced dot-points, or even its interlinking with impending structural change. For one of the formulators involved, 'it was one of the best things' she'd ever done:

I got so much out of it. For me it was one of the best exercises I've done with TH. And I mean I love what I do, I, I, I just really enjoy working for THS, but I found that to be one of the, the key things...

I got so much out of it...for me personally...

...because I just learnt so much

(Transcript, 27 August 1998)

It took me a while to understand that the striking intensity of emotion surrounding both Strategy 21 and its sister product in the speech I was coordinating, is simply not comprehensible through reference to textual tactics alone, for it arose out of the interactions and exchanges that both usher policy texts into being and follow their emergence.

18 months x 600 people = 5 pages

Strategy 21 had been collated out of a highly labour-intensive consultation pyramid. A specifically recruited and highly regarded management consultant had trained six health service staff in requisite interviewing techniques, each of whom had in turn trained a further 20 people, making a team of 120 trained interviewers who were to additionally talk to groups of 7 or 8 people at a time about their concerns for the department and its future directions. The material thus procured onto butcher's paper and into notebooks was summarised and categorised back up the pyramid, to eventually be considered by the senior executive team, the master facilitator and the original six interviewers in a two day 'lock-up'—that is, at a site of complete physical removal from the normal workplace.

Now, the drafting exercise for formulating key government documents is usually exhaustive, if not always to this extent. Ordinarily there are daily deadline pressures, to enable variously positioned powerbrokers to read and respond to the drafts, which must be continually rewritten to exacting standards until there is collective agreement that this is a good script (cf. Davis-Floyd 1998, Riles 1998: 381). Internal critiques are an organic part of the whole ritual of performing policy texts within institutions. Recollecting, for instance, the tussles over how to word the sentiment that THS should only provide programs where the non-government and private industry sectors couldn't, eventually captured in Strategy 21 with the phrase 'THS will be the lead provider of non-commercial services,' one senior executive easily revisited the intensity of the debate:

Exec...Department will still remain the lead provider of non-commercial health services but that is exactly...I mean we argued for a long time (but) nobody came up with a better word than commercial and I couldn't either. I mean I can't uh spend a lot of time [on resisting it] but I don't like that. Nobody liked it to be quite honest-most of the people—
Well, what’ll be left to government is those services which can’t be outsourced easily ((laughs)) and the phrase that was attached to that was ‘non commercial’ but I don’t like the word. I don’t like the word ‘commercial’...

There would be many reasons why you might not outsource a program and it’s not just because they’re ‘non commercial’. It’s: they’re not suitable, there’s no suitable provider. Some stuff I think they’ll find that out government will always have to provide it. It’s expensive and, and the stuff where you’re looking after the complex cases that nobody’s going to want to take on without driving it with a lot of money.

A thing like child protection. Just some stuff that’s so statutory and embedded in government that you couldn’t possibly, you can’t contract out investigation of child protection cases, you’ve got to do it yourself in government and there are, you know, child protection is probably one of the easiest ones to think of. No government I think would entrust that to a non-government organisation.

But I don’t think that the word ‘non commercial’—I don’t know, I don’t know if you’re going to be able to come up with a better phrase. I must say I meant to go home and do a thesaurus on it but lots of people objected to it. Ross didn’t like it, I didn’t like it. I can’t remember Trish saying anything but quite a lot of us said ‘No don’t like that word’ so, so he [the facilitator] said ‘Well what do you want to put down instead? ((laugh))
I said ‘xx’.

(Transcript 21 August )

It is interesting to me, in the extract above, the manager mentions not being able ‘to spend much time’—a nuanced understanding of workshop etiquette prevents her from pursuing objections beyond a discerned point. One calibrates one’s display of creativity within the constraints of situational acceptability, knowing that to overstay opposition, to ‘die in a ditch’ as policy people would say, risks the disdain and irritation of others. Like the Kabyle villagers of Bourdieu’s ethnography, to participate successfully in high level policy encounters requires a finessed knowledge of the interactional etiquette, in such a way that the two-stepping and ‘spontaneous’ improvisations of high level negotiations are expected and adroitly anticipated (Bourdieu 1977: 81, 91). The struggle is one of being artful (noticeably ‘constructive’) without tipping the balance of group judgement against one’s contributory style (to avoid the label ‘wanker’, for instance). Of course, the chair or facilitator also has on hand a number of techniques for rescinding objections, from an over-audible sigh to prim redirections: ‘I think that takes the discussion off subject. Can we return to the point made by Peter a moment ago?’

51 Helen Schwartzman (1989) provides a thorough analysis of the range of speech curtailing modulations inhering in meetings in her ethnography of a mental health facility, The Meeting: Gatherings in Organizations and Communities (see in particular pages 76, 80-1, 124). Schwartzman further draws attention to the fact that in social welfare organisations, meetings are frequently the place to enact ideals such as equality of status and consensual decision-making. (8-9) and that it is this heavy investment in participatory and circumspect styles of decision making that contributes to a sense that meetings are a waste of time yet dangerous to avoid (133-9). See also the work of Fred Myers and Donald Brenneis which finessed the ethnographic treatment of meetings as significant speech events, in particular highlighting the strategising artfulness and expertise deployed in knowing how to place choice words well in talk and interaction (Brenneis 1984, 1987, 1988, Myers 1986a, 1986b). These themes are pursued in more detail in Chapter Four.
Just as likely, the coperformance of amiability and collegiality that professionally facilitated workshops are choreographed to foster calls on members to know exactly when to put a halt to their own insistence (see also Chapter Four). Especially in lock-up situations, bound within a committee room, assent may also be sculpted out of exhaustion, when nobody wants to fight for key words anymore and it no longer matters whether it is ‘community control’ or ‘community capacity’ that is being described, just that the document is produced to form (see also Schwartzman 1989).

The absorbing and frustrating process of threshing out final words for documents like Strategy 21 is fed in part by a comprehension that these well-chosen words might not yet be final. Such intense and frequently exhausting discussions over wording are characterised by Donald Brenneis as ‘conditionally definitive discourse’ (1994: 30, see also Brenneis 1999). This is a forceful style of deceptively conclusive talk which assumes and anticipates a subsequent editorial audience: in this case, the Minister and his Cabinet colleagues uppermost. Here, in the always emergent yet preformatted space ‘between the pen and the paperwork’, or as Brenneis puts it, at ‘the intersection of text and talk’ (ibid), words must work hard, both as statements which act to declare the competence of their formulators at the time of their co-performed emergence (cf. Brown 1986, Gronn 1983, Myers and Brenneis 1984), then, if jointly consented to for inclusion, as words which must additionally transcend later judgement and perform later acts.

Collectively working with words is not only hard work, but, as I will show, the chosen words must themselves be hardworking. Not only that, but all this hard work goes into producing documents that prove the heavy work they are performing when they achieve the appearance and sound of any other. How can this be?

**Banality: the grandest achievement**

I would argue it is not so much that institutional words are considered to have no meaning and therefore an easy exchangeability (pace Riles 1998), but rather, that only a limited number of words can in and of themselves operate to simultaneously promise action and foreclose imagined dissent. This is what wording wrestles are so often about. Innocuousness or banality are hard won qualities, collective achievements borne out of the heavy work of meaning condensation and encapsulation. The wording for public and collectively scribed documents must not only be innocent and confidently prefigure actions; it must sound as if absolutely vital government action is catalysed by these very words, words which must also meet and appease contrasting political demands, with any blaming cast as euphemistically, as blamelessly, as possible. Only a small number of words handle such a burden. To take a small example, the alliterative duet ‘community control’ braids calls from Aboriginal advocates for more independence in how their health services should be run together with a Government concern to have less to do with (difficult and often futile) arenas of direct service delivery. Who could contest the virtue of Aboriginal people being in charge of their own health centres/being more responsible for their own health? A manager describes this antonymic quality graphically:
In terms of buy-in, we can sell Aboriginal health boards to the Aboriginal groups as about community control; and we can sell it to government as outsourcing and increasing the dollars into the NT...I mean, what's the difference between community control and outsourcing? Community control is a softly, softly term where we have a contractual relationship with other people delivering services. Same, same.

*(Transcript, 30 September, 1998)*

The hardworking nature of euphemistic phrasing is also captured in this manager's rationale for preferring the term 'growing the network' as a description of the government's intent to ensure non-government organisations conform to strict management expectations before they can be considered eligible for funding to provide additional (outsourced) services:

See what, what people do all this talking about, ... it's business language. I mean I don't, you know, I don't have a problem with it. I mean it's the kind of language you use for the thing you've got to write in the corporate plan. Interestingly though, (the CEO) wasn't using that. What he talked about was GROWing the networks, GROWing the networks right? Growing the numbers of people and the numbers of agencies and the whole network of service providers across the Territory. And I thought that was a much nicer way of actually saying it. What we want to do is...grow the industry out there. And for me you see 'growth' has a development thing in it and that's why I like the word 'growth.' Growth to me isn't just an expansion. It's developmental growth as well. That's how I always think of the word 'growth'... it's a ying word rather than a yang word. ((laughter)) But what (the CEO) talks about, and what I could resonate with, is this business of growing the networks and growing the skills ... so that services can be delivered more closely to people and be more responsive to people you know, and be more aligned with what it is that people need.

'Growing the networks' attempts to curtail the affront that might accompany a more direct statement of the same message: for instance, that the non-government sector is amateurish, weak or stagnant, and in any case, too dependent on the largesse of untied government grants for independent survival.

It is this detailed work of circumventing through careful wording that goes a long way toward explaining what critics see as policy's invariably vacuous language. In the hospital speech that I eventually put together, for example, the anticipation of staff protest to the proposed new management regime saw the inclusion of disclaimers that the reforms did not negate 'the dedicated services of many health workers and support staff' and further, that 'the public hospital system and staff have served Territorians well under some trying conditions. Our staff are good. They've put in hard for this community. But...’ A different version of the same attempt to control for imagined slights through careful wording is the necessity to ensure that all key regional centres in the THS network are mentioned at least once in any main script. Submitting an early draft of the Ministerial Statement for preliminary review, I was quickly advised to work in examples of 'good work' from other regions, lest people consider the focus too Darwin-centric.
I should have known better. Accusations clustered around concepts of regional marginality are one of the legitimate denunciations allowed in the contests between the geographically-defined bureaucratic cliques within Territory Health Services (see also Chapter Three). Ritual sensitivity to the insults of the 'Berrimah Line', the term used to describe an imaginary boundary marker between the near of Darwin and the far of all other places in the Northern Territory, is acute. Central office anticipation feeds off regional office sensitivity which in turn feeds off every slip-up as confirmation of the need for eternal vigilance. Such auto-policing soon becomes second nature. To omit consideration of the 'Berrimah Line' would be to concede an easy point to those regionally placed bureaucrats who are ritually poised to criticise the emissions from Central Office, a concession to be especially avoided in a text that is meant to be regarded as the condensation of serial forms of regional consultation.

Such reflex concern for proving inclusivity is characteristic of most bureaucratic discourse, explaining not just the wording but also the elaborate consultation steps taken to be able to claim democratic authority in and for policy texts. All formal proposals and submissions, such as might be presented to the senior management team for endorsing or to the minister for final ratification, are required to demonstrate evidence of widespread need or demand, with the representative spread and numerical depth of feeder consultations a key barometer testifying to the real of the problem and the veracity of the proposed solution. For instance, amidst the standardised structure of subheadings within Cabinet Submissions, which, it should be remembered, have legislative force if enacted, space exists within the document template for mandatorily summarising the 'Consultation and Coordination' actions associated with the particular proposal.

A good strategy document thus overflows itself to accommodate multiple functions: it is recognisably good when its inclusive wording satisfies the quibbling and dissension that featured in the jostling formulation process that ushered it into being, and when it is considered to adequately anticipate and circumvent likely receiver criticism. To achieve this latter function, past reactions to previous public airings of policy will be brought back into focus. Imagined and known 'enemies' become uncoopted authors of governmentality alongside policy practitioners and regional officers, who may themselves be advocates of some of the adversarial positions (see below). Like policy words themselves, then, we might say consultation itself contains within it a multitude of operations—from an intent to both imbibe from and to enlist oppositional positionings (cf. Cruikshank 1993), through to a method for inveigling citizen participation in the rationing responsibilities of governance (cf. Burchell 1991, Rose 1993)—but that, like policy, there are insider rules to the form. And here, as with every instance of institutional activity, the 'rules' are rich and contradictory, with much action lying in the discrepancy between the script and the real time acting.

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52 For instance, amongst the anticipated audiences are imaginary skeptical ones; those who are suspicious of government or of business rhetorics; idealistic adherents to 'higher' notions of public health and community service; or those who may be disadvantaged by the decisions being sounded out in the text. (Previous consultations and past initiatives will also have yielded protest orthodoxies that can be remembered and factored in).
Consulting for words

As hinted, institutional writing is a collective, factionalised and hierarchical process with its own highly specialised rules for choreographing members’ involvement, requiring careful parleying within and outside the organisation to identify and include not only those with representational status or with substantive knowledge of the matter at hand, but also those who will confer testimonial authority on the final product. As Porter notes of the need to assemble the look of objectivity in official discourse,

In public affairs, reliance on nothing more than seasoned judgement seems undemocratic, unless that judgement comes from a distinguished commission that can be interpreted as giving representation to the various interests. (Porter 1995: 7)

Clearly the type of policy that is being sounded out connects with the type of consultation that will occur. If the product is to be corporate strategy, then the input of select regionally based staff and their management representatives has to be sought. Now, this is no small undertaking. THS, like other welfare-oriented organisations, places a heavy emphasis on teamwork and collaboration in a context marked by multiple and competing perspectives, each contending for influence and authority (see Chapter Four; also Cullen and Howe 1991, Schwartzman 1989). Disputes are rife. All suggested changes in approach, small or large, textual or behavioural, from ‘the top’ or from ‘below’, are shot through with tensions. Everything must be bargained for and heavily negotiated, often through the formation of tactical allegiances and oppositions which cross-cut the organisation.

When an Aboriginal health project is at stake, the layering becomes far more elaborate and the timing allocated for contacting institutionally-placed indigenous representatives far more generous, but essentially the micropolitics of stakeholder management through consultation are much the same. There will be key mediators in any setting—the manager of an independent health service, say—who can be relied on to fulfill a representative function and provide authorising input. Even within localised THS work areas, very little proceeds without ‘workshopping’ the issues first. I might quickly add here that often these are occasions where much of the work of establishing rights to speak, exhibiting a ‘being there’ repertoire gained from exposure to Aborigines, or other renditions of closeness with ‘the grass roots,’ will be played out (see especially Chapter Four).

But while other institutional representatives are the main providers of ‘input’ for consultations when policy texts are still in-the-making, the convention is to describe it all as a mode of speaking to the public or the ‘grass roots.’ Yet it is not the grass roots or members of the general public but the press, government-dependent organisations and services, other politicians, bureaucrats across the public sector, businesses and corporations, who are truly the main audiences for consultations. Press coverage also functions here not so much to measure the effect on the public per se as to measure and talk to these unstated audiences via the artifice of disinterested journalism (see also Grefe and Linkskey 1995). But that is not quite right either, for key journalists and parliamentary
speech writers are called on to advise the Minister on what the public thinks, adding the finishing touch to speeches and public relations material with an eye to how 'Joe Public' or 'the punters' would react, their own powerful connectedness with and likeness to institutional actors denied in their reinvention as ventriloquists of the 'great unwashed' public interest.

The critical point is not how representative all these institutional representatives are (a vexed question in any setting, with added complexities in the context of Aboriginal health\textsuperscript{53}), for when it comes to arguing policy artefacts into being and defending or attacking them later, insiders will raise the problematics of representation only when the arguments needs to be discredited, or conversely, when external criticisms need to be deflected. That is, if the job is to claim widespread support for a proposal, consultations will be trumped up and their authenticity as barometers of need highlighted, and conversely, it can all be downplayed if a document needs to be quashed. At all times, to return to a focus on policy assemblage, it is understood by more astute policy collators that consultation is always a mediated form of translation, which inherently cannot have fidelity to the original, regardless of where or from whom 'the original' inputs have come (cf. Benjamin 1977: 69-82). At the moment of interchange, the inputs of the consulted are at once apprehended as direct, content-filled speech and filtered by a bureaucratic radar attuned to wording that can be bent into policy shape or deployed as a convincing 'one-liner.'

Now, this is not, of course, unique to policy formulators but is also a familiar strategy of bureaucratic processing at the 'street level' (Lipsky 1980). Out of the often harrowing detail of neediness volunteered in a social security applicant's original dialogue, for instance, front office processors home in on cues which not only identify the person in terms of their likely welfare category (homeless, single parent, disabled), but also determine whether this person is of sufficient moral value to be worth helping in the first place (Cullen and Howe 1991). It is a tailoring process that is undetectable if the 'text' of the payment details is the sole referent, as it is enacted through encounters, with staff listening to first-person supplications 'for key words and phrases they can latch on to' without necessarily being aware of the categorisation schemas they are using to sift what they are hearing (ibid: 4, see also Lipsky 1980, Mashaw 1983). As with policy, such discernment is undertaken with a practiced ear, a professional body knowledge that, without detailed reflecting, proficiently intuits the sorts of codifications that will succeed for formal processing purposes and which, by upholding the unarticulated moral schemas which classify clients as deserving or undeserving, also demonstrates assessor aptitude and finesse to peers further down the line.\textsuperscript{54} Meanwhile, unsurprisingly, the client who knows the expected and favoured representational terms, who knows and does not resist the operational pragmatics of the social regime of good into which they are being drawn, will more likely be processed with speed and dignity.

\textsuperscript{53} See, for various discussions of the politics of Aboriginal representation, Jeff Collman (1988); Gillian Cowlishaw (1993); Eric Michaels (1988); Fred Myers (1987, 1988); Jan Pettman (1988); and Elizabeth Povinelli (2003).

\textsuperscript{54} Describing a similar phenomenon in the work of social workers investigating suspected child abuse cases, Handelman notes 'The caseworker simulates the world of the client in order to build a case-form that makes sense in organizational terms. The dialectical synthesis of the overall case is then a bureaucratic creation; and interpretation, as the mediation between case-form and phenomenal content, becomes a dialogue which is imbued with bureaucratic purpose.' (Handelman 1983: 11)
In a similar set of selections, the most valuable informants for policy drafters will in fact be other ‘good operators’—fellow institutional actors with a more developed and implicit premonition of the types of words and anecdotes that will eventually scan, who will pre-select their own words with the same sense of the required form as the writer-in-charge. Such people will have established a reputation as being worth consulting, even if their place in the hierarchy may otherwise be unremarkable, for they can speak in the bites that have ‘crunch and punch’. That is to say, individuals will be regarded as essential contacts or as institutionally legitimate orchestrators of particular initiatives for reasons beyond their title or ascribed qualifications to more nebulous and provisional assessments of their skill or capacity (see also Jackall 1988: 17-40, Schwartzman 1989). Their inputs, whilst not necessarily very original or even particularly thoughtful, will be closely trolled for useful anecdotes that reinvigorate known formulations with new metaphorical flourish or which offer useable ‘effectiveness’ criticisms (reproaches which leave the apparatus of government alone to instead suggest a number of improvements and areas in need of reform, the need for greater coordination in most things being a likely example). In fact, being a ‘good operator’ seems to depend, at least in part, on this ability to give old managerialisms a new look and sound.

Meanwhile, officers or community representatives who are consulted but lack this finesse in proffering the self-regulated articulations of coded critique required, who instead genuinely believe there will be an unadulterated transmission of their testimonial transfer via butcher’s paper straight into a corporate text or through the vocal chords of the Minister to a wider public beyond, are seen as having a certain naïveté about the perfidies of policy work. In amused frustration, a manager exclaimed to me:

People think that being consulted means their opinions will immediately be inscribed as policy, word-for-word. And it doesn’t work that way, they have no idea about how policy works! So when they get something like the corporate plan back and it doesn’t have this direct translation, they get upset. Meanwhile (laughing) the plan has to be written in general language so that it includes everyone!

*(transcript, 30 September, 1998)*

In contrast, one woman, new to policy, exposed her neophyte status in her very enthusiasm for bringing the unmediated authentic voices of the people (staff in the regions, subjects who otherwise might not be heard) to the corporate planning process.

One of the ladies that we saw... (when she) had heard that she... had been selected... as giving some information out for this... she wanted to have her input so she drove 100km into Katherine to get to this planning facilitator to be able to sit down with her and go through stuff—because to her it was so important that her information got there. So we spent quite a few hours documenting stuff... so I mean I think that’s a really human touch story, it’s really nice and to me that’s a real bonus. So I got quite a thrill out of that because all her stuff is documented. I wouldn’t know which it is because there’s no names on it but people need to have a say.

*(Transcript, 21 August 1998)*

53 A remote area nurse.
Not only were these lady’s liberated words anonymous, they never found their verbatim way into Strategy 21 and, the real point, were never destined to do so in such unspun format. It is the fact of the enthusiastic interaction in the name of consultation that has premium value and can be used within policy talk/textual work as verification that the eventual texts truly are communal attestations. In other words, consultations allow bureaucratic proposals, devised in the intersubjective thick of bureaucratic dramas, to pose as the unmediated voice of social need and community desire, our interventionist devising hidden from view. These elisions are well-summarised in the contradictions of this manager’s version of consultative measures, as he moves from saying consultative processes are irrelevant to saying they provide ‘things we can use’:

It is totally ritualistic. Every steering committee has to have certain people in it and they don’t necessarily add anything we don’t know already but we need to show we haven’t just made it up. Because we haven’t really, we do take ideas and really welcome useful criticism. You know, practical stuff. Things we can use.

(Fieldnotes, February 2000)

And those like the over-eager junior officer above who took her role as ‘friend and advisor of the people’ (Robertson 1984: 156) too seriously, are viewed as lacking the pragmatic qualities required to be regarded as expert policy strategists. Indeed, I was told this officer had been selected to be one of the six Strategy 21 interviewers for her disingenuous belief in and enthusiasm for the importance of consultation processes, a genuineness which would help overcome ‘stakeholder’ cynicism about how seriously their inputs would be taken. But while she was seen as having ‘good people skills,’ she was equally deemed to have no strategic judgement. As Robertson notes of government officials working in development contexts, ‘a good rapport with the public is as likely to confine a junior official to the local office as is ineptitude’ (ibid: 157).

It is beginning to appear as if consultation is simply a cynical ruse, but this is by no means the case. Many health professionals have essentially non-hierarchical, egalitarian instincts. They earnestly believe that members of the public (and the regional officers/non-government personnel with whom they are collectively merged) are intellects to be reckoned with, people who may have better ideas about what kind of hospital and other health care should be made available to whom, where, how, at what cost and who should pay, than policy makers:

I think one of the big issues that this country has to come to grips with is how do you allocate, how you prioritise what services in health you’re going to deliver. There’s not enough engagement of the community I don’t think on how those, how those choices are made. .... The point that I was making is that—now we think of the population at large as being generally unable to come to collective decisions that are actually the right ones...But normal, actually common, common sense people actually come to the same conclusions that you should be putting money in at the front end ((prevention)).

(Transcript 29 August 1998)
A doctor repeated this theme to me, lamenting the lack of an institutional mechanism for genuinely engaging with community perspectives:

There’s a whole issue there about community dialogue and about you know—again, we haven’t got a methodology in place for doing it...a process for generating any kind of real intellectual dialogue with community (sic) about what they want.

*(Transcript 26 August 1998)*

Similarly, human relations management theories about participant decision making and the importance of employee empowerment drive the orthodoxy that corporate policies need to have widespread staff input (Grefe and Linkskey 1995, Kilmann, Saxton, and Serpa 1985, cf. Newfield 1998). Indeed, the will to consult is such a taken for granted virtue within Territory Health Services that both its absorption as an article of faith and its deployment as a strategy for everything bears repeat consideration throughout this ethnography. As we will see clearly in later pages, the privileging of local knowledges more than informs public health policy, it is normative as policy, and is part of a wider strategy of conscripting self-management within a liberatory program of empowerment (Hyatt 1997, see also Rose 1993, Sackett 1989). But back to the scene of the moment, and the need to continue the daunting task of accounting for the attraction of institutional work, despite its heavily formulaic nature and frequently duplicitous slights of hand.

**Surfing the Serendipitous**

Gathering ideas for the Health Minister’s Statement, conducting my own internal consultations, I joined in making criticisms of ‘the system’ as well: yes, to enter into and sustain the presumptions and conventions of our co-bodily, co-bureaucratic transactions; and yes, to gather naturalistic representations to feed my ethnography; but also, as I’ve already stressed, because critique informs the compelling logics we must-needs construct. Ironical banter about the origins, functionality and even the sense of policy priorities operates as a testing of the kinds of dissent the abstract and known others we write to may yet make and which we try to anticipate, not even cunningly, just routinely and mundanely as we sound each other out and solicit snippets of information in professional camaraderie and mild-mannered brinksmanship:

**Mgr:** ...the only country in the western world with a shit public health system is the country that has the most outsourcing, so you have to ask=

**Tess** =o:oh yes! You know, the other thing I’ve been doing, just for my own sanity, is looking at the I.T. literature where they’ve done a lot of outsourcing and issued their research, and you know, for every successful case study there’s another 20 of absolute disasters! And it’s the success cases that obviously I need to try and draw stuff out of but yeah anyway. But you realise that right now, this week, the Minister and Peter Plummer [the CEO] are doing their [interstate] tour with these guys [the consultants]? Basically probably having outsourcing and privatisation pissed in their ear at every second. It’s like the Emperor’s clothing.
Absolutely! An-an-and that's fine, um, it would, it would, um, the issue comes, how do you outsource something and maintain control in that, in the way that we are talking about? If I were running an outsourced organisation as a private hospital, then ah honestly, I couldn't care less about the public need anymore than I absolutely have to, or that it is contractually stipulated that I should. And it is impossible to contractually stipulate things like that. You must care about, if you're the manager of Joe Bloggs Proprietary Limited, you have a legal and a moral obligation to look after your shareholders before anything else. It is not a question of right or wrong, it is a question of you have a fiduciary duty to do that. How do you do that in an industry where what you're selling is a luxury?

Yeah. That's right and um—okay. So forget that. If you could have your way [with how the Statement is written], how would things go?

(In Transcript 22 August 1998)

In trying to understand the arduousness and simultaneously, the delicacy, of this interactive work, it is important to abandon notions that bureaucrats are propelled by motives of logic or efficacy alone. Policy documents are talked and written into existence by senescent beings who are living the moment and interacting with its discursive twists and turns at a bodily level. Knowing how to perform with finesse, how to enact the intricate steps and elusive rules for administrative comportment (via demeanor, dress, and verbal demonstrations of tactical expertise) can be a source of intense excitement and pleasure. 'I'll play the dumb blonde now,' I recall a fellow policy officer whispering to me during a tense negotiation moment in a (predominantly male) meeting, as she worked to head off a new excursion into the familiar grooves of a well-staked interdepartmental battle ground with a disarmingly silly query calculated to arouse their paternalistic sympathy, while I continued with a more aggressive tack. We are each others' present-time critics even as we play to imagined later audiences and projected goals, embarking on an 'incessant testing of the self through the other person and the other person through the self' (Merleau-Ponty 1964: 120). The virtuosity of each other's tactical performances within sets of administrative dramas are scrutinised in post mortems as bureaucrats 'de-brief', subjecting themselves and whomever they were co-strategizing with or competing against to close critique. After a particularly intensive bout of strategising, bureaucrats can be found in corridors, cafes and wine bars excitedly swapping details about who said what to whom, which words were accepted, which had to be fought over, and they will hint at the feelings that were racing through bodies as the next impromptu moves were deciphered.

People are not only speaking and wrestling with the wording, they are watching, scanning, monitoring, imbibing, cueing off and from each other closely and constantly, in formal settings of protocolled non-watching and ritual procedure, demure dress and polite transaction. There is exhaustion and elation, and even what one might describe as moments of policy ecstasy, when a project 'comes together', when a crisis is averted, or a deadline met with a draft that is indisputable and well regarded. Managers talk of 'thriving on the pressure' of being 'really under the pump', of being 'turned on' by the hectic pace, seduced by the adrenaline rush of making the right policy calls at the right time, of surfing the serendipitous with flair and elan—and they know at the most intensive of bodily levels when they have not performed the moment correctly or well.
When they did not anticipate an event on the horizon, or the strength of community feeling a Government move unexpectedly catalysed, when they weren't scanning the environment with sufficient dexterity to read its clues. Or when the good document, culled and coaxed through all the right stages, is nonetheless rejected at ensuing evaluative stopping stations: at the Minister's Office, or by other bureaucrats in more powerfully placed agencies—Treasury, say, or the Department of the Chief Minister. When something took them by unpleasant surprise and an acutely absorbing 'crisis' must then be unexpectedly managed, questions fielded, explanations drafted, anxious meetings held now, at the expense of every other activity. When suddenly a celebration at bringing a project to a successful closure turns into a stressful re-opening and all the hard-working attempts to hold multiple meanings within the parenthesis of texts are shown once again to be much more transitory accomplishments.

As for rejections, an interesting aside: despite all the work to attain 'ownership', objections to policy texts from groups who've already been representatively sounded through 'community' consultations are not that keenly felt. It is expected that policies will travel a beleaguered path through the minefield of non-government organisations or 'bolshie staff' and their complaints are often dismissed as perfunctory whining to be monitored for potential damage control, a huff and puff to be momentarily endured but not automatically heeded. 'Oh, that's just the Aboriginal industry.' Or, maybe the dissent really is known in advance, as when the protest letter of a non-government representative that appeared in the Letters to the Editor section of the local newspaper was explained to me as unsurprising because the author 'has to say that to show her grass roots credentials—she's surrounded by true believers, but she talked to us first.'

To summarise: Despite its initially unimpressive appearance, Strategy 21 traveled in the bureaucracy as a text that mattered because it operated simultaneously as a discrete and a satisfyingly innovative text. Its implementation would entail an organisational restructure and hence the promise of remedy through metamorphosis, and it had solid representative collateral as a communal attestation of staff input. The core group in the lock up may have held the final negotiating power over the penultimate draft, but the strategy document itself had been the catalyst for a plentitude of inclusive workshops and focus groups along the network of Territory Health Services' regional centres. 600 contributors over one and a half years made it a comprehensive miniaturisation, while its encompassing word combinations and presentational style satisfied production haggles and the aesthetic and aural requirements of a modernist business-like look and sound. It was a high status, high-gloss artefact, and involvement in it provided opportunity for displays of competency and sass amongst peers of note; its formulation

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56 This is not to say that bureaucrats operating out of Territory Health Service's policy headquarters are impervious to critique nor that outsiders have no means of challenging and radically transforming policy initiatives; neither scenario is the case (see, for studies of successful interventions in public affairs, Grefe and Linkskey 1995). Rather, my point here is that in the hierarchy of administrative constituencies known as stakeholder groups, there is also a hierarchy in whose concerns have legitimacy and when they are normally allowed a hearing: bureaucrats have different stakes in their stakeholders. And while policy directions can be re-shaped or even completely overturned through a groundswell of little resistances (as, presented another way, this hospital case study could also demonstrate), the wider point I am making in this ethnography is that all such amendments are grist for a far more resilient interventionist mill. Disruptions are ever recuperated within an overall interventionary logic that transforms but does not fundamentally alter under pressure.
over 18 months was a fair consultation period by the most demanding of measures; and its content, not just its circumstances of collation, gave managers the sense of being at the helm of an important sea-change in the entire administrative apparatus.

It even resulted in an official reformulation of the agency's Mission Statement, transformed from 'Our Mission: To improve the health status and well-being of all people in the Northern Territory' to its current formulation: 'To create and enhance a Territory-wide network of services which delivers continuing improvement in the health status and well being of all Territorians.'

This last, apparently minor change, illustrates my argument exquisitely. In its very banality, it conceals from casual view what is, from a bureaucrat's perspective, the heart of the matter: the shift toward greater levels of outsourcing. For the policy cognoscenti who could sense the density of consultative work invested in the formulation and interpret the significance of these words, it represented a major achievement. The fact that the new Mission Statement glides past the eyeballs, as I have to admit Strategy 21 initially did for me in its entirety, is, in a sense, the bureaucrat's triumph, a hard-won effect of hard-working words which both seem anodyne and yet resonate with all sorts of implications. Now, finally, I could see why people seemed so inordinately proud of Strategy 21, why it was being treated with such reverence, why it was being pressed upon me as something the Minister should 'put up in lights' in the speech I was preparing.

Yet, while ordinarily there will be significant agreement amongst the policy virtuosi on what words will do well when presented to the Minister's or other substantive critical eyes, while usually the expert predictive work closely approximates what will be accepted, in this case, the senior bureaucrats were miscalculating badly. The first text sent to the Minister was categorically rejected precisely because of its over emphasis on Strategy 21.

For by this time, Strategy 21 had been gazzumped.

**Recursivity**

Just as ethnographic research is guided by drift as much as by intent (cf. Van Maanen 1979: 539), so too Strategy 21 and the hospital outsourcing project interconnected both through temporal coincidence and designed conditions of emergence, within a wider economic instantiation of market competition as pivotal to securing efficient resource management within the welfare sector. The story of the co-emergence of Strategy 21 and the hospital proposal was recalled to me by the then CEO as entirely accidental:

CEO Well, Strategy 21 came out of the final workshop with the Executive group, with Doug [the master facilitator]. It just belongs to everyone in that workshop.

Tess And since then- the hospital project. Did the hospital project come out of Strategy 21 or not?
CEO: No. (long pause) No. But what came out of Strategy 21 was the issue of—we should be a provider of core services, and at that time we weren’t thinking, we weren’t even imagining that the public hospital might be subjected to privatisation analysis. But we had shifted to all-anything non-core should be shifted to the non-government or private sector and that we should start to explore that area, which was one of the outcomes that was articulated [in Strategy 21, which calls for ‘a quantum shift to service delivery by others’].

(Transcript, 24 March 2000)

As the policy event of most immediate concern, Strategy 21 was still the talk of Territory Health Services’ head office staff at my moment of re-entry into the policy arena, promoted as a ‘must include’ item for the Minister’s next key note address to Parliament. Yet precisely when Strategy 21 was at its zenith, the hospital initiative was in eclipical motion, quietly and surely moving into ascendancy as the new wave to be surfed.

Most inner circle managers knew the Minister was investigating outsourcing possibilities for the hospitals but had regarded this as a parallel policy development that would dovetail into the ‘greater’ Strategy 21—perhaps operating as a key example to be used to illustrate the more encompassing argument for transforming THS from being a majority deliverer of health services to one which funds others to do it on Government’s behalf. In the scanning and monitoring of policy waves, the Minister’s private consultants were initially diagnosed as ‘peddlers of vapor ware,’ in the Territory to make a fast quid like so many before them, to be watched suspiciously as they attended horse races and charity events and, using alcohol as lubricating vector, wine and dined local powerbrokers and Cabinet Ministers, systematically working their way through the 300 Territorians they’d pre-listed as contacts to slide into loose bind with. But there was not undue initial concern that they would have a serious or lasting impact. Besides, the bureaucrats speculated, the Government had just had its Referendum on Statehood unexpectedly and categorically rejected.57 There was no way they would risk another showdown with the electorate over the hospitals. That was all just bluff and bluster. No, the main event was undoubtedly Strategy 21, a policy that would reposition Territory Health Services for the next five years of organisational activity, right into the Twenty-First Century.

And so, in accordance with everyone’s expert editorial opinion, that’s what the Statement I was tasked with preparing initially focused upon. Yet, responding to the emphasis on Strategy 21 in the draft Ministerial Statement I submitted to him, the Health Minister angrily declared his complete disinterest in the Department’s corporate vision. ‘There is no question,’ he boomed, exasperated at the seeming ineptitude of the mandarins, ‘I just want to talk about the hospitals, I just want to tell everybody the truth! That Strategy 21 stuff isn’t even finished, why get me to talk about it now?’ (Fieldnotes, 22 October 1998).

57 The Northern Territory is not a full State in the Australian Federation, which is a source of some embarrassment to local politicians. During 1998 it was hoped that Territory residents would vote for statehood in a referendum that was coincidentally held with national elections on October 3 of that year. Despite polling showing strong support for statehood, it was defeated. Subsequent attributions laid the blame squarely on the shoulders of then Chief Minister Shane Stone, saying his consultation processes had been heavy handed and out of touch with ‘the people.’ This verdict was sustained both by members of the Opposition and disgruntled members of the CLP providing room for Dennis Burke to manoeuvre a leadership spill in the following months, with, it was said, his strong show of authority in being to hold with the hospital initiative.
Back at production headquarters, the news that the Minister was more interested in the project of privatising the hospitals than in their broader policy vision for the department as a whole, met a tense reaction. The Minister's sense of the truth that needed telling and the health bureaucrats' sense of it were massively out of kilter, an unusual and upsetting state for those well schooled in the arts of anticipating ministerial wants. Editorial changes are expected, yes, but wholesale rejection of one and half years of corporate strategising was a slap in the face of significant magnitude.

'This is a political mistake,' one Executive fulminated and, eliding quintessentially bureaucratic concerns with those of that imaginary unity, 'the public,' her own angry reaction became the gauge of others: 'Burke has got it wrong. He should know that he is going to be disappointing the public, disappointing staff. We've been telling staff in all the [Strategy 21 consultation] forums that everything will be made clear for them in the November Ministerial Statement—and now this!'

Another senior player expressed his anxiety about the extent of the bureaucracy's miscuing:

Well, we misread Dennis [the Health Minister] completely ... But, from my perspective, I was trying to put this in a context that kept Strategy 21 legitimate, and we misread Dennis and his minders, in that they had lost total interest in anything but the hospitals. That had become the sublime outcome. And I'd have said for about ten weeks at least, we had no control of that, none. In fact, almost no say. It was a terrible time, just terrible.

(Transcript, March 2000)

Tense weeks of to-ing and fro-ing followed, with the bureaucrats again attempting to second-guess the Minister, again miscuing, their radars well and truly scrambled. The Minister told me one thing, his Press Secretary another, the CEO of Territory Health and his senior executive managers something else again. The Statement would focus on Strategy 21, it would focus exclusively on outsourcing hospital management, it would mix both. It wouldn't go ahead at all. Strategy 21 was loathed by the Minister, it was supported, it would be implemented, it would be deferred.

Discussing it a year later with one of the Managers involved, I probed how normal such confusion at the penultimate stages of presenting material was in his experience:

Tess So was it possible, thinking about those events, to anticipate how it all transpired?
Exec No.... There was nothing I could have predicted about that. Nothing at all in fact when I think about it, despite all our work.
Tess Has there been anything else in your career to match it, in terms of turbulence, the world churning?
Exec Not quite...I've had other heady times, they were heady, but not in the same way—they're more in control, managing and so on. This was kind of out-of-left-field stuff that you had to really go for a sleigh ride on, and really try to manage at the same time when there ain't no rules.

(Transcript, March 2000—emphasis added)
All the techniques of anticipation had been broken and, recalling the betrayal felt by the informants whose words are not reflected in the final text, policy actors were left feeling wretched that their performance was lacking.\textsuperscript{58} I focused on the hospital project as the Minister had insisted—albeit wrongly influenced and coached by the evil HDI Consultants, his bureaucrats suspected—but the timing was out. For in the ironies of swift policy realignments, in the short time between rejection and rewrite, the hospital initiative had itself become on the nose. While the Minister went ahead with the speech at the scheduled time in the November Sittings, it had lost its edge as a launch of a major initiative. With the idea leaked to the media well before the Minister’s official announcement, the arguments for and against seeking private sector involvement were publicly aired in the lead up to the November Sittings. In the heated debates that ensued, hospital staff groups and allied unions threatened strike action on a daily basis. Residents were letter-bombed with leaflets from the political opposition warning of the imminent Americanisation of the Territory’s health care system.\textsuperscript{59} The singularly poor example of private sector performance represented by Darwin Private Hospital, the only private hospital in the Northern Territory, assumed centre stage in media and bureaucratic debates with attention paid to how, being understaffed and under-equipped, it had closed its casualty ward to instead shunt its critical acute care patients into the public system, destroying in-patient expectations of an exclusive private service. Press coverage became ever more antagonistic, talk-back radio drew increasingly hostile public comment, and negative opinion polls eventually convinced the Territory Cabinet that the move would not be supportable electorally at this moment in time.\textsuperscript{60}

In the work of hedging their bets about the outcome, as they had been with their ironic commentary all along, bureaucrats started letting it be known more loudly amongst themselves that the cost and saving projections marketed by HDI, the consultancy firm advising Minister Burke on the benefits of outsourcing, did not match those crafted by other consultants contracted in specifically for triangulation purposes. The Minister would have done better to woo people to the concept of outsourcing health services through the impeccable logic and considered

\textsuperscript{58} This account of the turbulence of policy formulation should be contrasted with Lesley Gill’s analysis of the failure of her attempt to ghost write a speech for a US Congressman (Gill 1985). Whilst operating as an anthropologist, ostensibly to study forms of political power, Gill chances upon an opportunity to draft a critique of the Panama invasion, which she insists on scribbling from her own liberal-humanist political perspective. It is her hope that this ‘against the grain’ approach will trigger revelatory objections from the Congressman and his staff, thereby yielding ‘additional insights into how power and policy operated’ (ibid: 321). The attempt instantly fails: her words go nowhere, a dismissal Gill interprets as proof of the impossibility of ethnography in elite spaces for ‘progressive anthropologists who want to practice anthropology in ways consistent with their own intellectual sensibilities’ (319). I would argue it is Gill’s spy model of anthropological investigation that prevents her from seeing the patterns in the practices around her: that is, the actors have already been sacrificed to her critical logic, while her refusal to participate in favour of hostile observation proves to be a fatal rejection of a full bodied anthropological approach.

\textsuperscript{59} For instance, an undated letter from the Leader of the Opposition admonished the Country Liberal Party’s ‘agenda to privatise everything from our hospitals to our water supply’ and further that ‘Territorians do not need or want an American style health system where only those with expensive private health insurance get decent health care’. The Opposition prepared a leaflet headed ‘10 Good Reasons to Keep Territory Hospitals in our hands’, which was hand-delivered to all mailboxes and turned into posters for mural and shop-front displays.

\textsuperscript{60} Whilst it would be overly simplistic to assume electoral considerations alone underpin policy success or failure but it is worth noting that in the Territory the tack of cutting back or transforming the delivery or shape of social benefits to the middle class is seldom taken, if only because the size of the public sector (18,700 local and NT Government employees) as a proportion of the registered voting population (17.5% out of 106,000 registered voters, 21% if Commonwealth employees are included, and more if industries dependent on government funding comes into the picture), sharpens the Government’s desire to intimately align its avowed policy initiatives with re-election considerations. This general ballot-proofing follows despite and out of the fact that the CLP had monopsonistic reign of regional administration since self-government in 1974 until mid 2001.
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(euphemistic) approach of Strategy 21, not gone for all the hospitals in one big bang. THS managers now told me. The Minister made his speech, but his decision to isolate the hospital initiative from the more sound framework of Strategy 21 cost him the project.

Or, was that really how it happened? Is this, finally, the homily point, the true account of 'what really' transpired?

Recall how the unexpected is also the expected amongst senior bureaucrats, where second-guessing, multiple positionings and fast switchback movements are insurance against the unknown. Bear in mind this (their within and withoutness, and their enjoyment of their own dexterity) is what makes them/me so suspect. Remember that the hospital project proceeded all the way past the Expressions of Interest stage, with several companies, including religious organisations, indicating they would compete for the final tender. Imagine how seriously these tendering companies (and the bureaucrats coaxing their offers forward) would have taken the preparation of their best and final bids. While bureaucrats were prophesying the Minister's decisions on how best to frame the hospital outsourcing was shortsighted, they still expected the project to proceed, at least to the point of calling for tenders.

Picture the bureaucrats still operating behind the scenes, the intense work required to manifest proprietary interest to the last moment. They are critiquing, subverting, and supporting simultaneously. Here, the surfing—assembling arguments, putting together data, preparing background briefings and publicity material, securing legal advice, talking to staff groups and unions, fielding calls, scanning networks andchurning through the excessive proliferation of electronic memos that surround any major event—all these activities will continue right up to the exhausting point, when, hovering in their offices, waiting for the decision that had seemed almost foregone, the hospital management outsourcing would be put to tender, the pin was unexpectedly pulled. Now, post the announcement that all bets were off, hear the words of the senior managers, explanations and rationalisations immediately stirring into motion at the unexpected result, saying it suits them to let the unions think their threats of strike action were key to retaining civil sector management of the hospitals, _when really_ it was about disempowering the unions all along, giving them a little scare with an eye to increasing the government's leverage in future industrial disputes...

The story doesn't even end there, with policy fizzle, wearied bureaucrats and near and far stories of 'what really', for there is no end to policy. By the time other audiences get their first taste, hearing the news on the media, policy makers will be starting to turn their attention to the next event that demands of them a unique yet repeat set of performances. There will be new words to be cast out, press releases and information kits, ministerial briefings, speaking notes, and cabinet submissions, each with their proforma guides to layout and style. There is a relentless circularity to policy production with a dense and repetitive patterning visible in the form/atta/ation. The timelessness or rather, the recursivity of policy is denied and disguised by its carefully selected...
passionately instrumental language, which, as I will show in the following chapters, in the effort to be blameless asserts a continual avant-gardism, an attempted historical expiation and disavowal of links with past attempts to educate and influence in similar directions. And for the words and calculations to sound fresh, they must be energised by the actors playing their parts with renewed interest in the now of the performance.

Policy virtuosity, or, to use THIS terms, the status of being ‘a good operator,’ is not permanently conceded with a singular performance but is tended and reaffirmed (or not, a fall from grace being all too easy) on an ongoing basis. Borrowing from Fabian’s theories of performance, we might see written policies as the visible tip of an ongoing series of rehearsals. They are a part, a moment of a process, which nonetheless contain within the repetition of required and expected forms elements of spontaneous improvisation and impromptu strategising, always with competing interests being juggled (Fabian 1990: esp. 11-20). At the same time, each surge has the potential to affect everyday conduct. As this case study shows, ‘new’ logics do emerge, with commercialised audit language taking over the previous style of presenting the moral worthiness of fully-government-run services.

My point in using the hospital drama is that by being an axiomatically ‘bad thing’—for how can we as liberal social critics help but detest profit-driven commercial logics?—privatisation represents a classic event for anthropological analysis, with sufficient controversy to yield rich material for deconstruction and exposure. The flux surrounding a major new initiative, with its inherent theatricality, attracts our attention as a discretely analysable event, a real scoop in fact, yet the endless repetition of the performance requirements of policy work is better characterised as dynamic inertia, for it is known that once these performance demands are over, new ones will arise, calling for new (re)nactments. Funding and service provision issues are stock standard items in the health policy trade. Sensitivity to the perilous nature of the hospital initiative and the outsourcing implications contained within Strategy 21 may well have given a particular intensity to their lived enactments but essentially the anticipatory operations, the poised readiness to adopt different postures and to pursue different unfoldings, the intensity of debate that the search for encompassing yet active words creates, the simulation of stakeholder consensus, are utterly characteristic of policies in their pre-legislative, per/formative moments of occurrence. The creation of a sense of crisis and need for change operates both as an argumentative tactic, justifying new interventions into practice, and as self-inspiration at a site where the repetition of novelty propels the action. The manager who says ‘the ultimate frustration is doing the same thing year after year expecting a result’ is expressing more than momentary and clichéd anger to capture an essential functionality of policy and program activity: within the high speed momentum of

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61 Povinelli’s ethnography of the labour actions of Aboriginal women in Belyuen makes a similar point about the constant monitoring of the form and content of individual knowledges in reaffirmations and re-establishings of the legitimacy of intra-group identity and practices (Povinelli 1993a). Authority and status are contested and negotiated interactively and recursively, a point which may seem obvious for all social formations, yet is glossed in representations of bureaucrats as alternately static and process-bound or slippery, complicit and self-promoting.

62 As Palmer and Short note, ‘Health policy making by the States and Territories has been influenced heavily by the need to resolve the continuing problems of public hospitals’ (Palmer and Short 1996: 97).
new formulations is a tremendous sameness both in the doing and in the worried ambitions propelling the doing.63

Understood anthropologically as an animated realm of interactively creative practical achievements, policy’s multiple identities must be apprehended as simultaneously the action of constrained yet actively creative subjects; as a discursive arena in which social categories, problems and classifications feed and emerge out of the cut-and thrust of earnest intersubjective meaning creation; and as a political site where the task at hand is ordering the lives of others, without this being explicitly acknowledged.

So it is now that I want to re-Pose the question: what is policy? It is at first blush an announcement of an intention, a systematised position statement, a plan to entertain certain programs of action, which we might evaluate for felicity, for rightness or wrongness. And it is also, as I’ve been at pains to stress, action itself, in which participants vigilantly strategise to announce what they know is expected of them, in this case at a point of conjuncture where imperatives toward redistributing responsibility for state services meet logics of welfare minimalism. Between the two extremes—bureaucrats immersed in game plays of their own making and bureaucrats immersed in wider political/economic regimes—we might begin to see policies not so much as discrete objects but as part of a social connection (cf. Gell 1992). And this is the most critical point at which the policy-as-text metaphor breaks down, for we cannot refuse to be touched by policies: once the reification of policy as text is suspended, its limits, like the knowledge circuits it draws on, cannot be pinned.

Yet, if we accept that policy generation is never achieved but is recursively processual, how to explain what is in it for practitioners, who, as their adept commentary reveals, cannot be conveniently dismissed as moronic or robotic? To get some way toward an answer, consider the following exploratory remarks of Donald Brenneis, who, pondering his role as a panel member of a national research proposal evaluation team, is curious to explain the rapidity with which he learnt both to do bureaucratic things, eliminating the truly unorthodox from consideration in order to process the normative, and yet derived intense satisfaction from the exercise. Rejecting explanations which spin on unquestioning conformity, conventional self-interest or peer equity, Brenneis observes that

We are often seduced into acquiescence or active complicity with these normalizing practices, procedures that we may well not countenance in our own scholarly work. The rewards for such seduction certainly include status, however transitory, as well as some degree of power. The relationships between these social achievements and the experience of satisfaction, however, are linked in complex ways. The enjoyment

63 People would often have such sentiments about the status quo and repetitions of 'the same old, same old' written on their office whiteboards, printed in desk calendars or magnetted onto a surface, and would manually underscore the concept of repetition when it appeared as a management finding in texts. As later chapters will show, reciting formulaic diagnoses is itself an important and repetitive feature of bureaucratic practice, a returning that is fed by the liberal-humanist faith that identification equals eradication, or at least is a talisman against 'reinventing the wheel.'
of technique, a sense not so much of responsibility as of successfully negotiating complex exchange relationships, and the shared production of social pleasure also need to be reckoned with.

(Brenneis 1994: 34)

Consider also the musings of Carol Cohn, who, despite a pre-ethnographic determination to expose American defence analysts as cold-blooded misogynists, found herself instead enthralled by the privilege and sexiness of mixing terms with men she had wanted to regard as enemies, a thrill which in part came from ‘the power of entering a secret kingdom, being someone in the know,’ able to meet prominent political figures and ‘listen to Washington gossip’ (Cohn 1987: 704), but which also came from mastering a conceptual system which puts insiders in the active ‘position of the planner, the user, the actor’ and not the subject or victim (ibid: 706). The combination of renewing a sense of one’s own ability to quickly adopt and flex a powerful new skill (and matching vocabulary) and performing these same in arenas which seem so supremely able to directly effect ‘the real world,’ is potently seductive.

For me, what these ethnographers are alluding to is the pleasure—and defeat—that is wrung out of intersubjective strategising and coperformance of a particular and professionally empowered kind. Like Cohn, I would argue that being amongst the policy virtuosi, the elite bureaucrats who are closest to calling the bureaucratic shots—for a funding agreement or new initiative here, for determination of ‘conditionally definitive’ wording there, mixing it with Ministers and expensive consultants—is seductive in its own right. With Brenneis, I would say there is an undeniable pleasure in being well-regarded—be it for technical proficiency or adroitness in the ironic yet committed talk of strategy, planning and discerning next steps—within the bureaucratic domain. And I would further reinforce the affective dimension of being a wielder of words which overwrite the multifarious contributions of others, yet make an issue of widespread community and employee participation, and which presumes, builds on and refuses to countenance alternative ideas about the virtue and necessity of change, growth, development, responsibility and good health.

As Foucault reminds us, power is productive, affectively and effectively. Within the tricky, sticky entanglements of agency and obligation, within the internal animation wrought out of being at once governed and governing, our compulsion is compelling. We are the enactors of governmentality, circumscribing the disclosures of others, hooked on the highs of seeming to be the deciders rather than the decided for, even whilst abutting the lived-in, externally-driven and consensual limits on our own agency. Intention and constraint is part of our quotidian world: by rehabilitating results to originary purposes we ideologically transmute the irony that Ortner recalls in pointing out the ironic consequence of intentionality:

Major social change does not for the most part come about as an intended consequence of action. Change is largely a by-product, an unintended consequence of action, however rational action may have been...to say that society and history are products of human action is true, but only in a certain ironic sense. They are rarely the products the actors themselves set out to make. (Ortner 1984: 157)
Comparing my notes from August 1998, when people were on the run, to versions I gathered well after the dust of the privatisation drama had settled, it is astonishing how much orderliness people quickly introduced to their involvement in retrospect—and how policy instructional these later retellings were. The clarity that comes afterwards depends on an active and mobile fastening of pared down and recast versions of the past to each original moment of an instrumentalist present. ‘Strategy 21’ was reasserted as the policy of the day following the renunciation of the hospital outsourcing, and as a postscript, THIS has since been officially divided into purchaser/funder/provider units with internal work groups commissioning work from each other via contractual agreement, introducing a new framing of the requirement to report returns for action within old forms of documented activity calculation (cf. Power 1997). The hospital experiment was immediately reframed as a ‘testing of the waters,’ as a clever strategy of sounding the public out on the most radical end of a suite of changes in service management. Its withdrawal was as an easy compromise in the context of continuing with the overall Strategy. In later recollections, the hospital project was disengaged from Strategy 21 altogether, isolated out as a momentary political aberration when politicians tried but failed to outwit bureau-professionals, unions and members of the public, whose struggle to overcome the misguided Minister and his worse consultants was triumphantly won by the organised will of the good guys, providing further proof of the importance of taking part in and organising public consultations. And participants have since replaced or enhanced their enthusiastic but ironic involvement of the time with a more purified rejecting of the initiative as the posture they were really striking all along.

Conclusion

In the above anatomy of policy, we saw policy-in-the making interacting with the ready-mades of policy, with apocryphal reconstructions of events formed in the wake of the decision not to proceed turning it all into intended outcomes. Had we delved into this case study with standard techniques of policy reconstruction, we would also find that what gets released both within ‘final’ policy products and in retrospective straightenings have by far the greater prescriptive and historic authority, directing our attention to the accomplished facts, even whilst anthropologically, the drift, the compromises and the uncertainty of the just happenings and adjacent meanings in the elusive ‘before’ are as deserving of critical attention.

Policy always achieves more than its authors articulate in original conception or post-rationalisation but assimilating elements of this indeterminancy, this ‘more’, is itself a routine feature of bureaucratic discursive practice. Indeterminancy compels scanning and involvement, malleability and incessant monitoring. It is expected and accepted, even distilled into its own management axioms as chaos theory and flexible, just-in-time management.\(^{64}\)

\(^{64}\) Chaos theory in management is a prominent theme in organisational literature. In essence, the argument is that organisations are best viewed as complex, adaptive systems in which ‘order comes for free.’ That is, that equilibrium or status are to be resisted, and chaos encouraged, allowing the tendencies of living structures to assert their inherent and always emergent complexity and capacity for self-organising. Where things settle is where they were meant to: the job is to judiciously unsettle to allow natural orderings to emerge. Managers are advised that they cannot assume a particular result from any particular input, as one cannot direct a living system, only disturb it—but in the disturbing, (unpredictable) change will result in the form of breakthrough innovations and new successes, which must be harnessed, or rather, surfed (Pascale 1999: 1, for a foundational text, see also Wheatley 1992).
For practitioners, policies are meant to produce other, forthcoming acts as part of their necessary effect beyond the direct intentionality of its authors, even whilst editorial effort has attempted to prescribe the meanings of ‘what goes out.’ The incontrovertible text, the holy grail of policy work, is an ever so fragile achievement. The critical point to policy wording is not that it contains more than its authors intend, which the social scientists alone can draw out, but that this excess is, in a mundane and untheorised kind of way, anticipated or at least assimilated by formulators, who assume the capricious and ad hoc to be a constituent feature of their work, and of the life their work assumes beyond their input. But this does not negate attempts to control outcomes or direct events—on the contrary, the simulation of order and intentionality is an intense focus of activity and intellectual effort. Whatever the outcome, the stories that over time are worked into firmer formulations, become credible, sermonisable accounts testifying to the logic of policy processes.

We also saw that a bureaucrat never has the complete measure of any particular situation. Context is never pre-given, a complete package of knowing in the before-hand of an event, but rather is an artifice of representational devising. People are constantly attending workplace gatherings where their knowledge about the specific program or issue at hand is partial and fragmented and their responses have to be partly worked out in situ. That is to say, institutional actors participate without full and advance propositional content of a given situation, enabled by their tacit incorporation of the rules of participation. It is not necessarily a matter of putting one’s truer, more authentic ‘values’ to one side, as Kunda suggests. These moments are at once inhabited intensely and with a certain detachment, which is part-paistic of being involved. One ‘stance’ is not more deluded than the other, not in the rationalistic way of understanding delusion anyway. It is a permanently hologrammatic outlook mastered through immersion in ‘an assemblage of diverse components, persons, forms of knowledge, technical procedures, and modes of judgement and sanctions’ (Rose 1993: 287). It remains to be shown how this mastery takes place, looking firstly at the organisation as a whole, its formalised history and its modes of historical allegory (Chapter Three), before returning to the small-scale detail of imbibing, where the task of learning to be a bureaucrat becomes both more formalised and capricious in the give and take of institutional co-presence.

The critical point to export from this to later chapters, where public health philosophy and Aboriginal health practice will sharpen more clearly into focus, is that policy, for all its regulatory power, is not an orderly transport of a stable idea into stable practice (whether resistant or accepting), ripe for our critical apprehension, but is more the proliferation of little instances across a field of authorised and unauthorised bureaucratic and non-bureaucratic encounters. Or, more simply, it is all much more complex and messy than that. To present Aboriginal health policies in too stark terms as, a-priori, the attempt of social engineers to make fit and healthy a downtrodden group, would be to miss the subtleties, constraints and contradictions of bureaucratic action. This, finally, is my own ‘what really.’
Chapter Three

Placing

Between the Pen
and the Paperwork
Chapter Three

Placing

Master narratives speak a war of positions. In this case, in this doubly occupied space, there is first the perspective of industry and the status quo that would write the history of this place as an inevitable progress of events. In response, a critical voice claims events as evidence of the forceful exploitation of a people and the tragic death and destruction of a culture. Both are powerful stories that script hope and mourning into the very meaning of History for us. Both lurk in the wings of the political unconscious waiting to make a move in the search for causes of blame or celebration.

(Stewart 1996: 97)

One way of presenting a master narrative of Territory Health Service bureau-professionals would be to position them as brokers of just such a ‘doubly occupied space’; new residents in an already occupied land, colonised and scarred, called to administer the settler and indigenous communities of the still frontier Northern Territory. The burden of ill-health carried by Aboriginal Territorians in their sickly blood and diseased bone is itself readable as the result of loss: loss of land, loss of culture. In the story of mourning and hope that could be scripted here, it would begin with invasion, rape, murder, dispossession, exploitation, disease and decay, slavery, stolen children, attempted assimilation, thwarted self-determination. And it would end with the cautious optimism of an as yet unreached reconciliation, mutual dialogue, partnership, collaboration, equality in difference. Steps for getting to this point would fill the narrative body, and would include addressing the ongoing outrages of inadequate housing, poverty, unemployment, incarceration and unheeded political voice in order to ease the grim burden of early death, injury and chronic disease.\(^6\)

Yet while a clear repression-liberation narrative, rich with pathos and dignity, is available to order explanations of the underlying causes of high Aboriginal mortality and morbidity rates, a point to which I shall return, the formal administrative history of health governance in the Territory lacks this storied density. The few administrative histories that have been written are heroic, tracing the pioneer efforts of individual doctors and nurses who shone the light of science onto the diseased

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\(^6\) The literature falling into this script of hope and mourning is immense. Limiting it to health sources alone, the *Australian and New Zealand Journal of Public Health* dedicates at least one article per issue, and one special edition per year, to Aboriginal health and thus illustrates the way public health knowledge productions secure a sense of mission and redemption. A recent special edition of the *Medical Journal of Australia* (Volume 172, May 2000), likewise dedicated to indigenous health, begins with the editorial proclamation that ‘The current state of health of Indigenous Australians is a cause for national shame, and has its roots in the wholesale exclusion of Indigenous people from Australian society since 1788’ (Eades 2000: 468). An article by the former director of the Menzies School of Health Research in Darwin is precisely titled ‘The Past is All About Us and Within’ (Mathews, Weeranandhi, and D’Albs 1995), leaving the reader in no mistake that the terms of representation are to allocate a particularly sequenced historical causation to what is frequently called ‘the contemporary burden of disease.’ Ernest Hunter’s work, *Aboriginal Health and History: Power and Prejudice in Remote Australia* (1993) likewise makes over the past in the direction of a singular history of disease-causing oppression. See also edited collections by Alan Gray, *A Matter of Life and Death: Contemporary Aboriginal Mortality* (1990) and Gary Robinson *Aboriginal Health: Social and Cultural Transitions* (1996).
black bodies of the north, under professionally arduous and climatically hostile conditions (see, for instance, Kettle 1991, Reid 1997, Riddett 1987). And where northern clinical history has predominantly been the concern of autobiographical medical professionals, accounts of the health administration as a whole have tended to be absorbed into the a priori negative category ‘the state’ in revisionist accounts of racial conflict.

The corporate history of THS stands as another instance where our own administrative actions are made both historically simple and, bar a handful of eponymous figures, relatively anonymous, so as to foreground detailed projections of Aboriginal pain and misery. In such revisionist accounts of our strangely unpeopled racist history, major pieces of legislated policy (the tidied versions we saw coalescing in the previous chapter) become the established facts ordering the chronologically noteworthy, as if government policy is the key variable prompting the reflexes of the political economic and social order. As race relations historian Rosalind Kidd notes of Queensland records, a far more densely populated and heavily administered state than the Northern Territory,

Little can be learned from history books about the operations of Queensland’s Aboriginal department for the first half of this century. The few historians who venture into this area, having defined the 1897 Aboriginals Protection Act as an instrument of racial segregation, await in vain for the overturning of reserve policy as an indication of administrative reform. (Kidd 1997: 80)

But if the administrative history of Territory Health Services is largely absent from the historical canon, the use of historical narratives in everyday health discourse cannot be missed. In THS, as I will show, a regretful knowing of loss, a sense of the tragic destruction of the former health and harmony of indigenous people, are explanatory grammars for viewing the impossibilities of the present. The exploitative past, in other words, is used to explain the dysfunctions of today, subtending the present’s complexity with a homily of past (t)error, whilst simultaneously distancing the company of contemporary progressives from the vicious and narrow-minded policies of a simpler but harsher colonial yesteryear. Thus, coinciding with the narrative of despoiled indigenous wellbeing, there is also a narrative of headway: what our forebears did to them back then in the ignorantly brutal heretofore is not what we will do in the more informed and inclusive now. Complicating this, a form of bleak professional self-criticism turns on the related idea that the public health effort ameliorates without deconstructing the underlying historical conditions, leaving intact the legacies of colonialism, poverty, racism, under-resourcing—the ‘real causes’—so that we are only ever patching up, spak-filling, band-aiding.

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66 Other notable works which focus on the trials of medical pioneers in the Northern Territory include Doris Allen’s Frank Flynn, M.C. A Remarkable Territorian (1984); Frank Flynn’s Northern Frontiers (1986); Clyde Fenton’s Flying Doctor (1962, see also Wilson 1987); and Ella and Harold Shepherdson’s account of their health and education efforts as missionaries in Half a Century in Arnhem Land (1981).

67 For an account of autobiographies as a genre of American medical history, see Pollock (1996).
History in the Setting

The point I am making is simple enough. While academics may well have discredited constructions which make of the present a linear march from the past, this chapter is forced to account for the ways people in THS unashamedly (or more accurately, with great sorrow and great shame) express themselves and make meaning through a teleological grid. By default it explores how the intellectualist approach of dispelling the master narrative of History, with its rejection of notions of progress, is here brought into the everyday and put to use. In THS, forms of explanation which cadge answers from history are put to the ethnographer as the detail of what has to be understood about the intricacies and dilemmas of working in this terribly difficult arena. Accordingly, if I am to give any sense of the past and present history of THS as a structure, I need also to give some sense of it as a structure which is lived, including the multiple ways in which history is brought into the everyday and put to use as people inhabit and travel through the organisation.

In this place where history is both explanation and diagnosis, health ‘factoids’ (hybrid anecdotes which circulate with the efficacy of the tabloid story and the believability of the established truth (Dumit 1997: 99-100, n.5)) are stripped of empirical historical content to circulate as authoritative accounts. Factoids do not need to be seen to be believed, iteration is all that is required.

I know that in 1991 when we were looking at changing the health system in Queensland that we were looking to the Territory for all the answers, and you-know we thought the Territory, they've got [Aboriginal] health workers running clinics, they've got this, they've got that, we can do this too! And we did it but then I come to the Territory and I find that it's nothing like that and there's only very isolated pockets of talented people. And they, the [Aboriginal] health workers, seem to be isolated, disempowered. I think there were some really good strong systems for education, training and support that are not here now and consequently we have a fairly dysfunctional health worker workforce. Now I'm not, I don't think we can't turn that around, I think that we can and we've started to, but it's gunna take a lot of work and effort.

*Rural Health Manager (fieldnotes, April 1998)*

These are constructions necessary to hopes of transcendence, a live teleological impulse that is incorporated and transmitted as necessary messages of ‘can do’. Without the stories, health professionals become bleak, pessimistic, mired in the mass of previous efforts. They cannot see how to keep on doing. ‘Burn out’. A phenomenon of pitting one's own helpfulness against an alterity that refuses to budge in the direction of performance indicators.

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68 The expectation of progress out of the litany of past failures has been expelled with dishonor in recent historiography and anthropological theory (Appadurai 1986b, Carter 1987, Dening 1988, Lerner 1986, Wolf 1982). This chapter explores the retention of teleological accounts in the health department, not only because of an inherent health system bias toward positivism, but because, in THS, history operates in a Barthesian way as an efficient sign of wider cultural concepts.
It got to the stage where if I heard one more person tell me to get ‘runs on the board,’ if I had to organise one more trip, to badger a group of people who see me as no different to all the other bloody whitefellas that have been before me, I was gonna go under. I had to stop. I was being set up to fail, you know? Set up. I’d been doing it for too long by then. Lost my naïveté.

*Former remote area worker, Darwin rural (fieldnotes, December 1999)*

Telling

Some of this can be explored in terms of the primacy of certain ways of telling about success and the iterative processes through which such historicised tales become unarguable and compelling. Entering Territory Health Services, for instance, one quickly learns the name of the Strong Women, Strong Babies, Strong Culture (SWSBSC) program. In the orientation courses for remote area health personnel, in seminars and conferences, briefing papers and policy documents, the program is multiply mentioned, and newcomers are soon able to recognise the title—if not the program’s precise history or content. From the vast mass of program stories available, it is curious that this tale above all others is so quickly transmitted and acclaimed. What recommends it, what explains its fascination, its noteworthiness?

One explanation of the program’s eminent relatability is its clear claim to a rare and elusive quality, ‘real health gains’ (Cross-Cultural-Consultants 1996: 4):

Evaluation of the Strong Women, Strong Babies program for those communities involved in the project has shown a 43% reduction in the number of low birth weight infants, a 55% reduction in the number of premature births and a 140g increase in the mean birth weight (pre-natal n = 226, post-natal n = 137).

(Territory Health Services, 1996: 48)

But its quantifiable eligibility for the label ‘successful’ is only part of the story. There are other remedial interventions which could be related, others which have numeric proof of their effectiveness—tuberculosis eradication, say, or sexually transmitted disease reductions—that are not circulated with anywhere near the same rapidity. The appeal of the Strong Women’s program, I want to argue, lies in its proof of other, uncountable aspects. It lies in its promise that Aboriginal

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69 The slippage into self-proclaimed anonymity revealed here, where the worker is no longer an individual but portrays himself as just another ‘bloody whitefella,’ is related to a complex process in which, I argue, professionals incorporate the corporation. In communities, health professionals represent themselves in terms of their program identities, and tend to (antagonistically) reproduce a distilled version of a wider institutional logic even while they are desperately seeking to establish some kind of individualised rapport with the Aboriginal people they encounter. How this anonymity is transacted within embodied encounters is explored in detail in Chapter Six: ‘Encounters.’

70 Note that this program has been officially evaluated twice. The first, cited here, was conducted internally by researchers employed within Territory Health Services, while the second was commissioned through the Menzies School of Health Research (MSHR), a bio-medical and public health research and training institute which was established in 1985 to conduct work particular to northern and central Australia, with one of its key functions listed as ‘an independent evaluator and/or commentator on health practice and policy in the Northern Territory’ (MSHR 1998:21). This second evaluation was conducted by MSHR employee Dr Dorothy Mackerras, a nutritional epidemiologist, and confirmed the findings of the first (see Mackerras 1996).
ill health can be improved when people are inspired to help themselves, in its evidence of what can be achieved with dedication to the right approach and, my interest here, in its ease of place as an historical vector. In this tale, there is a logical sequence of events: a program, a philosophy, a partnership, and a real public health gain. The program, in the words of one of the Galiwinku Strong Women Workers, offers a model of ‘two way learning’ (Aboriginal Development Unit 1996), or, more emphatically, as its formal evaluators put it, ‘as the degree of Aboriginal control over the process increased, a shift in [black-white] relationships to one of equivalence also occurred’ (Cross-Cultural-Consultants 1996: 3). In it:

Community based Aboriginal women, who are recognised by their community as having specialised cultural knowledge, are trained in basic nutrition and antenatal care ... These ‘strong women workers’ in conjunction with health staff in the community provide education about women's health to their community. (THS, 1996: 48)

Let me tell the Strong Women story as it has been alternately described to me by health professionals, as I myself have described it for others in policy writings, and as it is presented in numerous summary reports and newsletters. The program was developed in 1993, catalysed by numerous studies indicating many more low birthweight babies are born to Aboriginal women than to non-Aboriginal (Markey et al. 1998, Sayers and Powers 1997). Such lightweight infants are more likely to die in their first year or have significant illness problems in early childhood than their heavier counterparts, with cumulative effects manifesting in such chronic and debilitating diseases as diabetes, hypertension and renal failure, ischaemic and rheumatic heart disease, and in ongoing susceptibility to multiple and simultaneous infections throughout the life-span (d'Espaignet et al. 1998, Kruske, Ruben, and Brewster 1999, Lee et al. 1994, Mathews 1996). The program aims to disrupt such lifetime susceptibility by having older Aboriginal women share with younger women ‘The Strong Women's Story’, an affirmative ‘narrative using graphic images that provide information about the nutritional status of women and their general reproductive health’ (Fejo and Rae 1996: 3).71

The narrative is built around a flip-chart showing how the road to good health involves a series of rejections: don’t drink too much alcohol or eat fatty foods, don’t smoke ganja72 and don’t have unprotected sex. I recall one page showing a line drawing of a road over a peninsula with tangents leading people to fall off cliffs called ‘alcohol’ and ‘gambling,’ little people figures scrambling up ladders from the rocks below their falls, others lying still, them ones finished up now, and the unbattered steadfast remainder dedicated to the path, unswerving in their commitment to the health of their own and their baby’s fragile bodies.

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71 The description continues as follows:

The story identifies barriers to healthy mothers and babies and opportunities for women to take more control over their own health and the survival of their children;

• It incorporates cultural affirmation and revival of women’s ceremony as integral components;

• The process has identified specific health service barriers to participation in antenatal care by Aboriginal women; and

• A Strong Women Kit has been produced comprising the Strong Women, Strong Babies, Strong Culture Story manual, the SWSBSC Nutrition manual: a set of four videos; and SWSBSC T-shirts for workers. (Fejo and Rae 1996)

72 The Indian hemp plant Cannabis sativa or, more commonly, marijuana.
The Strong Women Workers use the flipchart as a pedagogical device to educate young girls and expectant mothers on how best to comport themselves through pregnancy and beyond, including advice on the critical times for presenting to the health clinic for examinations and monitoring.

Since its inception up until her retirement in June 1998, the public face of the program was represented by a venerated Aboriginal woman, Lorna Fejo, a former hospital cleaner who, in 1992, was employed to coordinate an ante-natal education program targeting Aboriginal women 'at a salary level usually paid to professional staff' (Fejo and Rae 1996: 2). In the first three communities involved, Galiwinku, Wadeye, and Milingimbi, the program operated on a cascade model. Respecting the cultural truism that pregnancy, birth and infant care fall into the domain of 'women's business', teams of strong women workers, nominated by the targeted communities on the basis of their cultural standing, were trained in maternal and infant nutrition and infection control and as a group, developed the 'Strong Women's Story' as the media to promote ante-natal discussions. The strong women workers in turn trained non-Aboriginal staff on the nature of those non-western ante-natal practices that were formerly active in communities and incorporated these retrieved rites into the program:

[the women] focused on images of the smoking ceremony, which in contemporary times had fallen into disuse. The whole concept of ante-natal care became interwoven into a holistic and very powerful vision of women as nurturers of their culture represented by their participation in the smoking ceremony and other women's ceremonies. (Cross-Cultural-Consultants 1996: 18-19).

As a result of the strong women worker interventions, younger women in the pilot communities presented for ante-natal care with Aboriginal Health Workers in community health centres more frequently and earlier in their pregnancies than before, an outcome which has since been correlated with reduced incidences of recurrent infections in both the target women and their children, increased pregnancy weight gains, and increased infant birth weights. The program is now being implemented in ten other communities within the Northern Territory, including some in the southern desert areas, and is attracting interest from communities in Queensland and Western Australia as a program which succeeds because of its recognition of the traditional nurturing and healing practices of Aboriginal women (THS 1999).

73 Lorna Fejo is her real name, given here because of her clear association with the program. Indeed, it is worth noting how individual identities become so significantly aligned to programs in processes which claim to be impersonal—or rather, in processes which ostensibly aim to make programs operate on principles that are independent of the individuals that run them. That they do not is frequently lamented and recorded in diagnoses of program success and failure aetiologies ('enablers and inhibitors' in the language of evaluation focus groups), with 'dependency on key individuals' dot-pointed as a problem more intensive future effort to include whole communities and train more locals will rectify, even as the reinstatement of a singular representative is required to provide a definite point of reference and public personality for the program.
Not all successes succeed

SWSBSC has warm appeal. I want to argue, because it speaks of a break with the past in the same moment as the past is retrieved from the disease-causing weight of colonial history. Under the Strong Women program, Aboriginal health is resurrected by summoning and paying wages for a faded and regionally-specific custom reformulated in the direction of positive health outcomes for all Indigenous Territorians. And in that small program manoeuvre, the health department functionalises and becomes the institutional bearer of Aboriginal Culture, assuaging health professional fears that attempts to transform Aboriginal health does collateral damage to Aboriginal traditions and lifestyle, not even one step removed from our destructive colonial forebears. For buried within the bureaucrat’s rescuing embrace of a superior (older) indigenous knowledge lies the trace of a deeper fear amongst health professionals: a futile sense of only ever compounding the cultural damage whites were responsible for starting in the first instance.

Strong Women, Strong Culture, Strong Babies operates as an economical sign of program efficacy because it arrests the (secretly expressed) despair that Aboriginal ill-health is a foregone conclusion, using the healing power of a frozen Aboriginal tradition, stripped of its own historicity to interrupt the failure trajectory of the present. In the designation of older women as senior teachers reviving a forgotten practice, it has forced a buried custom into a productive relation with the problems of the contemporary.

In its compulsory freeing of Aboriginal agency via the logic of problem solving and committed intervention, it recalls for me another moment in fieldwork, when I heard health professionals being advised by a remote area manager to

reinforce the strength of the older men by demonstrating respect. When we go to the community make sure to see the elders first so that we model through our behaviour to the younger (Aboriginal) people how the elders should be treated. And that doesn’t cost us any dollars but it makes a big difference to the self-esteem of that community.

(Fieldnotes, May 1998)

In the face of widely bemoaned cultural dysfunction, bureaucrats are told to remind community people of the customary values that should still matter to them. To paraphrase Fabian, enlightened borrowing from a wiser Aboriginal heritage becomes the catalyst from which to salvage an otherwise hopeless present, a move which contains within it elements of ‘romantic pessimism and nostalgia’ where ‘the posited authenticity of the past (savage, tribal, peasant) serves to denounce an inauthentic present (the uprooted, évolués, acculturated)’ (Fabian 1983: 10-11).

More than this, we find it is the assertion of a particularised understanding of Aboriginal cultural practices that matters here, an understanding which lends itself as proof of the efficacy of community development and the power of subject inclusion in program design and delivery. Strong Women is a program success story which can be delivered with certitude not only because it has statistical merit—for so has the dramatic leveling of infant mortality rates across the Northern Territory from the 1980s onward (Thompson 1991: 49), a barely ratable achievement in narratives
of program success set against 140 grams of increased birthweight in three communities—but because it affirms the community development optimism that, encouraged to call on a sanctified past reconstructed in terms recognisable to the public health imagination and design something for themselves (within program parameters), Aboriginal people can overcome their own grim present.

Engaged through the right processes, they can, in other words, transcend the historical determinations that limit their social place—the pernicious and sickening effects of racism and structural inequality—to move into the contemporary, sharing the good health that will come with a dedication to shaping one's own corporeal biography with appropriate early intervention into lifestyle and habit (cf. Beck 1992, Lupton 1995). They can become active participants in the construction of solutions, deciders of their own fate, empowered by health funding and the supportive encouragement of fieldworkers to move beyond colonised victimhood and welfare dependency to a new location as co-occupants of modernity. As the empowered architects rather than the passive recipients of policy, Aboriginal people can live the self-regulating embodiments traced by Niklas Rose when he tells us:

Whilst welfare sought to govern people through society, advanced liberalism asks whether it is possible to govern without governing society, that is to say, to govern through the regulated and accountable choices of autonomous agents—citizens, consumers, parents, employees, investors.

(Rose 1993: 218-9, original emphasis)

Program achievements based on successful medical therapies or improved infrastructure (better airstrips leading to faster emergency retrievals leading to fewer infant deaths, for instance), achievements which do not promise this transformative administrative inclusion, do not have the same currency as stories which proffer the formal hope that one day, Aboriginal people will no longer need to be acted upon but will instead be as self-regulating as the professional classes, cultural distinctiveness intact. Here finally, Aboriginal people are not only taking up health facts and acting upon them, they are in charge of the whole process, with measurable results. In the words of one senior manager, describing the symbolism of the program retrospectively to me,

So much of what we do is unconsciously culturally biased. Most of our approaches are bound up in our own culture. Strong Women Strong Babies is a rare counter example. Strong Women is quite clearly successful because it belongs to the women, to the community, and not just with the Department.

(Fieldnotes, January 1998)
Note again that only some parts of the story are needed here, where history bent to optimistic projection outweighs any need for detailed empiricism. For those closest to the Strong Women program, it takes on a more complex hue, its contradictions are more intimately known and harder to transmute into a clear salvationary tale. Like many public health professionals I’ve encountered, Jan Paddle, a nutritionist, was thrown into her first meetings with Aboriginal women armed only with a profound sense of wanting to transform the health and well-being of the Yolngu people in northern East Arnhem Land by using community development methodologies.

When I first started, I can remember meeting one of the people at Territory Health, she came out just about a week after I started the job, she came out for a routine visit saying she wanted to get a Strong Women’s! program started at Yirrkala. And we were sitting at this meeting at Yirrkala, when she said [indicating Aboriginal women] ‘alright, you, you and you are strong women and Jan, you’ll come out on Monday. Alright I’m going back to Darwin’ and this is, this was about the Thursday of the second week and I thought, ‘Far out! I don’t know what the program’s about, I don’t know the women, what do I do?’ And I felt really discomfited going out on that Monday and walking into the Women’s Resource Centre. Walking in, I didn’t know what to say, I didn’t know what to do, I don’t know what to go on, how do I develop a program from here? It was horrible! A really horrible period. Cause I just didn’t know, didn’t know how to do it. And yet, we all know community development- I mean, I had a vague way of working but I didn’t have the training, skills or confidence to know how to do it. It was sort of, I suppose I’m saying that somehow I was given this program to support and given the, not through my own nomination but given the women, and it wasn’t even the women’s nomination, it was just ‘you, you, you’re doing it’ so the process to get me there on the Monday wasn’t consultative (sic). It wasn’t through the community development model, it wasn’t consultative. So I had to then redirect it firstly and it was a real downer period. Every time I’d go out, the women weren’t there, I couldn’t understand the language, I didn’t understand the people. It took about six months before we actually got it together. I’d be going out, not knowing what people were doing or key things that were happening, that was really very difficult.

(Transcript, February 2000)

Three years on and the women nominated under the ‘you, you and you’ Aboriginal designed-and-led process have long since abandoned the program so Jan ‘worked with the Council and the Women’s Centre to identify new ones,’ only now she must prove to her regional managers that autonomous Strong Women Workers really are working autonomously, by insisting they keep daily diaries to record just how many other community women they talk to and refer to the clinic, and just how many go to the clinic as a result.

75 The word ‘Yolngu’ is the term inhabitants of north-eastern Arnhem Land call themselves and are in turn collectively called by Euro-Australians wishing to signal their respect. Yolngu can be taken to mean ‘person’ in Yolngu matha, the common language group of the region (matha, literally ‘tongue’ and by extension language, comprises all the dialects of the north-east Arnhem region).

76 A former Methodist mission settlement, first established in 1934, only a short (approximately 8 kilometres) trip from the banquise mining town of Nhulunbuy (Gove). Yirrkala is famous in Aboriginal legal history for bringing forward the first land rights suit heard in an Australian court of law. For a detailed history of the land holding clans and their survival of missionary and government order, see Nancy Williams (1986; see also Peterson and Langton, 1985).
The new coordinator of the program is worried about the flip charts she's inherited from her predecessor, Lorna Fejo, arguing the Strong Women Workers are reluctant to use such overly moralistic media. She has ideas of her own she wants to develop, including a desire to talk to the young girls about how poison transmits to the foetus through the umbilical cord and a new handbook describing how much 'gut damage' (villi stunting) occurs with repeat gastrointestinal infections in young children. Jan worries in turn that the Strong Women Workers have had no professional development since the program was conceived, that Head Office only cares about the number of communities enrolled in the program, not any real information about its ongoing impact nor the fact that the Strong Women are expected to repeat the same activities year in, year out without balking at the tedium. And when Head Office do pay attention it is to demand bizarre quantifications, like diary records of the clinic visits attributable to the interventions of Strong Women Workers.

So I said 'so how about giving them some literacy skills? How about giving them a place in the clinic to store these diaries? How about giving them a role in the clinic?' These women find it hard to even have knives in the home! It is so unrealistic! The strength of Strong Women is that it started as a grass roots project and now with all these new expectations but no additional support the women don't know what they should be doing anymore. I think it is really sad. With all the intrusions from THS, it [the Strong Women program] is losing its power.

(ibid)

At the same time that the new coordinator and the nutritionist complain that the grass roots Aboriginal women are not sufficiently included, their battle is with each other and who consults with the women the best. An educational workshop for the Strong Women Workers is being planned (one of many and not particularly special), but there is intense disagreement about the focus and approach. Jan wants to tackle the issues indirectly, at the women's pace, in the spaces in between catch up gossip and basket weaving with stripped pandanus leaves, building up to the complex issue of villi attrition over time, carefully, with preparatory work introducing the intestinal system and the critical function of the minute, finger-like vascular filaments plussily matting the insides of the small intestine. (If they are repeatedly starved via recurrent bouts of diarrhoea and impoverished diet, the stricken velvet villi eventually and permanently stunt, unable to perform their nutrient absorbing function with any efficiency, consigning the growing child to a lifetime of under-nutrition regardless of future diet type or volume (cf. Kukuruzovic et al. 1999, Ruben and Walker 1995).

There are complex issues and difficult cause and effect patterns to be explained—the bush women will need time to learn, to be brought to the stage where they can begin to probe for themselves the aetiologies that matter. But the new coordinator doesn't want an indirect approach—the issue is just too important, it must be tackled head-on, they need to be assertive and set the agenda now. 'The women will wonder what the workshop is for if all they do is gather bush tucker, and anyway it is not Jan's program!' she insists and, so powerfully unsaid it hovers in the air: unlike her, Jan is not Aboriginal, so what would she know?
Meanwhile the chief paediatrician at Royal Darwin Hospital complains that no one is talking to Aboriginal people properly about the grave implications of the intestinal damage, the villi atrophy and microcephaly\textsuperscript{77} he is witnessing on a scale that would be considered a national emergency if this was a refugee camp but because we are a first world country we're content to kill people with a benign refusal to attribute blame and accurately locate responsibility. Let's face it, the Strong Women program is nice and all but it isn't getting to the heart of the issue:

we have \textit{gotta} put pressure on communities to get their act together. I think this is because of white man's burden there's been a there's been real tendency to \textit{not} negotiate, not to you-know because we get this 'oh it's all our fault' sort-of-thing so people back off. I think that no longer can we accept this \textit{guilt blame} scenario and I think that's got to end. It's amazing to me coming from the developing world- I have two black children, I've spent twenty years in the developing world on a miserable salary so I \textit{really don't} have-I mean in Africa if you have white man's burden you're dead on the ground, I mean you just can't do \textit{anything} 'cause they know how to play it! They're much more sophisticated in West Africa, they're playing-and I just see this all the time around me [here in the Northern Territory] white people back off and don't say anything and-except totally acceptable points of view and I think that's got to \textit{end} ...I see in the Territory we've got microcephaly in much, much higher proportions that I've ever seen before and the reason ...

I mean in \textit{Africa} a breastfeeding mother that hasn't got AIDS, I mean they're \textit{healthy}, they'll \textit{survive}, they do fine, they get diarrhoea and they recover. It's a very different situation here and why is that? I think it's because they've \textit{WORSE} underlying gut rot, because the hygiene situation and their skin is much more diseased and, and there's much more infection of their \textit{gut}. These are the two external things ...[their skin and intestines] get colonised and diseased much more than in the developing world or in many developing countries and I think the way to—okay it would be nice to fix that overnight but the interventions that fix that are \textit{not} readily available in a dysfunctional community. I mean it's literacy—it takes time, \textit{years} of time. What's concerning me is that we're really not addressing this even in the long-term—I mean let's be very clear. I mean I think we've \textit{got to keep saying this} ...If we're really serious about improving child health—and child health determines adult health in these communities—these organisms, the diabetes, and heart disease and respiratory infections and bronchi-kind of lung disease in Aboriginal communities— I should say renal disease as well—\textit{all} have their origins not only in childhood, but in infancy, in pregnancy and early infancy, that's where it's all starting.

\textit{(Transcript, March 1998)}

\textsuperscript{77} Microcephaly is the generic term given to any manifestation of small head size for age, gender and gestation. It is generally equated (but not automatically correlated) with mental retardation or, at the very least, with fewer brain cells and reduced counts of brain DNA, as it is always caused by microencephaly (a small brain), and the two terms are used interchangeably. As a generic phenomenon, microcephaly is caused by many different abnormalities, both genetic and non-genetic. Within Northern Territory paediatric material, attribution is usually given to small birth weights and in its post-gestational guise as 'failure to thrive' which is in turn associated with infant under- and malnutrition. All prognoses point to maternal education combined with nutritional and lifestyle interventions as key remedies (see, for example, Ruben and Walker 1993). Note that the term replaces one in previous use, 'dysmaturity,' to refer to full-term but small for date babies.
History’s applications

The countering optimism behind the repetition of the Strong Women’s story brings into focus the different temporalizing registers that history assumes in the grammars of exchange in Territory Health Services. In brief;

1. Aboriginal people have had no time: the pace of change since invasion has been so rapid, the people have been left bewildered and perplexed, unable genetically or socially to adapt to a dramatically altered landscape and lifestyle, a culture deemed to be as old as a culture can be shattered by change so monumental that pathological and refractory behaviour, fatalism, victimhood, community dysfunction and premature decline are understandable and predictable responses.

2. They have had too much time: after such vast investments of effort and resources, there should be more results by now. The intensity of the welfare effort in fact has so disempowered the people they have in turn become dependent and demanding of more institutional insertions, lacking the hunger that would drive the subject peoples of other colonies to greater self-determination.

3. They are trapped in time: kinship obligations, patterns of exchange and dependence, tethered to a hunter-gatherer mode of living (no harboring, no rationing, no budgeting, no investing, no

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78 While I am emphasising the range of intersubjective expressions of the past in the present as they are put to work by health professionals, these views have a strong research presence as well, reflecting the shared biographies of scholarly work and bureaucratic opinion. For contemporary medical theorising on the relationship between genetic preparedness and morbidity patterns, see work by Kerryn O’Dea on the genetic thriftiness of attributed insulin resistance of Aboriginal people (O’Dea 1991, also discussion in Scrimgeor, Rowse, and Lucas 1997:1-2).

79 Rob Moodie, former Medical Director of the Central Australian Aboriginal Congress, has written movingly but not atypically of the plight of formerly mobile and economically vibrant and self-sustaining populations who, in being reduced to a forced, dependent sedentarism, face continuing upheavals...superimposed by an overwhelming burden of virulent racism resulting in tremendous social and cultural dislocation. This has led in many cases to a breakdown in social controls and laws that have impacted upon and marginalized urban Aborigines in particular (Moodie 1981: 33).

80 Australian anthropologist Mary Edmunds, describing the ‘startling’ proliferation of administrative bodies and government organisations in an Aboriginal town in Western Australia, draws attention to the effect of this seemingly massive level of activity on perceptions of so much action for ‘so little apparent result’ (Edmunds 1989: 92-3). As I will show, this is not just an opinion of condemnatory members of the anti-black community. Edmund’s focus, but is also a frequently voiced concern by progressives within the health bureaucracy itself, raised over and over again as a problem standing in the way of effective service delivery.

81 In addition to the comparisons with Africa made by the paediatrician above, the Hon Dr Richard Lim, sitting member of the formerly ascendant Country Liberal Party and also by profession a general medical practitioner, had this to say in the Northern Territory Legislative Assembly on 23 February 1995, responding to ‘the ongoing bluster and rhetoric about health care for Aboriginal people in the Northern Territory’ from members of the then Opposition:

All I heard were criticisms, whines and the continual carping that we should pour more and more money into Aboriginal health care. It is like pouring water into the desert sand, it goes nowhere except to all those people working in the Aboriginal industry...I grew up in a third world country in third world conditions. I survived, and I am here today. Before I went to school each day, my mother would check my fingernails to be sure that I was clean. That was something that we did at home within our family. We took pride in cleanliness...You have not been there. You do not know. What do you know about life 40 years ago in Malaysia? You understand nothing about it. If people take personal pride in personal hygiene, things will improve. ..why do [Aboriginal] people get renal diseases? They get them from streptococcal infections. Where do these come from? Basic upper respiratory tract infection starts it off. People become infected because they are not clean. It is about overcrowding and not being clean....People can live in appropriate housing, but cleanliness is something they have to be responsible for themselves. If they keep themselves clean, they will not contract streptococcal infections. It is unlikely then that they will develop kidney infections and they will not suffer the consequences of kidney failure.

(Northern Territory Hansard: Seventh Assembly First Session 21/02/95; Parliamentary Record No:8; Part One Debates 23/02/1995).
deferring) subverts the rational individualism required for sustainable health improvements. In this formulation, culture loses its appeal as a creative resource which can be mobilised toward health gain to become instead just plain obstacle. At the same time, the benefits of primitive time, when people were mobile across the country, wisely avoiding sustained contact with their own detritus and faecal matter, always moving on before micro-parasites could proliferate, have been lost to colonial time. Fixed and unable to adapt, the new sedentary lifestyles in overcrowded dwellings admit hyper-infestation, inviting multiple and simultaneous contact diseases from an early age that are repeated throughout the prematurely shortened life course.

4. Health interventions will take time: reduction of mortality and morbidity rates require generational transition and long term government commitment. Health improvements 'may only be sustained on the basis of significantly changed environments, patterns of activity and consumption and household patterns which influence childcare and development' (Robinson 1996: 3). And even then, improvements may be indirect, their connection with singular interventions lost in time, thwarting the evaluative measurements of present gain against past status quo in calculations of productive time.

5. Nothing lasts: health interventions in communities are dependent on the commitment and enthusiasm of the (high turnover) project officers who initiate them, for lamentably, in the highly distractible hands of indigenous protagonists, very little durability obtains.

6. We are never in the right time: the Territory's diseconomies of scale, national isolation, scarcity of talent, puts it permanently behind all other jurisdictions in the national competition for leadership status and fiscal strength. Further, under the demands of New Public Management, change is constantly required: to reach the 'there' (cf. Fabian 1983: 27) of the new global (entrepreneurial, information) economy, all old certainties must be shed....

7. ....standing aside, that is, the certainty embedded within post-welfare practice, never open to overt question, that Aboriginal involvement in, and control of, their health services are essential preconditions for their own healthful futures. In eventual utopian time, Aboriginal people will be able to assume control for their own health, socio-economic well-being and management of services. As such, a positive future obsolescence underwrites all project determinations, recruitment and training practices.

8. There is never enough time, our work is always incomplete.

Within Territory Health Services, there is a detailed and repeated historicity circulating through the narratives of public health, constituting more than a shared body of knowledge to become a means of framing action, of capturing and prefabricating interpretation and encounter, of

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82 At a conference sponsored by the Northern Territory Government's Office of Aboriginal Development, 'Generating Service Delivery Opportunities and Outcomes for Aboriginal Communities' held 11-12 April 2000 in Alice Springs, Terry Bullemor, current town clerk in Wadeye (Port Keats) in the Daly River region of the Northern Territory, provided exactly this historical encapsulation: Also unlike most fair skinned Australians they [Aboriginal people of the area] have not been subject to the winter syndrome which has resulted in (sic) many of whom, having a built instinct to 'save for a rainy day' or 'store up supplies for winter' is not understood by many non-Aboriginals.' Recent publications by Roger Sandall (2001) and Peter Sutton (2001) repeat the theme in a more academic framing.
conjuring optimism and encapsulating failure. Who makes these arguments and how they become dominant themes will be traced in the chapters that follow, with a closer analysis of how stories are exchanged—the styles and spaces, the methods and modes of transmission—further elaborated in the following chapter. We will then see how already my descriptions do small justice to the story of the telling of stories in THS, for the interactions of the health bureaucracy, encapsulated as they are within multiple forms of information exchange and coordinating encounters, are more complex again, at once pedagogic, therapeutic, inculcating, and prophylactic.

But to get there I need first to provide a preliminary and derivative chronological sketch of the health bureaucracy’s interest in Aboriginal health, registered as a series of conventionally narrated historical events, before outlining the contemporary bureaucratic context where historicised tropes are narrated and made experientially salient.

My purpose here is twofold. Firstly, I want to establish something of the fieldsites which figure in this ethnography, and secondly, I want to register something of the power of an historical recounting that formulates as it is spoken the causes and effects that are held to matter. The condensed history which follows is not an original contribution but features here as a strategy in event telling of a more prosaic kind: for history that is straightened out (Stewart 1996: 106) is not the other to the everyday idioms that are deployed as ways of knowing in Territory Health Services, but are a daily part of those very interactions. As I watch, and record for the ethnographic record, the contradictions in the formulations of Strong Women narratives, I know the messy program interventions they motivate will be stripped and smoothed by the time the story is transmitted as a parable of can do in an annual report or ministerial speech, in turn to become different sorts of artefacts with new impacts and routes of travel. I also know that if I was operating in a policy guise I might be the one doing the distilling, holding complications at bay with carefully culled and simplified wording designed to inspire confidence in the manageability of complex social problems, attempting to out-maneouvre with conclusive descriptions those critics who might hold that nothing can be done, it’s all been tried before, or that too many resources have been wasted already.

To put this another way, the efficiency of the linear historical narrative mimics the paring away to create a ripple-free parable of governmental logic and necessity which virtuosi policy formulators are so skilled in crafting. It is by naming causal associations that historical links are created and re-pronounced to generate effects of either overwhelming problem or intervention effectivity, often in the same explanatory register. By recreating the chronological to make sense of the infinite possible versions of explaining the emergence of Aboriginal health as an organisational issue within Territory Health Services, my historical account will replicate the attempts to make order out of complexity evidenced in the interpretive moves of anxious health professionals. My objective, then, is to rework the now well-theorised problems of historiography and anthropological representation through what could well be regarded as reenactment of native ways of knowing and telling (cf. Riles 2000: 27), only here I am aiming for efficiency of another kind, that of contextualisation, so that my ethnography ‘makes sense’ to a new and differently intellectualising audience.
This doubling back or replicative manoeuvre recalls a now standard representational strategy within anthropology, where the simulation of the original ethnographic scene is conveyed using indigenous concepts, words, and images, optimistically hailed in the 1980s as a means of overriding the elitism of ethnographic authority by ‘sharing the text’. But in a space where reflexivity is a part of the everyday spaces of those who are considered less as the voiceless and more as the anonymously voiced, the historical ‘domaining’ (Strathern 1991: xvi) which follows does not operate as a strategy of amplifying muted indigenous forms of knowledge. Rather, it points to the impossibility of standing outside the conceptualisations deployed by health professionals, as if one was lifting the veil on what has been obscured, to instead acknowledge, as health professionals also must, serial forms of implication and enmeshment (see also discussion, Chapter Eight).

From Colonial Medicine to Public Health: the Emergence of THS

The dominance of Aboriginal health as a specific category of bureaucratic effort has a surprisingly recent aetiology. For while Aboriginal people formed the largest population group in the Territory until relatively recently—from the date of permanent white settlement in 1869 through to at least the Second World War—the concentration of health effort was directed at establishing a numerically flourishing and industrially profitable white population, in the face of numerous setbacks. It was during this period in particular that national interest in the Northern Territory was at its most ambivalent: on the one hand, the Territory was an imaginary site for armchair fancies of rapid entrepreneurial gain; on the other, it was repeatedly dismissed by financial analysts as economically marginal and hence unpopulatable (Donovan 1984, Powell 1986, Reid 1990).

On 1 January 1911, following agonised contemplation of whether or not the Northern Territory should in fact be returned to the British, ceded once and for all from the newly formed federation as an economic burden of no decent return, a compromise was struck and responsibility for the northern administration was shifted from the South Australian to the Commonwealth Government (Donovan 1981).

At the time of the transfer, the Commonwealth's economically depressed new jurisdiction comprised 'a small port town and a scattering of hamlets, a railway that ran to nowhere, the care of a few industries, mining, pastoralism, [and] pearlimg, all badly run down' (Powell 1988: 143).

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83 See, for instance, such now classic anthologies as James Clifford and George E. Marcus Writing Culture: the Poetics and Politics of Ethnography (1986); and George E. Marcus and Michael M.J. Fischer Anthropology as Cultural Critique: An Experimental Moment in the Human Sciences (1986).

84 For different but analogous critical points, which condemns the feminist desire to transcend structural inequalities through an egalitarian writing ethic and commitment to 'polyvocality', see Bordo (1990).

85 The non-Aboriginal population in 1911 totalled 3271 while Aboriginal numbers, according to Baldwin Spencer, were 'probably more nearly 50,000 than 20,000' (as cited in Powell 1988: 143). Historian Gordon Reid has the number of Europeans in 1911 as 'only about 1200 and the total non-Aboriginal population was only 2800. The Aboriginal population during the period of South Australian administration decreased from perhaps 50,000 to about 22,000' (Reid 1988: 196). Estimates for 1921 put the number of Aboriginal people at 17,973 (Yarwood and Knowling 1982: 249). Suzanne Parry covers the whole period more conservatively, stating that 'The extent of Aboriginal occupation of the Territory only became known to white administrators as white settlement spread but, based on later estimates, it was likely to have been well in excess of 20,000 people' (Parry 1996: 291).
At the same time, while Aboriginal people constituted an historical non-numeric, with their true numbers being 'anybody's guess' (ibid.), the mapping of Aboriginal disease profiles in the NT commenced its long history as a technique for diagnosing points of intervention.\textsuperscript{86} In this pre-war period, the driving concern was protecting the fragile and heavily outnumbered Anglo-European settler population from contracting the menacing contagions borne by Aboriginal and Asian vectors.\textsuperscript{87}

In a European intellectual world made over to the discovery of genetic inheritance, the devastating impact of such introduced diseases as tuberculosis, malaria, venereal disease, measles, diphtheria, respiratory infections and leprosy on the Aboriginal population was acknowledged, yet Aborigines were held to transform these conditions into more intensely ravaging and dangerous pathogens of far greater reciprocal threat to whites, fuelling calls for complete racial segregation. Government interventions were directed at detecting and containing incidence to protect the fledgling European population, rather than curing the afflicted: treatments for Aboriginal people were rare and expenditure minimal (Markus 1994: 133-137).\textsuperscript{88} When for instance, Herbert Basedow, an anthropologist from Adelaide who briefly became the first Chief Medical Officer and Chief Protector of Aborigines in the Northern Territory (an appointment that lasted only a few weeks from mid 1911), conducted one of the earliest epidemiological surveys of the native population in 1919, he found that Aboriginal people suffered high rates of infant mortality, malnutrition and trachoma, but also tuberculosis, syphilis and leprosy.\textsuperscript{89}

\textsuperscript{86} The importance of statistical inventories to health professionals in Territory Health Services is discussed further in Chapter Five. For now, it is important to note that the limited early taxonomies of Aboriginal health in northern Australia emerged within the broader context of progressive public health reform, in which statistical enquiries provided the synoptic arguments necessary to focus architectural and engineering solutions on population-wide sanitation measures, disease containment and the like (see Bunton, Nettleton, and Burrows 1995: Chapter 16, Davis and George 1993: Chapters 2-3, cf Foucault 1984, Lupton and Peterson 1996: 28-37, Porter 1999). For an account of what stood for early epidemiology, see RS. Soong's *Cultural Brokers in Western Arnhem Land: A Study of the Role of the Aboriginal Health Worker* (1981: 30-31) and also S. Parry Disease, Medicine and Settlement: The Role of Health and Medical Services in the Settlement of the Northern Territory, 1911-1939 (1992).

\textsuperscript{87} The Northern Territory at this time did not rate as highly as Western Australia, Queensland or Papua New Guinea in terms of epidemiological interest in tropical medicine, where the emphasis was more particularly on white settlers in exotic places and their vulnerability to insect-borne diseases (see Denoon 1991, Hunter 1993: 58-60, Parry 1992: 316-344).

\textsuperscript{88} For example, the Australian Inland Mission hostels, then the key health service for non-urban areas, mostly refused Aboriginal admitance, with the occasional exception of an injured worker (Riddett 1987). Markus records repeat reports of the medical neglect of conditions such as yaws, a horribly disfiguring yet quite treatable disease, in the Northern Territory during the pre- and inter-war periods (Markus 1994: 135).

\textsuperscript{89} As noted, the mapping of Aboriginal disease profiles occurred sporadically in this period. A later Aboriginal medical survey was conducted by Dr Cecil Cook in 1925 on behalf of the London School of Tropical Medicine, the results of which are summarised in his 1964 Herbert Moran Memorial Lecture in Medical History given in Canberra and later published (Cook 1966). It was Cook's recommendation that the position of Chief Protector be held by a medically qualified male and combined with the role of Chief Medical Officer. When, in 1927, the Commonwealth established the North Australian Medical Service, Cook was appointed to what was in fact the first government salaried medical position in Australia, a position he occupied until 1939 (Austin 1950). Cook's recollection of his period in the north, given to the Royal College of Surgeons in 1964, provides an insightful rationale for combining the functions of public health control with extensive powers to control Aboriginal employment, wages, physical movement and sexual relations under changing Ordinances (Cowlishaw 1999: 85-6, 312-13). As Cook summarised it: combining the functions of health administration and native welfare, the Health Officer now gained direct access with full authority to every native (whether employed or not), to every employer of native labour, to every camp and to every mission. Active search for disease was undertaken by routine medical inspection of every native in contact at least once every year (Cook 1966: 563).

For an acerbically critical appraisal of Cook's period as Chief Protector, see Markus *Governing Savages* (1990: 133-135). A more circumspect analysis can be found in Austin (1990).
These were diseases that automatically inscribed compulsory attention and confinement, arguably unnecessary given the extra powers of the Aboriginal Ordinances of 1910 and 1918, which further entailed the Chief Medical Officer to intern any Aboriginal person at any time under the rubric of health maintenance. The spectre of burgeoning pathology and pestilence, combined with fears of miscegenation (also Austin 1990, Cowlishaw 1987a, Cowlishaw 1999: 317n), prompted Basedow to align with such others as the anthropologist Baldwin Spencer in the call for reserves, which were finally gazetted in 1920 (NTMS 1973: 1.1.1). Missionaries then joined government officials in providing a more routinised method of composing the natives and allotting a disciplined place for them in the new colonial order, as household domestics and stockmen, gardeners and concubines, in dormitories and pastoral stations, compounds and mission settlements (Cowlishaw 1983, Dewar 1992, McGrath 1987, Rowley 1970).

Given its role as a sentinel outpost, the war build-up at the end of the 1930s gave Darwin a major new hospital on the cliff overlooking the Arafura Sea; communications technology (especially radio); motorised vehicles; sealed roads; improved water and power supplies; and an aerial medical service taking the place of camels, horses and telegraphs, permanently altering health's service topography. Those Aborigines who to that point had been incarcerated within urban compounds, wearing steel disk 'dog tags' engraved with their names and treated 'like store supplies, to be listed, counted, moved to places of need, or stored until further required' (Povinelli 1993a: 88), were now evacuated to equally controlled southern camps during World War Two (Rowley 1970, 1972). The Army also moved coastal island-dwellers to inland camps (fearful, amongst other things, of Aboriginal-Japanese collaboration), and experts like anthropologist W.E.H. Stanner, then an Army Major, and Donald Thomson, were given the task of creating Aboriginal surveillance units to protect the vast and sparsely populated coastlines.  

90 Chief Protector Cook, for example, motivated by a progressive notion of disease prevention, sought a rigid quarantining of inter-racial sexual relations: women already confined in Aboriginal compounds were chained within their quarters for the purpose of controlling the spread of venereal disease and leprosy (James 1989: 122). The Northern Territory was unique in Australia in enacting legislation specifically directed at the control of leprosy, and as Parry notes, it has been argued that the Leprosy Ordinance of 1938 was enacted as a direct result of the Aboriginal population being the most severely affected group (Parry 1996: 204). For a detailed consideration of the isolation of Aboriginal leprosy sufferers in the Northern Territory, and the social impact of that isolation during this period, see Saunders A Suitable Island Site: Leprosy in the Northern Territory and the Channel Island Leprosarium 1880-1955 (1989). Rowna Ivers also provides a vivid account of leprosy experiences in the Territory in her novel The Spotted Skin (Ivers 1998).

91 Darwin was the scene of the first and only sustained official military conflict on Australian soil experienced to date. It was first bombed on 19 February 1942 by a force of 188 Japanese planes launched from aircraft carriers in the Timor Sea, only four days after the fall of Singapore. 243 people were killed, a further 360-406 wounded, eight ships sunk, four were beached, and eleven were on fire or severely damaged. Bombing continued until late 1943, with 64 Japanese air raids recorded in total, although most Australians knew only of the first foray until relatively recently. It is estimated that at least 250,000 allied personnel moved through Darwin on despatch to the nearby islands of Timor and Ambon in this period (Hall 1987, Hall 1991, Powell 1988: 207-9). For a populist version of Darwin's 'Pearl Harbour episode,' see Frank Aclorta's special commemorative edition Australia's Frontline: The Northern Territory's War (1991, also Alford 1995). On Aboriginal perspectives on the war, see Robert Hall Fighters from the Fringe: Aborigines and Torres Strait Islanders Recall the Second World War (1995); and also Desmond Hall's edition Aborigines in the Defence of Australia (1981). An account of anthropological enlistment of Aboriginal effort can be found in Richard Walker and Helen Walker's account Curtin's Cowboys: Australia's Secret Bush Commandos (1986: esp. 3-10) and also Donald Thomson's autobiographical account, Donald Thomson in Anthem Land (1983).
In terms of health, the military camps' insistence on disciplined personal hygiene and orderly waste disposal, the provision of functioning latrines, showering facilities, regular meals and the availability of health clinics with reliable pathology supplies were thought to have reduced infectious disease rates.\textsuperscript{92} But of course, this is most difficult to tell in the absence of reliable data.\textsuperscript{93}

Following the war, the link was maintained between keeping Aboriginal people together in a state of logical order and managing their health, although now the emphasis was also on neatening health's administrative systems. The establishment of extensive medical records on individuals, long interrupted by the continual strafing of the Top End coastal region by Japanese bombers, now became an urgent task (Kettle 1991: 26-8). The Native Affairs Branch (more commonly known as the Welfare Branch) of the Northern Territory Administration was now responsible for nursing services on missions and government settlements, signalling a new focus on Aboriginal health as a specific category of concern, while the Commonwealth Health Department controlled the Aerial Medical Service, urban areas and the hospitals (ibid, see also NTMS 1978b). This bifurcated administration, and the question of running hospitals down to the detail of patient services from the distant site of Canberra (not part of the national administration's normal charter), were put to official review in 1971.

A three-man Board of Inquiry found that Commonwealth control rendered Territory service delivery inflexible; lowered the quality of services; and absorbed the local Director of Health and his senior officers into absurdly time-consuming written communications over what should have been 'routine matters of procedure' (Edmunds, Vanderfield, and Dearlove 1972: 26). What was more, welfare responsibility for health had led to the development of:

predominantly paternalistic programmes of preventative medicine and European type curative services rather than an integrated service based upon the cultural and traditional needs of recipients (ibid.)

Based on the recommendations of the Inquiry, in 1973 responsibility for the delivery of health care to Aboriginal communities moved to the Northern Territory Medical Service (NTMS), a regional division of the Commonwealth Department of Health. And so it remained until 1979, when the forerunner to Territory Health Services, the Northern Territory Department of Health, was established upon Northern Territory Self Government in 1978 (THS 1996: 30).

\textsuperscript{92} In a number of the war texts listed above, this period is posed as a turning point in Aboriginal-settler relations, in which each gained a mutual sense of the other's contributions and worth. In other accounts we are reminded this is also the time when dealing with 'half-caste' offspring and bodily regulations of all kinds tightened as governmental interest in controlling all aspects of Aboriginal life increased (see, for example, Cowlishaw 1999, and Povinelli 1993a).

\textsuperscript{93} A conference dedicated to the discussion of Aboriginal health statistics in 1993 reports that progress remained slow even in the 1960s and 1970s, when research advocacy was still necessary for Aboriginality to be identified in collections: 'It is unfortunate to note that no Aboriginal health statistics were available in any State or Territory before 1980' and that by 1985 only the most basic health statistics existed (Achamfuno-Yofoah 1995: 10). The gathering of health statistics is most usually aligned with progress against resistance in this way, hardening the unshaken faith of epidemiologists in the power of their methods to remove health inequalities in its highlighting of the radical determination required for them to install adequate data collections. The alignment of statistics with social justice is explored further in Chapter Five.
It was at this time that Dr Charles Gurd, a medical doctor with colonial health experience from Africa and Fiji, was moved from his position as Medical Superintendent of Royal Darwin Hospital to assume the job of Director of Health (1974-1978), initially under the Commonwealth's jurisdiction, before becoming the inaugural Secretary of the first Department of Health to be run by the Northern Territory Government in its own right in 1978 (a post held until 1981). Speaking of this period, the late Dr Gurd recalled for me his initial shock in confronting how poorly resourced the Territory health system was, compared to Fiji, Africa and the rest of Australia, and in particular, how lacking in any infrastructure for training indigenous health staff, despite the desire of his community development officers to establish such a program.  

Gurd's comments, and the concerns of the 1971 Inquiry regarding the cultural insensitivity of health's programs, presage a more widespread shift in public administration operations. In both management and community health theory, traditional notions of organisation, hierarchy and authority were being critiqued: organisations were to be flatter, the 'voice of the community' was to drive service delivery and a client-focus in policy became paramount (Barley and Kunda 1992, Lupton and Peterson 1996: 127-32, Yeatman 1993). At the same time, upon assuming federal power in late 1972, Gough Whitlam's Labor Government established the Commonwealth Department of Aboriginal Affairs and inaugurated the Aboriginal self-determination policy which 'explicitly coopted Aborigines into the new administration as planners, welfare workers and administrators' and ostensibly made 'Aboriginal ideas about social well-being ...the basis for planning, not those of white welfare workers' (Collmann 1988: 18).  

Official concern with community participation extended to the health sphere, with the same Labor Government launching the Community Health Program in 1973, with its formal aims of equity, community involvement and health promotion driving the availability of funding for a range of new services (women's health centres, day-care centres, drop-in centres for adolescents, drug referral services and so on (Broom 1991).

Thus, in the same year that the NT Division of the Commonwealth Health Department assumed full responsibility for Aboriginal health administration and Gurd introduced his expectations about Aboriginal involvement in the delivery of health services, a decentralised area based service was established (NTMS 1978a); the Aboriginal Health Worker Training Program was introduced (Soong 1981); an orientation manual for remote area workers which advised the terms of cross-cultural respect was developed (NTMS 1973); research into the significance of traditional medical systems was undertaken by departmental staff (NTMS 1978b); and survey units were resourced to undertake more accurate reviews of the depth and spread of Aboriginal ill-health.

94 When asked if the then Minister for Health, Ian Tuxworth, supported his moves to get more Aboriginal people into the health system, Gurd gently replied: 'I think not, I think that he was, and I think I'm right in this, or on the other hand, I hope I am wrong that he was anti-Aboriginal, so it wasn't easy to work from that position.' (Transcript, 7 October 1997). The systems chaos created by the impact of Cyclone Tracy at the end of 1974, a category four cyclone that literally leveled the towns of Darwin and to a lesser extent Katherine, combined with the openly public hostilities unleashed by the introduction of Land Rights legislation in the Northern Territory in 1976, did not make Gurd's reformist tasks easier.

95 This period in Aboriginal administration which saw the transition from an official policy of assimilation to one of self-determination has been extensively documented and critiqued (see, for example, Cowlishaw 1998, Myers 1985, Sackett 1989, Tsey 1997).

96 What the surveys found was alarming: high levels of anaemia, malnutrition, gastroenteritis, chronic ear and respiratory diseases, persistent skin infections, hypertension, diabetes, and alcoholism had taken the place of the leprosy, tuberculosis and small pox scourges of the pre-war years (NTMS 1978a).
It was also during the 1970s that homage to perceived Aboriginal sensitivities began to surface in epidemiological material. In a 1978 submission by the Northern Territory Medical Service to a House of Representatives inquiry into Aboriginal health, for instance, the agency drew attention to its inhibitions with regard to detailing death rates at the community level:

It will be appreciated that this is a matter of some sensitivity to Aboriginal people and we accordingly have refrained from relating deaths to actual townships in this public document (NTMS 1978a: 30).

While it is just as likely that manual data gathering systems at the health centre level would have been too inconsistent to permit such localised demographic accounting (the case today), it is the appearance of such assured explanations about Aboriginal cultural morés within health policy discourse that should be marked.

The 1970s are regarded as a watershed period in the Northern Territory’s administrative history, when self-government was awarded and the issue of Aboriginal self-determination arose as a major national concern, when governments began to encourage Aboriginal people to form corporations as land-holding and service delivery organisations and when a horrified focus on Aboriginal experiences of colonialism beckoned the emergence of a new administrative phenomenon in the community development worker. These last were highly educated professionals with undergraduate and higher level degrees interested in the politicisation of an oppressed people, using an apparatus of intervention based on community development theory (Apthorpe 1985, Chambers and Ghildyal 1985). The 1970s also witnessed the appearance of the first community controlled Aboriginal medical services in the Northern Territory, beginning with the Central Australian Aboriginal Congress in Alice Springs in 1973 and followed closely by Wurli Wurlinjang (Katherine), Mutitjulu (Uluru), Nganampa Health (Pitjantjatjara Lands, South Australia), Imanpa, Pintupi Homelands (Kintore), and Urapuntja health service in Utopia (Bartlett, 1995: 209; see also Scrimgeour 1994, 1997).

**The Organisation**

Officially, Territory Health Services itself was formed as a distinct organisation when the liberatory ethic of self-determination was in the air, following the granting of self-government to the Northern Territory in 1978 (after a brief ‘hand-over’ period from the Commonwealth between 1974 and 1976). The 1995-96 THS Annual Report explains THS’ corporate history as follows:

On July 1 1978 the Northern Territory Government established a Department of Community Development. Responsibility for health was transferred from the Commonwealth on 1 January 1979 establishing the NT Department of Health. The two departments were amalgamated in 1987 to more closely integrate services affecting the welfare and well-being of people. This amalgam was given the name Department of Health and Community Services ... Due to similarities in the name and function with the Commonwealth Department responsible for health and community services, the public was often confused as to which level of government was responsible for which services. This factor, combined with the length of the departmental name, made it awkward to project a clear corporate identity (1996, 10).
And so in 1996 the department 'became Territory Health Services, defining health as the totality of health and well-being' (ibid).

Both before and since this time the organisation has been subject to numerous re-organisations and corporate charts are rarely up-to-date, to the current point where the agency is once again called the Department of Health and Community Services. Figure 7 for instance, is considered a draft; its very conditionality an accurate reflection of the work-in-progress that is the organisational structure. 97

97 Commenting on a similarly malleable organisation in his account of an engineering company, Gideon Kunda observes: 'Organization charts are not easy to come by. Although they exist, for working purposes, for various subgroups and may be collected through the efforts of secretaries or the painstaking piecing together of information, gossip, and organizational announcements, there is an accepted tendency to frown on simple mappings of the complex network of activities, to be vague about or fashionably dismissive of mechanistic structure.' (Kunda 1992:30). While policy officers and senior managers in Territory Health Services do not have the same mocking view, with most regarding organisational charts as indexing complex matrices of delegated authority within a visually efficient layout, neither do they expect them to adequately depict the networks of informal alliance and webs of deference and connection that must be discerned for effective interaction to occur. In other words, the inherent inaccuracy of organisational charts or rather, their abstractly symbolic character, is not an invitation to be sceptical about reality dissonance, but is expected, accepted and deployed accordingly.
The Northern Territory of Australia is spread across a large geographic base, approximately one-sixth of the continent, with a total area of 1,346,300 square kilometres (Australian Bureau of Statistics 1994b). Even so, it has the smallest population of any of the States and Territories of Australia (a preliminary inter-censal estimation of the population up to December 1999 projects the resident population of the Northern Territory as comprising 194,200 people, approximately 1% of the overall Australian population (Australian Bureau of Statistics 2000). Contained within that smallness are further signifiers of unique demographic status, of importance to bureaucratic constructions of difference and need in national contests for policy and funding priority. At approximately 28%, the indigenous population makes up a far higher proportion of the Territory’s population than any other jurisdiction (compared with 2% nationally), and represents 13.4% of Australia’s overall indigenous population.\footnote{To give a taste of the ways in which statistical artefacts are used to bring weight to bear on the omnipresence of Aboriginal morbidity, discussed in detail in Chapter Five, I could add here that ‘Of the 871 deaths registered in the Northern Territory in 1998, 415 or 47.6% were Indigenous deaths. There were 29 Indigenous infant deaths which comprised 64.4% of the total infant deaths recorded in the Northern Territory in 1998 (Australian Bureau of Statistics 1994a) or further, that in the Northern Territory, South Australia and Western Australia ‘More than half of the deaths among Indigenous males in 1995-97 occurred among people who had not yet reached their 50th birthday. Three out of four Indigenous males who died had not yet turned 65. Among Indigenous females, about four in ten deaths occurred before age 50 and two in three before age 65. By contrast, the majority of deaths in Australia (73% of male deaths and 84% of female deaths) occurred in people older than 65 years.’ (Australian Bureau of Statistics 1999).}

Further, the Territory is ethnically divided, with most whitefellas located on the north and south of the Stuart Highway, and most blackfellas (64%) in the hinterland on either side. The Stuart Highway joins the southernmost capital of Adelaide to the northernmost capital of Darwin, cutting through the smaller towns of Alice Springs, Elliott, Tennant Creek and Katherine along the way.

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\textbf{Figure 8: Official THS Service Outlets}
In functional terms, the health service outlets which are accessed by members of the public are operated through two regions, known as Operations North (covering the geographic areas north of Elliott) and Operations Central (central Australia and the Barkly tablelands). The central administration or central office operates from Darwin out of a squat pastel apricot building, five stories high, named 'Health House,' (Hell House or Unhealthy House in other namings), which sits midpoint along one of the four long main streets making up the Central Business District of this, the smallest capital city in Australia. It is from here that the official administrative functions of supporting the Health Minister, undertaking system-wide planning, monitoring and evaluation, allocating funding, establishing standards and guidelines, and providing policy and strategy advice takes place. Health House is thus the main home of the strategists, analysts and planners, forecasters and advisors featured in Chapter Two, all of whom constitute the cluster which is collectively called 'policy', in contrast to 'operations', which are in turn based in regional offices operating out of Alice Springs, Tennant Creek, Katherine, Nhulunbuy and Darwin itself (as a base for the surrounding rural areas).  

These five towns also house the public hospitals earmarked for outsourcing in the previous chapter. As it operates today, the public hospitals in Katherine, Nhulunbuy and Tennant Creek operate as referral centres, with more advanced specialist services being provided from Royal Darwin and when necessary, by hospitals in the southern capital cities.

There are smaller primary health care service sites in all major townships and officially recognised Aboriginal communities, known as health clinics or community health centres, which are staffed by resident nurses and Aboriginal health workers, and, very occasionally, by a general practitioner. More usually, therapeutic and clinical services are provided by a range of visiting professionals, including District Medical Officers who fly or drive out to communities on a weekly, fortnightly or monthly basis depending on the population size, locale and ease of access and accommodation quality.

99 The majority of employees are based in or around Darwin (61%). The Alice Springs/Barkly region accounts for 26%; followed by Katherine and Nhulunbuy (13%). Nurses form the single largest employment category (36%) out of a total of approximately 3500 employees, followed by a grouping called 'administration' (26%), which amalgamates policy, corporate and technical support, and executive management. More broadly still, responsibility for publicly funded health services is shared amongst Commonwealth, State/Territory and local governments (shire and community councils). Overall health funding is the prime responsibility of the Commonwealth Government since, from 1942, it has held income tax powers and therefore the bulk of revenue (Davis and George 1993: 98-107).

100 Patients are transported to the Darwin and Alice Springs Hospitals or interstate through direct medical evacuation (Medevac), by Inter-Hospital Transfer (IHT) and through the Patient Travel Assistant Scheme (PATS). The rate of use against each of these schemes is a key indicator of health care expenditure and, as seen in Chapter Two, significant attention is paid to figuring strategies for reducing interstate movements. The savings arguments for increasing the number of clinical specialists by opening the public hospitals to private sector management, for instance, was that they would mitigate the costly practice of sending complex cases interstate at the government's expense. Patients must travel extensively within the Territory. Chillingly, research conducted in a East Arnhem community estimated that all Aboriginal infants will be evacuated in a life critical state for emergency care at least once in their first year of life (Weight 1996). While for an increasing number of adult Aboriginals, certain treatments for chronic medical conditions, such as end-stage renal dialysis, require permanent residency in Darwin or Alice Springs and sometimes, Adelaide.

101 The frequency of visits to communities invariably drops off in the monsoon season in the Top End, and it is commonly noted that the highly picturesque coastal and wetland communities are more frequently accessed than those in the arid inland, which correspondingly have fewer on-site visiting officer amenities or agency service outlets. Conversely, the Tiwi Islands, being a short flight from Darwin, are visited on a daily basis by a wide range of government and other institutional representatives.
Likewise, the main subjects of this ethnography, public health professionals, travel extensively throughout the regions, representing programs spanning alcohol and other drugs, dental health, nutrition, communicable diseases, environmental health, health promotion, medical entomology and women’s cancer prevention. Each program area divides its geographic responsibilities ('my communities') amongst the number of specialist officers available, and, as will be seen, there is considerable competition amongst officers about who knows which community the best. Their trips away are usually two to three days in duration, often only a day, seldom more than a week, with partners and children left behind. In any week that an officer plans a community visit, at least two days are spent organising to get there and another day at the end restoring office order.

As we will see, being able to lay claim to the arduous, exhausting nature of community visits is an important component of the committed public health demeanor. Typically, organising a trip involves faxing the community council with details of preferred visiting dates and an abbreviated summary of the intended purpose; making numerous phone calls (to secure travel allowance payments, to work out who else might be heading out on the same day, to make flight bookings or organise vehicle use); then numerous sorties to round up the items that will be shown or delivered (posters, books, produce samples, medical supplies or grocery items for either personal use or to take to the residential clinic staff). Finally, there will be a re-familiarising run through of the program information and educational material that give public health purpose to the visit. Long preparation delays are to be expected and forbearance is a posture expected of the fieldworker who has 'got what it takes'. For instance, in the midst of an unexpected delay which saw us circling a coastal community for 40 minutes from the air awaiting low-level cloud to lift, one public health officer remarked 'The thing people don't know is that this is totally out of our hands—you have to learn it’s incredibly important to prepare well but still be able to go with the flow. Are you still interested in being one of us Tess?'

With the exception of health promotion and some generalist research positions, public health officers have professional qualifications specific to their program area (for example, a degree in nutrition or dietetics). In the main, they share similar ethnic backgrounds as tertiary educated Euro-Australians, together with similar political allegiances as anti-elitist liberals concerned to support Aboriginal struggles for empowerment and to create a vanguard against the 'clinical method'. (While Aboriginal employees also feature within each public health program, they are usually attached to project and outreach work as opposed to the more generic middle and upper-management positions. Of course, significant narratable exceptions exist.\textsuperscript{102})

\textsuperscript{102} The Health Promotion program has a history of dedicated recruitment and training of Aboriginal employees to fulfill both policy (middle management) and project officer work. Aboriginal Health Promotion Officers are expected to pursue higher studies and several have undertaken undergraduate courses at Curtin University in Western Australia as a result of being in the program. Until recently, the program was managed by an Aboriginal woman whose position as an Administrative Officer Level 8 is the highest middle management rung before executive positions begin. A history of the program and its deliberate indigenous recruitment practices can be found in Nea Harrison's masters thesis, \textit{A Journey Towards Partnership: The Participatory Process for Developing a Training Program} (1996).
The work of public health professionals falls into two main areas. The first involves activities related to preparing, implementing and supervising projects in Aboriginal communities; while the second involves nurturing data collections, research projects and releasing best practice guidelines. Uniting these disparate activities is an understanding that the overall aim is to improve the dire state of Aboriginal health, through both direct relief and the encouraging processes of self-determination, or as it is more commonly expressed in public health discourse, community development and capacity building.

Without exception, all the public health practitioners complain they are under-equipped for the work demanded of them: they need more staff, time, resources, project funding, opportunities for debriefing and stress management to cope with, and more professional development and ongoing preparation to meet, the huge problems associated with Aboriginal ill-health. They argue that because they are stretched so thin, they have to be more effective at coordinating their activities, but that the work of coordination is itself time-consuming and beleaguered with emotionally grueling internecine battles. They say that having so many communities to look after means they suffer from the 'squeaky wheel syndrome,' attending issues that are complained about loudest or attract the most media attention, leaving whole sweeps of geographic areas and potential clients unaided. (That there are clear selection criteria demarcating desirable from undesirable communities is less frequently acknowledged). Yet describing public health professionals in terms of their overall commonalities obscures their own sense of difference and distance, both from each other and from other groups within THS. More usually, public health professionals see themselves as divided by multiple cleavages specified in terms of their personal education profiles, place of origin, specialty qualifications, outside interests, political attitudes, values and personalities, and most caustically, as subsequent chapters will show, in respect of each others' level of engagement or commitment to Aboriginal health.

Further, the type of activity public health officers are engaged in are heuristically divided by practitioners into three competing categories: prevention, early intervention and treatment, each of which has a long and complex tradition of definitional difference and passionate philosophical adherence. Those seen to be working at the clinical or treatment end of the public health scale are accused of ignoring the root (social, political and historical) causes of ill health in favour of band-aiding technical solutions, whilst those at the prevention end are condemned as loose-thinking 'bleeding hearts' who, in the words of one unbeliever, 'are more in need of blackfellas than blackfellas are in need of them.'

Officially, THS places a high priority on public health approaches, listing it as one of the five key areas for whole-of-agency attention in its Corporate Plan, yet each year, public health practitioners reliably claim their program monies have been clawed back to bail out the acute care budget deficits inevitably created by the high expense hospitals. Conversely, THS Managers also insist that public health practitioners are not cautious enough with money, spending too much

103 For a more detailed discussion of these points of critique and schism as they are manifest in health promotion research and other theorised accounts of public health practice, see Nettleton and Bunton (1995).
time on workshops and activities aimed at vague ends (such as boosting a community's self-esteem) and not enough on actions that give measurable results. As an aside we might note that the funder/purchaser/provider regime, introduced in the aftermath of the attempt to outsource the management of the public hospital network, was promoted as a fix for these suspicions. At the same time, the very existence of such suspicions fuels the related sense that the avowedly activist approaches of public health workers are resisted by the reactionary forces of 'management', 'economic rationalists' and the pernicious 'bio-medical model', thereby authenticating their sense of system radicalism.\(^{104}\)

Opportunities for enmity abound. Each regional district has its own local hierarchy, run by a district manager who occupies an intermediary position between the 'head office' and a plethora of regional roles. This person, and the supporting regional managers structurally closest to this position, face the ongoing predicament of brokering the concerns and priorities of the senior ministerial officers and managers in Health House with the more particular and immediate demands and tensions of their local office, community interests included. Typically, regional office staff see emanations from Health House as unsympathetic, rigid and out of touch, with little sensitivity to the nuances of local areas, always over- or undershooting with unrealistic funding categories, program objectives and implementation timetables, never understanding the delicacy of liaison activities with Aboriginal people and far too impatient for returns before relationships can be properly developed.

In turn, head office people view the catch cry complaints of regional staff as over-worked and under-consulted with a sympathy tempered by a sense that local officers cannot see beyond their own fine-grained concerns to the 'big picture' beyond, a coded reference to the range of pragmatic considerations policy formulators have adjudicated in the process of juggling projects into being. Suspicious of the meandering involved in the sweep of activities clustered under the rubric 'community development', they insist that public health officers adopt a project management approach to their efforts, with its in-built requirements for definite conclusions, benchmarks for deadlines and interim reviews, documentation and specification of project 'deliverables'.

In each case, the 'they', the imagined final location of the decision-making apparatus, is always in another place. For central office personnel, it is variously positioned: an unwanted instruction may be attributed to the 'fourth floor', a reference to the locational coordinates of both the Chief Executive Officer's suite on the uppermost floor of Health House and to the adjacent meeting room where the top management layer meet on a fortnightly basis; or else, depending on the issue, the authorial centre of insulated and illogical decision-making may be simply 'the Minister' or 'Cabinet' or 'Canberra', the seat of Federal Government. For regional office staff, the originating centre may be attributed to any of these categories and additionally to officers located within any of the Darwin office networks.

\(^{104}\) Note the clear aligning of health promotion (a wider term for prevention) with progressive attitudes in the following definition: The term 'health promotion' has come to refer to a movement which gathered momentum in the 1980s. The movement is a radical one which challenges the medicalization of health, stresses its social and economic aspects, and portrays health as having a central place in a flourishing life (Downie, Fyfe, and Tannahill 1990: 1).
As Allen Feldman notes of conspiracy rumors locating terminus sites from whence the state determines who should be assassinated in Northern Ireland, these pin-pointing ascriptions, frequently parried in everyday talk, constitute 'a reaction to the actual diffuse, capillary threading of state surveillance and power through the warp of everyday life' (Feldman 1997: 29). Only in Territory Health Services, it is not surveillance and intrusion that are being contested but the implication of being we, not they, of being the state itself, inextricably embroiled in and responsible for its operations. In the refusal of agency implied in such disavowals of initiatory responsibility, the remote area health professional and central office bureaucrat alike repeat the denials of connectivity with 'the state', (variously represented as the Commonwealth, Central Office, management or the bureaucracy), that are likewise made within anthropological circles, where state power is similarly imagined as emanating from a discrete site that remains somehow other to the critical self (cf. Herzfeld 1992). Latent within 'them' and 'they' separations, within the assertive passivity, is a suppressed recognition that the state is the self, activated through an ensemble of micro-practices which structure the very actions of the subject who wants the political convenience of being the object.

The refusal to allow that one's own mundane practices are part of the web of governmental operation is not just a denial of imbrication, however. It is also a constitutive feature of organisational framing, a necessary part of learning the vocabularies and assuming the inferential classification system distinguishing here and us against them and there within specific work sites (cf. Van Maanen 1978b). Indeed, doing fieldwork with brand new health professionals less than six weeks into their exposure to Territory Health Services, it is hard to ignore the striking rapidity with which the registers of regional and central office distinction (dress, comportment, problem diagnosis) are absorbed and adopted. Screen printed t-shirts with Aboriginal motifs and/or program acronyms, combined with enraged condemnation of the emblematic 'Berrimah Line' (the imaginary barricade to information exchange and initiatory involvement between Darwin and the outlying THS network), are swiftly adopted perceptual coordinates marking those proclaiming self-identification as, or allegiance with, regional officers who live or go 'out bush', from those suspected of not caring about Aboriginal people, of being budget-obsessed bureaucrats in head office.

Possibly these markers cannot be taken at face value, and deceive more than they speak, but in the new recruits' accidental or rather, their unspoken analysis of local marks of distinction, is a mimetic uncovering of identifiers of place that are otherwise difficult to isolate. People are literally donning forms which perception has told them are the markers of belonging, and it is at this moment, right at the moment of wordless apprehension, before it all becomes tacit knowing, that the demarcations of us and them are made tangible. Clothing and formulaic complaints alike are in this sense a form of conceptual shorthand which reveals a more systematic set of orientations, what Shields calls 'the socially maintained reputation of a place' (1991: 14—original emphasis).  

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105 Shields goes on to argue that the expression of social divisions and categorisations using spatial metaphors, an ensemble of 'imaginary geographies', ground a cultural edifice of perceptions and prejudices, images of places and regions, and ... establish performative codes which relate practices and modes of social interaction to appropriate settings. ... That is to say that myths become directive images and 'metaphors we live by' (Shields 1991: 46-7). Bourdieu's (1984) notion of patterned assemblages as the insignias we live by is also pertinent here. Some of these issues as they are lived out in regional offices are taken up in Chapters Six and Seven.
Coordinating uncoordination

In an effort to broach the frequently lamented divide between Central Office policy staff and their regional counterparts, networking, 'professional development' or 'in-service' events of different kinds (workshops, mini-conferences, planned joint projects) are constantly in the process of either being attended or organised. Always these are put together with coordination of activity and information sharing amongst the stated aims: 'Welcome to our first Tiwi Health Board Newsletter designed to bring everyone up to date with the activities of the Board. We aim to make sure everyone knows what we are doing and why' (opening paragraph, Tiwi for Life Newsletter for April, 1998).

Coordination is an ambition which for many years has been identified as a problematic lack and, by super-imposed correlation, as an explanation for continued program failure in the Aboriginal domain. Yet I would argue that the proliferation of and intense commitment to forms of coordination (alternately: collaboration, cooperation, networking, team building, information sharing, joint planning, industrial democracy, group work) cannot be accounted for in such barren terms. Robertson, commenting on the numerous formations of junior officials from different agencies into development 'teams', attempts an alternate interpretation, arguing such institutional forms represent

an appeal for cohesion and 'inner democratisation' across the base of a sprawling and compartmentalised government hierarchy [that] may be as much a gesture of despair as a gesture of optimism...a last ditch stand against bureaucratic collapse. (Robertson 1984: 159)

But considered less as a desperate stand against fragmentation and more as an alive social form in their own right, the ubiquity of organisational gatherings can be seen as dwarfing their original coordination purpose. Continually renewed linkages 'succeed' even as they fail their stated function. By recreating the problem identified as the problem in the first place, coordination becomes a self-sustaining end in itself: more coordinating forms mathematically create greater dispersion and fragmentation. Unable to solve the problem of uncoordinated activity, micro-niches of attempted coordination synthesise the repeat identification of fragmentation as a problem, to the point where liaising activities become self-generating forms contributing to an overwhelming sense of proliferating disorder requiring greater coordination to solve. 'Everyone descends on the community and we don't even know who's going to be there' one public health officer announced in a public health coordination meeting in the Nhulunbuy regional office, precisely as the members present were listing each East Arnhem community and what each had done or was planning to do in that place. Examples of outrageously uncoordinated activity will be exchanged in coordination get-togethers to affirm the ever-present threat of wasted effort, with coordination meetings being a prime site for relaying such readily-available tales, solidifying the refrain 'the right hand never knows what the left is doing' into an information sharing economy that compels further dispersion in the name of containment and consistency.
It is difficult to convey a sense of just how omnipresent the ambition toward information dissemination and exchange under the banner of coordination is within Territory Health Services. It takes form in and articulates through multiple and ongoing practices at every level of interaction, posing as both outcome and approach. The organisation as a whole disseminates written information through newsletters, electronic mail, memoranda, reports, research papers, pamphlets, articles for in-house publications and media release, conferences and research symposia; and then again through countless verbal exchanges in set meetings or chance encounters in corridors, tearooms, coffee shops and remote area shopping centres, all reflecting the smallness of the population and the overlap in activities. Add here too the peculiar intimacy of community travels taken together and opportunistic encounters in 'the field'. These ever-renewing points of connection, expanded and contracted in multi-layered attempts to 'be in the loop' within every work area, assume a fractal dimension in their capacity to be viewed both as discrete phenomena—as this particular meeting or that specific newsletter—and as an enchainment of like and proliferating forms.106 Each occasion, resembles, even in its local (geographic, informational, configurational) specificity, the overall shape that the never-complete (infinite) system of coordinating bureaucratic forms takes on. It also contributes to what Kim Fortun, describing her own feeling of fraudulently dispersed ethnographic knowledge in her tracking of the Bhopal environmental disaster, calls 'the aleatory effect' of information deluge:

The aleatory, often associated with the music of John Cage, has an effect of 'alloverness.' It is produced by an undetermined deluge of stimuli lacking any syntax or hierarchy of significance. The deluge is scrambled, overtly marked as contingent, and at obvious odds with hegemonic logic. Sources of information vary, in reliability as well as genre. Quantifications proliferate, as do references trooped as unquestionable but laced with indicators of interest and institutional rationality.

(Fortun 1999: 213)

This sense of deluge complements the sense THS employees have of the density of their own agency networks and the terrible complication this must present for outsiders, particularly for Aboriginal communities, a problem which further corroborates the need for more coordination.107 Lest the message is not osmotically absorbed through the information deluge, newcomers to the department are handed the following chart (Figure 9), or others like it, which itself creates an image of bombardment.

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106 In mathematics, fractals are any of a class of complex geometric shapes that commonly exhibit the property of self-similarity, iterating the same pattern yet capable of holding infinite variation (as with a fern leaf), and in which the form of the whole can be seen in the isolated part. It is the relationship between classes of phenomena that matter in fractal equations. Within anthropology, Roy Wagner deploying the metaphor of fractality in his analysis of Melanesian big men as a means of describing the simultaneity of being both individual and group; or, in his paraphrase of Marilyn Strathern's work, to describe a subject who is neither singular nor plural (Wagner 1991: esp. 162-3). Strathern's own work, *Partial Connections*, uses fractal physics structurally and analogically to avoid attributing precedence to either the Melanesian cross-cultural comparisons she brings into focus, or to the theoretical positionings marked out for elaboration in her text (Strathern 1991). Here I am using a fractal metaphor in its capacity to be both a singular object and a rapidly reproducing formation with different coordinates that at any point of drilling down, has its own specificity within an overall pattern of sameness. As we shall see, the concept has multiple applications in its capacity to speak to the anthropological problems of meaningful representation of detailed complexity and synoptic overview (see also Riles 2000: 18-19), or again, the description of patterned or structured cultural reproduction out of uniquely lived and idiosyncratic events.

107 The concept is further reinforced by critical inputs from the range of advocacy groups and research reports which regularly make policy recommendations, following their examination of the causes of Aboriginal ill-health, that invariably call for a greater coordination of effort.
Figure 9: Factors Affecting Remote Aboriginal Communities, anonymously authored THS document
Looking at it, I heard people comment ‘that’s not all,’ that they could easily expand the infinite connections behind and within each box—each organisation having its own avalanche of players and programs—but then the diagram would be lost in the multiple and tangled strands of its own portrayal. This problem of representational scale—how to make the weight of institutional proliferation visible (cf. Strathern 1991: xiv-xv)—is itself used to prompt further analysis of the fractured and incomplete nature of bureaucratic work and of the overwhelming number of players to be considered and known, thus giving the incantation of the need to coordinate renewed life. The taxonomies of complexity thus turn back on themselves to perpetuate a simultaneous sense of impossibility (we can’t be all things to all people) and potential for improvement (our services need to be coordinated in the interests of efficiency and effect).

The repeat identification of fragmentation as a problem and coordination as a solution is almost perfectly infinite. Almost—but not completely—self-replicating in and of itself. A run of organisational restructures and mobile personnel (to the point where two years in any one position is seen as ‘long enough’) adds another dimension to bifurcating forms of coordination. Such macro and micro transformations constitute the renewable energy source of what are better called coordinations, embodied in the form of individuals new to tasks, topics, geographic areas or titles who, in their concern to rapidly gain perspective on the layers they are newly enmeshed within and expected to strategically navigate, alternately attend coordination events or manufacture their own. Where the density of institutional intrusion is identified as a problem, the solution is a matter of coordinating more, organising better, dovetailing approaches within and between agencies and players, opening a whole field of endeavour to more intense planning and integration effort. And then of course, coordination and collaboration, like consultation, are authoritative concepts in and of themselves, operating as unarguable tropes that can be safely deployed in summative policy writing as words capturing the allure of deeds (action) and fixability (solution), with the added attribute of being generically inoffensive. That is to say, a call for less coordination is as unthinkable as calling for less community involvement.

These compulsions are themes I will repeat and elaborate below and beyond, for the interpretation I wish to explore—how problems are simultaneously asserted and re-created and how the critical discourse on them are the mechanism of their reproduction—itself reappears, like the need for coordination, in many guises and scales in the ongoing striving for headway within THS.

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108 This is in situations where six to nine months is more likely to be the norm, either because the project itself is short term or, where a position is permanent but its filing is not because of the rapid turnover (as is the case with remote area nurses who in some parts of the Territory have a life of three months). It is difficult for bureaucrats to render this precisely in charts or statistics, as electronically tracked ‘position separations’ cannot distinguish whether a person is lost to the system altogether or has simply moved locations to reappear with a different title elsewhere in the organisation. One can know turnover at the level of the whole domain (overall appointments, resignations and retirements without the detail of who is where) or at a magnified level of local area detail, but not both at once.
Networking

Because Darwin is also the capital city of the Northern Territory, it serves as an administrative and networking base for a large range of different authorities and industries, each with its own bureaucracy and layers of coordination and information flow. The Commonwealth Government has its regional office headquarters located here, and more recently Darwin became the logistic base for the military and humanitarian response following the East Timorese transition to independence in 1999. Since the late 1960s, Australia's defence policy has shifted from reliance on 'great and powerful friends' to a policy of self-reliance. It is now assumed that, given 'the basic facts of our geographic location...conventional military attack against Australia would most likely be directed against the northern part of the mainland' (Beazley 1987: 21). In recent years the Australian Defence Force has relocated the majority of its personnel to Darwin and Tindal, an Air Force base on the outskirts of Katherine that was purpose-built in the late 1980s. Darwin is also home to the state headquarters of such national welfare groups as the Red Cross and Salvation Army; such health issue specific groups such as the Heart Foundation, the Asthma Foundation (NT), KidSafe (the Child Accident Prevention Foundation), and the Australian Kidney Foundation (NT); and such private-for-profit health outlets as Western Diagnostic Pathology and Corporate Health Dimensions, the last specialising in occupational health, workplace fitness programs and injury management.

Many of these organisations receive substantial grants from Territory Health Services which extend the reach of service availability beyond the organisation's bounds whilst broadening responsibility for rationing through multiple intermediaries (cf Preston, Chua, and Neu 1997), but these linked extensions are not represented on corporate charts as part of the organisation. Even so, it is expected that policy and project staff within each regional and district office, and most especially within the Darwin headquarters, will form alliances and collaborative networks with the many others who might have an interest or an overlapping responsibility with their own roles. To this end, people are engaged in multitudinous 'liaison' activities on an ongoing and daily basis. For more senior personnel, such liaison work may take place in formal committees, task groups and official working parties, membership of which itself reflects one's standing and authority.

For all middle ranking officers (and up), liaison activities will be in face-to-face, expressly purposeful but formally agenda-less meetings.\textsuperscript{109} It needs noting here that while there are titled, salaried ranked grades and different classificatory streams (professional, administrative, technical, medical, executive, executive contract, and so forth) within the health bureaucracy, the politics of rank—or what we might more accurately call, of repute and renown—\textit{within} each classification, is more permeable, transient and less sequential than the nominal hierarchy implies.

\textsuperscript{109} By this I mean that if the meeting is by diary appointment and in business hours, it will always have an ostensible purpose toward which participants will specifically orient themselves, despite the lack of a written agenda or any formalised recording of the decisions reached. For a technical breakdown of the conversational tactics used in the 'mini-meetings' of organisations from a socio-linguistic point of view, see Deirdre Boden's detailed work \textit{The Business of Talk} (1994: esp. 79-106).
As it was described in Chapter Two, one means of placing an iodine trace on the unofficial reporting lines and otherwise invisible strands of status and authority is to capture their operation as interlocutory judgements and knowledge exchange in the spaces of the brokenly said and tacitly decided. People continually sound each other out as part of the work of their frequent encounters to glean other officer characteristics and fealties. For example, in a discussion commissioned to analyse budget figures, I witnessed a completely separate and minor new project being hatched in an aside to the finance talk, together with a preliminary assessment of who might qualify to lead the project if it came into being. 'What about Eliza? could she manage that?' one manager asked of the other about a middle ranking project officer known to them both. Quickly assessing the meaning and intent of the snuffed grimace and modest shoulder shrug, the inquiring manager seamlessly echoed the wordless rejecting judgement: 'No? Yeah, no, I agree, she's a good marketer, but not one to lead strategy.' And so, in the continual trade of exchanges estimating people's capacities and situation-specific worthiness, Eliza's fitness was at once assembled and disassembled without need for reference to 'objective' criteria or further investigation.

The official status of these prompt-response floats of speculation and innuendo is interactively negotiated. It could be that an idea or decision needs to be documented 'for the record' or taken to an instituted authorising body for a recorded, technically official response that can be subsequently represented as the outcome of routinised procedure more reminiscent of the functionally rational techniques described by Weber (1968: 85-6; see also Etzioni 1965: 50-7). Formal rank and representative function matter in these authorising spaces most of all, for of course bureaucratic work cannot proceed without the formal sanction of those who are literally entitled to 'sign off.' But members of the organisation must also apprehend the unstated webs of authority and influence if they are to successfully navigate through their own systems.

Within each and every project there are unofficial matrices of opinion and influence, a specific stakeholder community, a core and a marginal. With the exception of people in the hierarchical positions documented in organisational charts, these alternate matrices index ephemeral locations as people travel the structure and as projects change. And just as the fitness of individuals can be (re)arranged through casual discussion, so too are the attributes of representatives from other organisations, and even entire spatial areas and categories of people. The Education Department is a 'real old boys club, straight out of Moresby'; the Aboriginal settlement of Numbulwar on the Arnhem coast 'is really turning things around with the new community health nurse there, she's working really well with the elders, they have some strong leaders there'; while the young lads in Wadeye, a community south-west of Darwin which distills the essence of dysfunction in bureaucratic talk, 'are really keen to learn about health, they don't like everyone thinking they're violent.'

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110 Extracts randomly selected from a two day public health coordination meeting featuring program managers from across the Top End, held in Darwin, August 1998. This issue of geographic shorthanding and the sedimentation of distinctions is discussed further in Chapters Four and Six.
Weaving tangled webs

To appreciate the complexity of the THS organisational structure as it is enacted on an everyday basis in terms of official and unofficial information retrieval, consultation and reporting circuits, consider briefly the following case study, drawn from the dispersed array of activities assembled under the program title 'Environmental Health,' where we again pick up the narrative thread of both formalised health history, and the role of historical referencing in narratives of the present.

In 1994, the Commonwealth-funded Aboriginal and Torres Strait Islander Commission (ATSIC) established the Health Infrastructure Priority Projects (HIPP) scheme as a program specifically targeted at large scale housing and infrastructure (such as roads, water and power supplies, effluent disposal systems) considered to be too large for any lone community to finance. The scheme was not to be considered as simply a building and works program but as a complete environmental health intervention: it would improve Aboriginal health by attending to living conditions, ensuring less overcrowding, more appropriately designed and durable housing, safe water supplies, and reliable sewage disposal, and would further leave Aboriginal people trained in correct infrastructure maintenance techniques to ensure ongoing sustainability (see also Chapter Seven). The scheme has been established from the outset with the goal of coordinating government and other industry support through shared funding and servicing arrangements, an ambition to which Territory Government officials successfully appealed in 1996 by organising a joint agency submission (in its own right, a triumph of coordination), arguing the Territory's case for a greater proportion of the available national allocation, partly on the basis of its superior coordination processes (THS 1995).

The case set out in the submission for the Territory's greater need itself relies on classifying Aboriginal places as historically constituted arenas of dire ill health and vast unmet demand for housing and amenities needing urgent national funding to remedy (estimated overall cost of four billion dollars to fix nation-wide, one billion in the Territory). That is, the coordination proposal deploys a form of geographic conceptual shorthand which, by availing a pre-existing spatial metaphor of a remote and stricken Territory as 'the space of alterity itself' (Stewart 1996: 67), is able to assume a southern administrative readership well-acquainted with imagining Aboriginal domains as deeply distressed and historically ravaged, replete with makeshift corrugated iron humpies, beds of moth-eaten blankets piled in the dirt and shared with half-alive worm-infested dogs; and tumble-down two-room huts, built badly in mission and welfare times, despised for their evocation of a paternalistic yesteryear when the people weren't consulted about housing design or sympathetically given skills in how to maintain the new facilities (see Heppel 1979).

Imagine now that the money has been 'won'. ATSIC has decided to allocate over half ($48 million) the available national bucket ($80.43 million) to the Territory, contracting engineering and architectural firms as project managers (with a preference for Aboriginal organisations wherever possible) to install housing and infrastructure in remote area communities. Note also that a
coordination promise held out by the Northern Territory Government in its original submission is that it will evaluate the impact of the infrastructure investments on the people's health, thereby helping ATISC meet its own stated aim of measuring improvements associated with the program:

Quantification of community health improvements is to be an integral part of HIPP evaluation, with assessments made before and after provision of the infrastructure. Relevant health agencies have been contacted in relation to monitoring the health status of target employees. (ATISC 1994-95 Annual Report: 153)

As lead agency responsible for health, a steering committee is established in Territory Health Services to follow through on the coordination commitments of the original funding submission. Nearly eighteen months into the life of the Committee, the issue of how to conduct the promised evaluation has been a standing agenda item, and members are increasingly impatient with the circular skirmishes and indecision its consideration has prompted. Delays have been caused in part by the irregularity of formal committee meetings, as the participation of certain people is deemed consequential, and their cancellations a reason for rescheduling in the moment of reinforcing their precedence as high status members (cf. Schwartzman 1989). Tensions between members are starting to become explicit, and there is considerable pressure to 'produce a result' after so much 'fucking around.' The committee member that had been originally assigned to coordinate the evaluation effort is increasingly regarded, in the position-determining talk that takes place outside formal meetings, as inadequate to the task, but other potential candidates within the organisation are considered shorthanded and overworked. In the relentless pursuit of closure that bureaucratic operations are typified as seeking, the scene is set for an enthusiastic researcher from the Alice Springs office to propose a way forward.

Switch to Central Australia: After a period of months where she ferreted out as much as she could about the national and local intricacies of the HIPP scheme, and following intensive negotiations with her regional office counterparts to garner their interest in volunteering for what is really a non-assigned piece of work dreamt up in Darwin, Gwen Mark, an epidemiologist with no prior involvement in HIPP activities, but inspired by its aims, puts together a comprehensive evaluation proposal. She works long hours into many nights to piece it together, balancing the wording inputs of different contributors in both the Central Australian regional office and organisations beyond to produce a generically acceptable text. It is a break-through out of the Steering Committee's evaluation impasse.

Much of the project negotiation work is already complete. Gwen has approached two recently renovated communities earmarked\textsuperscript{111} for the evaluation proper and received favourable

\textsuperscript{111} This earmarking itself borrows from the reputational schemas elaborated above. Determining which communities to approach for permission would itself have been the topic of coordinating discussions, with merits against such criteria as council management stability, proximity, population size (for sampling purposes), level of upheaval, likely willingness to participate etc used as the distal yard sticks. Some communities, such as Alpurruru, are pre-defined as impossibly problematic and are ruled out, thus reinstating the uneven distribution of resources development projects are meant to ameliorate. A response to this point is also at the ready in the logic that we should concentrate resources in a fewer number of areas to build 'real successes' that other communities would be inspired to emulate, rather than failing equitably by spreading too thin.
preliminary responses. Candidates nominated for inclusion in the Alice Springs project team to actually do the evaluation have not only indicated their availability to take on the extra work but, better yet, have been vetted and found suitable by appropriate players in quick reputation exchanges. A regional committee has been established with representatives from the other Northern Territory Government agencies based in Alice Springs, as Gwen describes it, ‘to coordinate agency input and ensure the proposed new database does not duplicate any existing information sets’ (fieldnotes, April 1998). What’s more, Gwen has investigated a mechanism for salvaging the evaluation funds set aside by the main Steering Committee by arranging their transfer to an incorporated body, thereby ensuring that annual budget claw-backs of unspent monies within THS do not impose an impossible timeframe on the planned research. (We may take quick note of how moving money is a key concern in welfare bureaucracies, where not spending funds that have been hard-won through argumentation and passionate constructions of need is symptom of poor management indeed.) All key elements accounted for, the evaluation proposal now only need come to the Steering Committee for official endorsement to proceed. The Committee, in other words, forms the next evaluative transit point for Gwen’s near-final text.

But then, unexpectedly, a complaint is received by one of two THS Executive representatives on the Steering Committee, from a senior ATSIC manager wanting to know why someone unknown to ATSIC, some junior woman from THS, purportedly from Alice Springs, has contacted the National Office of Audit in Canberra ‘demanding’ the terms of reference for a project they are not even undertaking, an audit of HIPP. The Canberra-based ATSIC bureau, it transpires, are undertaking a routine internal administrative review of their program, of no concern to either the federal Audit Office or to Territory Health Services, but somehow in Gwen’s research of the networks she thought she had to navigate, she has garbled the connections and her quest to coordinate evaluation efforts has gone off on a confused tangent. Worse yet, the engineering company ATSIC has commissioned to oversee all their projects are also complaining; they say a woman called ‘Gwen’ has been asking for data they’re not sure she—unvouched, unknown and a bit too strident for their liking—should have. By whose authority is she seeking information? What do we want them to say to her?

And in the flurry of sorting the chain of small misunderstandings, Gwen’s previously admired proactiveness is now considered ‘out of line,’ her intelligent pursuit of background information is now a breach of delicate protocols, and in that delicate breach she has unintentionally executed an ever-so-slight impugning of the management acumen of the two executive managers on the THS Steering Committee, who feel co-implicated by her lack of finesse. And so, when an advance copy of Gwen’s hard-worked near-final draft of the evaluation proposal is faxed through from Alice Springs for pre-assessment and review—a standard vetting practice designed to remove surprises from formal Steering Committee considerations—three of the more senior Committee members, including the chair, with me as scribe, are already set to convene informally to discuss how ‘to reign Gwen back into line.’
Switch to Darwin. In this smaller, more task-focused, gathering decision-makers, of Gwen's draft proposal is painstakingly analysed, line by line. A section detailing how 'any change in community perceptions of quality of life' will be quantitatively measured is isolated for attack. It, like her, 'goes too far.' It is intrusive, the select party of three-plus-scribe now say. It doesn't respect Aboriginal people's privacy, it 'assumes quality of life is a shared cultural concept.' It will be 'far too risky' to permit the fraught activity of what amounts to 'psychological testing', so dangerously akin to the 'head measuring' anthropologists used to inflict on Aboriginal people, to proceed in the hands of yes, a well intentioned but let's face it, an essentially inexpert regional officer.

The rest of the proposal is deemed acceptable but the problematic section on quality of life will be refused funding and must be removed (regardless of the intense formal Steering Committee discussion about its merits that in fact does follow). Nor are the words in her draft yet final: the proposal will require pedantic re-editing and re-submittal. Moreover, to ensure 'the politics are better managed in future,' someone from Health House will have to be put on Gwen's project team 'to keep an eye on things' and, finally, she will be instructed to invite a member of the Alice Springs ATSIC regional office to participate as well—a friend of one of the Steering Committee members—'to ensure good information flow.'

**Historical containment**

As this brief description of project politics suggests, there is an inherent instability to both reputation and network alliances and a multiplicity to the layers of coordination that enmesh as much as they transmit information. Responsibility for the evaluation disappears from the originally-assigned (but found to be wanting) Steering Committee member to fix on Gwen, yet, before it starts, her project team is already recombined, precipitated by a subtle mishandling of the layers and pathways that needed to be considered, when her networking transforms into a need for a lesson in coordination. She is now adjudged someone who means well, is bright but naïve. She will 'need to be managed,' a typical verdict made of the over-enthusiastic regional project officer who, in this case (formal offence) does not know that the National Audit Office should not be approached by a relatively junior regional officer and (informal offence) has not accurately apprehended the tacit reputational order. More coordination (and opportunity for delay) have been ensured in the reflex form of a new regional committee, but some of its members will operate as satellites of central office, introducing a new level of segmentation to the consolidating work Gwen must perform as she masterminds the project through all the micro-forms of talk and situational adjustment its coordination will require. One can anticipate that the satellite members will diligently examine Gwen's future liaison attempts and relate their assessments informally and casually, most likely as opportunistic inserts within encounters assembled for other reasons, but invariably for the greater good of information flow and coordination.
As it is recorded in the minutes and presented to the full Steering Committee (who know nothing of the mini-meeting and are thus still enthusiastic supporters of that keen officer in Alice who seems so on the ball), the clipping of the proposal is framed as necessary for different reasons entirely. The component on quality of life has been removed ‘for the moment’, because firstly, it is more complex than the other proposed actions and secondly, decisions are urgently required now. As the Chair frames it for Committee members:

The basis for doing that ['deferring' the 'quality of life' measurement] at the moment is that we need to make a decision very quickly, at least on the bulk of the proposed study, which is relatively uncomplicated—though people may have comments that they want to make on it—so [let’s] get on with that. It is rather less complex than the quality of life area which will probably involve a bit more discussion with more agencies at a higher level. It doesn’t mean it’s been dropped, it means it’s been taken off this particular proposal for the purpose of this particular meeting.

(Meeting transcript, 21 April 1998)

Tellingly, the aesthetic of right and wrong regarding Aboriginal people, so potently wielded within the pre-Committee mini-meeting’s dissection of Gwen’s faxed proposal, disappears from view in the Steering Committee meeting proper, camouflaged instead under a rubric of strategic priority (quick decisions on the bulk) and need for more senior inter-agency liaison. This reframing not only preserves a sense of mutuality with regard to producing joint practical actions within the Committee—they can discuss all aspects of the proposal, except just this one part, and even this pause is ever so temporary—it also endows the action with an organisational logic recordable for the minutes and unarguable in situ (Gumperz and Cook-Gumperz 1982a: 146, 150). For of course, minutes, like policies and every other form of official documentation, are, as we have seen, collectively agreed scripts which come to be so agreed by a proper engineering of a specific collectivity in which agreement itself makes and breaks alliances. They must achieve a coalition character and anticipate the possibility of future scrutiny whilst smoothing over and writing out the more discordant practices meetings actually engender. As I have previously argued, banality is a hard worked and essential requirement of institutional texts.

In the implication wrought by its very absence, the Chair has further determined that an explicit use of prescriptions about what is right or not for Aboriginal people, so successfully flourished within the powerful ‘mini-meeting’, would here spiral into a new contest. Without saying anything, for there is much tacit social knowledge pulsing through such ordered occasions, the Chair knows that a discussion on the politics of Aboriginal sensitivities would open space for competitive displays of intimate and superior knowledge about the Other and diminutive tests of loyalty within the Steering Committee. In other words, it would create opportunities for rupture that only much more talk work could close, as opposed to the neat elision offered by the more procedural argument the Chair in fact strikes for the Committee’s formal considerations. Trading on a different rationale in the Committee meeting proper thus ensures a clean rebuf of Gwen takes place in the defensible guise of a quick decision to proceed, a progression which cannot be easily contested in the context of months of procrastination and indecision amongst members who understand and abide by the circumscriptions of the rules of the meeting form (cf. Myers 1986b).
But in its covertness, the invocation of cultural (in)appropriateness reveals the intensity of its import as a transactional tool for bureaucratic decision making, authorising some actions and denying legitimacy to others. Indeed, as we will see, the intricacies of asserting authority in relation to knowing specific Aboriginal people and speaking with authority about their generic needs and desires, forms the lifeblood of reputation damage and sustenance within public health webs of opinion formation and classification.

Conclusion

At the time of writing, the Strong Women, Strong Babies, Strong Culture program still operates with the unquestionability of the established fact: it is a program which ‘works’, that much everyone can always assume to be true, even if only in vague awareness of the two formal evaluations announcing it to be so. In many ways it captures some defining attributes of my ethnographic experience of Territory Health Services. It is learnt through multiple forms of encounter in which insistence and repetition, relayed in the inexhaustible lateral configurations of information sharing which organise the organisation, lend gravity and veracity to the tale. It operates at once as an emblematic end in itself and an objective to be reached. In its continual recitation of a successful track record, which sympathetically selects from the vanquished Aboriginal past to create wholesome contemporary effect, a one-day-to-be-arrived-at future is glimpsed when all efforts to have Aboriginal people assume responsibility are at last fruitful and professionals reach their repeatedly announced desire for eventual redundancy.

Out of the ups and downs of the uses of history, a progress charter can be crafted: the program operates as a promissory note luring the dedicated toward the success that could be theirs if they could only speak to and form relationships with Aboriginal people with sufficient attention to inclusion and motivational information sharing. In the glimmer of a definable outcome (140 grams increased birthweight) out of the tangled circuitry of state-funded activity, the solicited indigeneity of the program gives the appearance of durability to technologies of governance that otherwise seem so ephemeral (short-lived, stop-start) in bureaucratic encounters with Aboriginal domains. Finally, the investment in it being true out ranks other reportable gains and withstands known schisms in practice because it meets a need larger than the literal program itself—a need for evidence of the efficacy of community development as both philosophy and method.

The tendency of health professionals to recuperate discordant experiences into an evolutionary schema of progress isn’t the product of a smooth ideological hoodwinking but of learning and iteration, arising out of the ‘diffuse oral commerce’ (Marcus 1992: 151) of everyday interaction. It is not peculiar to policy formulat ors or ‘management’, as the next chapter will reveal, but features as a technique of perpetuation in a range of different institutional settings as THS actors work arduously to head off the repetition of their self-identified shortcomings. The story about poor Gwen Marks, a real story this one, leading to another real evaluation with relatable results to become known facts (it transpires that in both the selected communities that were finally evaluated for the health-bearing impact of infrastructure investment, non-Aboriginal expatriate
residents occupy the most functional houses and have fewer occupants within each house), this story about Gwen also shows the uses of history in the everyday of the said and the unsayable. The players do not admit to themselves what they are doing by claiming to purify Gwen's research proposal of its assumed traumatic, if unstated, resemblance to the head-counting and brain-measuring practices of our colonial forebears, nor do we need much in the way of historical detail about such practices for their efficacy as indictment to work their magic.

Lived out daily, these historical and cultural abstractions are the raw material for the tacit little acts of semiotic damage people enact on each others' work to effect the work of reputation maintenance and disassembly. And, this being the beauty of references to doing what is right for Aboriginal people, the plot is catapulted by its deftness of historical containment. The factoid historical references to such unarguably denouncable acts as head measuring, lend their weight to the need to appear industrious and ethically concerned as Gwen's administrative slap is plotted. At every step, the reasonableness of proceedings is perfectly executed. History appears in the work of appearances as much as in the work of explanation.

The presence of history as part both of concentrated explanation and radical posturing figures prominently in constructions of THS program logics and more widely, in the arguments of public health advocates for addressing the political economy of Aboriginal ill-health: matters such as poverty, dispossession, social disruption, unemployment, poor housing conditions, overcrowding, sub-standard amenities. Simply instructing people on healthy behaviours, public health professionals argue, will be of little effect in the face of such powerful historical legacies: the structural means and social conditions must also be addressed if individual health status is ever to be improved (see Figure 10).
Figure 10: Historical impacts (from MSHR 1998: 45)
There is, in such compact models of causality, the creation of an entire genealogy of institutional exposure which, in its co-joining of fundamental forces, is simultaneously self-completing and unable to imagine life outside government activity. These are the stories of mourning and hope that substitute for a detailed administrative history, scripted into health professional accounts of present day pathology:

To understand why the health of Aboriginal people has failed to improve (and has probably deteriorated), we need to understand how most Aboriginal people have been marginalised by the dominant culture in a land that was originally theirs. They suffer disproportionately from poor education, unemployment, poverty, poor housing, poor nutrition, alcohol, poor health services and all other ills of Australian society. These social and historical origins of poor Aboriginal health can be traced back to the time of colonisation. (Mathews 1996: 30)

As I shall show in subsequent chapters, it is of no matter that housing, education, unemployment and so forth are culturally specific and institutionally over-determined formulations of what it takes to lead a proper life, posing instead as universal and apolitical indicators of need. Such conceptualisations simply take for granted a complete sense that for all subjects, historically and today, all aspects of life are propelled primarily by government policy. I stress the all, for it is a fact of bureaucratic logic (and of academic representations which abide by its formulations) that the full sweep of human experience can be distilled into categories of assumed wider historical import (eg. economics, politics, colonisation). The pedestrian phraseology (marginalisation, poor education, unemployment, and so on) is itself a giveaway to the conceptual orderings involved. Whatever else might matter to life as it is individually and alternately lived is not attended to, or rather, is overridden by an insistence that (our socially-conceived) characterisations of ‘social forces’ are more crucial. Seeing the world this way is essential for imagining such bourgeois ethics of cleanliness and sobriety, sturdy housing and regular education are universal requirements for a decent and socially just life.

It is by imposing such iconic orderings that the space occupied by Territory Aborigines is transformed into a ‘symbolic pocket of poverty’ which lacks, and so sets into sharp relief, ‘the gains of ‘our’ material wealth, education, literacy, sophistication’ (Stewart 1996: 118). How we conceptualise our own administrative history and thus the history of others is bound up in this totalising logic. In the magical circularity of interventionary perception, our failures to be fair about resource allocation and other matters of policy in the past, necessitates much greater additional (more enlightened and reformed) government intervention in the present. Because government can be imagined as making up everything that matters for a life, the only way forward is more governance.

In the causal link modes of interpretation familiar to public health, the solution to the serial and forced removals of Aboriginal agency is empowerment, particularly as mediated through the instrument of community development projects, combined with coordinated government action, known as intersectoral collaboration, across a range of sectors (transport, environment, land
use planning, early childhood services, education, business and industry, housing and so forth), to address the underlying, contributing, social conditions. This approach is well-represented in the World Health Organisation's (WHO) Alma Ata Declaration of 1977 (1978), frequently cited in health promotion literature as a founding text and source of program inspiration. In the Declaration of Alma Ata, a distinction is drawn between health for the people and health by the people, and a primary health care policy approach is advocated stressing four basic principles: collaborative networking; consumer and community participation; balancing health care priorities between immediate and long-term needs; and partnership with related sectors (ibid.: 11, Palmer and Short 1996: 202-241).\textsuperscript{112}

Sympathetic moves all, bringing us closer to the one day when the history of improper engagement between the races is eradicated and good health is shared by everyone, with much coordinating and developing work to be done in the interim to bring this desirable future forward. There will be more to say about community development, the forms of passivity it assumes and the arduous efforts of its promoters to return agency to its disabled target groups in later pages. For now, let’s simply note its deftness as a causal summary: these things were done to them, with these results, requiring our further involvement to fix.

It would be churlish to question the origins of Aboriginal pathology in colonisation, or to deny, in the fragments of program narratives about how to strike forward, the efficacy of Strong Women, Strong Babies, Strong Culture as a community development success story. Important truths are being re-produced here—Aboriginal people have been victims of an oppressive history borne in the present day by their profound levels of disease and premature death, highlighting in turn health system failure and the urgent need to have them assume greater control over and responsibility for their corporeal and social conditions (with culturally appropriate organisational help and training).

It is a governmental historicising which reappears in each new, hard-fought-for program and health status investigation, within each sympathetic public health formulation which argues the case for greater resourcing of that which is lacking and that which needs correcting. Such motifs freely stand out in the following research summary, describing the results of a survey of the health profile of adults in a Northern Territory Aboriginal community:

The screen revealed high rates of smoking and excessive drinking, of preventable infections and their sequelae, and of hypertension, insulin resistance, diabetes and renal disease. Most morbidities were strongly associated with identifiable risk factors,

\textsuperscript{112} At the risk of overdoing my representation of the dominance of these modes of figuring health's historical interconnectivities, consider also this analysis of the strategies most likely to yield 'excellent outcomes in contemporary primary health care in Australia.' Following an investigation of one hundred and eighty-five published accounts of practice, a closer evaluation of ninety-nine of these and detailed study of 25 of the most highly rated cases, Eight broad strategies of primary health care practice were identified which appeared to have contributed to excellent outcomes in the cases studied: consumer and community involvement; collaborative local networking; strong vertical partnerships; intersectional collaboration; integration of the macro and micro; organisational learning; policy participation; and good management.' (Legge et al. 1986: 12)
such as overweight, smoking, excessive drinking, skin sores and scabies, all of which are amenable to modification. Problems with food supply and pricing, poor food choices and diversion of money to cigarettes, beer and gambling all contribute to poor nutrition. Low birthweight probably compounds the risk for serious adult disease associated with these environmental influences. This profile highlights the failure of current systems to deal with health needs. Improvements in infrastructure, education and employment, and reinvigoration of preventive and primary health care programs, assumption of responsibility for health by the community and individuals themselves, and better management of existing morbidities are essential to rectifying this shameful situation. (Hoy et al. 1997: 121)

Within the main text, we learn also that ‘the epidemic of noncommunicable disease in Aboriginal adults might be the legacy, in part, of improved infant survival over the last few decades’ (ibid: 125), a more formal statement of a melancholy view frequently put to me that all we (whites) have managed to do is stop Aboriginal people from dying in infancy, in order that they die instead in their thirties and forties, a curse which leaves few grandparents and even fewer keepers of the customary culture redemptive bureaucrats are at pains to rescue from its history of pain and adulteration.

It is from these non-victim-blaming self-binding analyses that public health professionals order their task, seeing in their work a battle against the pernicious imprint of the past in the day-to-day of Aboriginal community fatalism and despondency, system resistance to their work, under-resourcing and wider societal hostility to Aboriginal issues. But it is not a struggle that can be waged on people, as in ‘you will have more of my governance or you die!’ The for and with are important prepositions, declaring an insistent need to have the health discipline desired of Aboriginal people (in conformity with Euro-Australian specifications) transmute into acts of Aboriginal self-determination and community desire. In which case, as we shall see, the focus returns again to an intensification of the (mind-bendingly difficult) effort to develop Aboriginal people sufficiently that they become effective advocates for resourcing the management of, and for self-managing, their own ill-health, by first learning the terms for developing ourselves to be more effective developers (Chapter Four). Which further requires in tandem (Chapter Five) that THS bureaucrats better know and understand the underlying causes of ill-health (the anomie-inducing pathology of enforced westernisation) in ever refined statistical detail so that they can in turn share what they know with Aboriginal people. For with that empowering knowledge, Aborigines will feel a swell of white hot anger that will energise a life-transforming response that will finally break the stranglehold that history has on continuing Aboriginal misery and acquiescence. They will finally self-govern.
PART TWO
Absorbing and Delivering

Part One of this thesis focused on the doing of bureaucratic work. In it, I argued that gatherings (meetings, workshops and various forms of information exchange) assure fragmentation even as they enact coordination. I focused on the power of historical formulations to the creation of a sense of progress within the everyday registers of program talk. And I devoted considerable attention to how relationships and consequences both require the constant attention of participants.

A key argument was that there is always a performative tension involved as the situational demands of particular institutional interactions are 'surfaced.' While the patterns for doing bureaucratic things may be pre-laid and iterative, each new development contains within it possibilities for derailment, lending situational intensity and an element of capriciousness to familiar and repetitious forms. Administrators operate, as it were, in situations of constrained contingency. Dissent and opinion must be couched in convoluted neologisms so as not to cause offense and yet both opinion and dissent, ironic detachment and cynical adherence, are necessary to the act of being engaged and involved, in order to continually re-achieve the status of 'good operator.' Bureaucratic work in full flight can be exhilarating when surfaced well, excruciating when done badly, accounting for the both the seductive pleasure and painful intensity its actors are so familiar with.

Yet 'good' and 'bad' imply judgements. Part Two of this ethnography moves from the general structural emphases of the opening chapters to explore in closer detail how one learns the criteria and citational chain of formulations for articulating and inhabiting the interpersonal judgements through which bureaucratic operations are given shape. Pursuing my interest in the discursive and affective aspects of institutional subjectivity, Part Two also explores the emotional and visceral import of public health knowledges on professionals themselves.

My broader theoretical goal is to show that the work of formulating the problematic of Aboriginal health is not simply discursive. It also produces and categorises health professional's feelings, their expectations, satisfactions and frustrations, their bodily experiences, and of course, their means of talking about it all. Central to my analysis are the ways in which inhabitants learn to generate what are often severe constraints on interpersonal talk and action within encounters which claim to be the opposite—that is, unfettered, supportive and freely disclosing. I argue that the myriad forms of professional introspection and critique which characterise public health are not only imbued with organisational logic. They also antagonistically reproduce the organisational logics they seem to be contesting by installing a critical grammar, including through negative judgements of 'the government,' 'the state,' and Territory Health Services as a whole. I further aim to show the ways in which professional and general public knowledges combine with intimate
and personally acquired experiences of cultural identity and differentiation to then circulate as objective, intuitive or incontrovertible facts, which in turn feed back into intellectual and liberal accounts and embodied experiences of the same. In an effort to appreciate the significance of the narcissism of bureaucratic forms, how they keep referring back into themselves, I also begin the hard work of explaining the magical power attributed to bureaucratic projections about a world that requires our expert-led improvement, in which our representations of that world become the means by which we hope to alter it.
Chapter Four

Learning
Chapter Four
Learning

This chapter is driven by a beguilingly simple question. How does one learn to do and say bureaucratic things (cf. Brenneis 1994)?

Being so deceptively easy, the question lends itself to a deceptively easy answer. If we turn to the ready-mades of social scientific judgement, it's simply a matter of complicity. With heavy investments in self-interest and promotion, ingratiating bureaucrats will readily adopt the stances required of them to be regarded as competent or worthy in the eyes of important superiors (cf. Jackall 1988, Kunda 1992, Munro 1999). They will act and speak in organisationally acceptable ways and knowingly contrive acceptable arguments or affect visible displays of loyalty to issues of the moment, performing expected forms of assent whilst evincing ironic distance, exactly fitting the complicit disposition. Equally, bureau-speak can be glossed as 'jargon', and viewed as constituting its own world of circumscribed disclosure, sensible to speakers alone. In such closed spaces of self-fulfilling and self-generating organisational forms and language codes, the argument could easily go, bureaucrats will do what it takes to achieve the effect of necessariness for their solutions to (their constructions of) necessity without serious fear of discursive interruption (Apthorpe 1985: 91-3)\textsuperscript{113}.

Neat, rhetorically self-referential, the tacit coming into being through indoctrination, actors taken in by and performing to the tune of infinite webs of corporate illusio (cf. Bourdieu and Wacquant 1992)—no wonder, we might say, no wonder bureau-professionals cannot imagine social improvement without their direct involvement and control, despite talk to the contrary. As the authors of the obvious prescriptions they generate and are dependent upon, bureau-professionals actively create social pathologies they alone are able to diagnose and treat, tokenistically enlisting the involvement of the community they keep at arms length from any real transformation of their techniques of problem formation and resolution.\textsuperscript{114} In such a rendition, bureaucratic and professional health knowledge is somehow ready-made, its actors controlled by the organisational logic they play an unwitting part in reproducing.

\textsuperscript{113} Hummel's work, The Bureaucratic Experience (1994), reprinted four times since its first release in 1974, is a sustained example of this approach, in which he argues that the bureaucracy systematically stifles humanitarian impulses amongst employees, and transforms individuals into clients and cases. As he can allude to the myriad nightmare tales of encounter with administrative stupidity and heartlessness that we all have in our experiential repertoires, his typcast holds up too well to be dismissible, I have been at pains to argue that the incitement to bag bureaucracy and the portrayal of its inhabitants in both popular and anthropological literature as insensitive intruders into more genuine modes of being, is part of the analytic problem. Amongst other things it ignores the equally myriad encounters with bureaucracy in which a blind eye has been turned, ambiguities exploited and inconsistencies mined for the benefit of clients. Yet even this counter critique (a defensive promotion of 'the good guys' working on the inside) simply upholds the original framework and its methods of apprehending the bureaucracy as the discrete site of either good or bad practice, when these are the binaries that need to be overturned.

\textsuperscript{114} Drawing on Foucault, James Ferguson describes this closed circuitry with sophisticated detail, arguing that development bureaucrats may have a ready ear for criticisms of their projects, but only so long as these are followed up with calls for 'good development projects'—that is, with calls for improvements which leave untouched the overall contours of the development apparatus. As he puts it, 'in development,' as in criminology, 'problems' and calls for reform are necessary to the functioning of the machine. Pointing out errors and suggesting improvements is an integral part of the process of justifying and legitimating 'development' interventions (Ferguson 1990: 285).
It is a difficult conclusion for me to contradict, for it is supported by much of what has been established ethnographically to this point, and herein too, with further vignettes showing how the multiple and competing views which are an encouraged and constitutive part of a modernist, professionally reflexive organisation, are smoothed into singular institutional (dot-pointed) narratives. Rather than rejecting conformity as an explanation, then, this chapter takes the puzzle of conformity and institutional socialisation as its core questions. My theoretical ambition is twofold. I want to show the inescapability of classificatory knowledges within THS, and how such knowledges foster a sense of purposefulness and morality for professional activities. Equally, I want to explore how the sedimentation of professional knowledges goes beyond communicative acts to include material forms—literally, a force exerted by such seemingly neutral or unmediating apparatuses as workshop layouts and whiteboards, which I argue shape and compel institutionalised inhabitation. To explore this fusion of institutional form and function, I discuss three interrelated aspects of identity formation and knowledge acquisition in THS.

The work of talk in talk of work

To begin with, there is the need to account for the tremendous speed with which the performative aspects of public health interaction are both imbibed and reproduced, to the point where, as I have shown, newcomers are able to mimic bodily dispositions and clothing styles, and cite key words, stories and anti/institutionalisms, within short weeks of their starting in the organisation. While such identity markers are clearly organisationally-produced, they are not included in the formal content of induction materials, nor are they open to the explicit control of managers—much to their regret. It is as if a public health sensorium is developed in spite of, whilst clearly informed by, formal processes of bureaucratic knowledge transfer.

A clue for how this absorption takes place lies in the fact that public health is an intensely verbalising profession. Paraphrasing Foucault’s astonishment at the insistent presence of sex and talk about sex in a supposedly repressed and silent era, the most intriguing feature of the ‘discursive ferment’ surrounding the problems of doing health work is ‘the institutional incitement to speak about it. And to do so more and more; a determination on the part of the agencies of power to hear it spoken about, and to cause it to speak through explicit articulation and endlessly accumulated detail’ (Foucault 1990: 18).

The progressiveness of public health approaches, deemed part of a new age of holism in health care, are emphasised in their ground rules for creating permissive, unthreatening environments designed to surpass the historically power-clad distinctions between clinician and patient (Hawe and Shiell 2000). In their workplaces, public health professionals model these imagined equalisations with and to each other. The very consultation and collaboration instruments which are advocated as techniques for partnership building with ‘the community’—such as focus groups, delphic processes, brainstorming and nominal group techniques (cf. Feuerstein 1986, Hawe, Degeling, and Hall 1991, Krueger 1988)—are also deployed within formal sessions of professional introspection. Public health professionals further believe in the power of talking things through, of having facilitated group sessions which democratise problem-solving and decision-making.
By sharing stories about one's work within supportive group encounters, professional boundaries will be broken down, coordination synergies will be created, and the emotional burden of working in such arduous areas as remote area Aboriginal health will be managed.

The talking nature of public health immediately suggests the fruitfulness of combining the insights of ethnomethodology and sociolinguistics. As these bodies of work have shown, \textit{doing} can never be strictly separated from \textit{saying}, or to put that differently, spoken language is always more than referential (cf. Bauman 1977, Garfinkel 1984 (1967), Paine 1981). Verbal communication 'is itself a form of life or a realm of activity in its own right' (Maynard 1989: 143):

\begin{quote}
This means that spoken language has to be appreciated not as a vehicle for communication ... (but) ... as congeries of practices that enact the world in the here and now in such a way as to preserve perspective and experience, and yet achieve a sense of mutuality with regard to producing joint practical actions. (ibid.: 143-4)
\end{quote}

In institutional settings, talk performs work both as talk about work, and as a vehicle for intersubjectivity, through being highly attenuated to the factionalisms and alliances inherent within organisational interactions. As ethno-methodologist Deidre Boden points out, talk is the means through which people constitute organisations (1994: see especially pp. 79-130)\textsuperscript{15}:

\begin{quote}
Since the organizing and structuring of organizations is a primarily talk-based process, talk and task tend to intertwine in finely tuned ways. The casual talk that fills the air at the beginning of a meeting, or in a colleague's doorway, or around the high-tech workstations of the modern office deftly weaves sociable personal news and stories with organizational maxims, practical advice, direct queries about work in progress, tales of distant divisions, gossip about new accounting procedures, rumors of reorganization, and outright myths about organizational battles of old. In the process, talk at work is merged with talk as work. (ibid.: 51)
\end{quote}

A number of accounts of the talk-work that takes place in meetings or workplace symposia (project presentations or training sessions) pursue this focus on their constituting function: how such speech events enact the order of the organisation even as they accomplish their intersubjective business.\textsuperscript{16}

\textsuperscript{15} The recognition that talk dominates institutional interactions also animates Peter Groom's (1983) close linguistic analysis of school management systems.

\textsuperscript{16} Once again, I am invoking an immense body of organisational literature which defies easy summary, although comprehensive overviews can be found in Boden (op.cit: see esp. 28-54) and section one of Schwartzman's seminal work \textit{The Meeting: Gatherings in Organizations and Communities} (1989). For work explicitly focusing on the work performed by story-telling within institutional settings, see in addition, Goodall (1988); Jefferson (1978); Kunda (1992); Maynard (1989); Schwartzman (1984, 1989, 1993, 1994); and Van Maanen (1979, 1988). The range of approaches represented within even this highly selective sample vary widely, from the high empiricism of ethnomethodology and its enfranchisement with questions of communicative involvement, to disembodied linguistic treatments of institutional talk as formal texts to be analysed for the structural logic of the words, separable from but isomorphic with the structuring of the organisation itself. Workplace stories themselves may be analysed for their internal narrative patterning and rule-governed grammars (see, for an innovative analysis which unusually draws on literary criticism to look at story-telling and performance genres in organisations, Czarniawaska 1997). Note also that several authors have pursued Helen Schwartzman's injunction to 'see with meetings' (Schwartzman and Berman 1984: 66) specifically in relation to Aboriginal groupings, by asking what meetings accomplish—not so much in terms of their resolved outcomes but their sense- and structure-making (see, for example, Harris 1980: 129-137. Myers 1986b; Rowe 1982: esp. Ch.3, Williams 1985). Other authors who have focused on black-white interactions using town or citizen meetings as part foci include Cowlidgshaw (1988); Kapferer (1985) and Morris (1985). For a sustained ethnographic analysis of the role of white brokers amongst Aboriginal fringe dwellers in Alice Springs, see Collman (1981, 1988: esp. Ch.1). However, despite this abundance, it remains that the behind-the-scenes talk work of bureaucrats as they ponder on how to deal with Aboriginal people amongst themselves and within their own organisations is far less represented in the anthropological literature, except by way of conjecture.
What I have in mind in this chapter draws on these approaches to also explore how acquiring an eye for the look of a thing, an ear for its sound, is informed by, but transcends, the specific content of spoken words. That is, my emphasis is on how people come to comprehend the operating rules of professional public health deportment beyond the explicit instructions they may receive in formal induction programs and guidelines, beyond the words (cf. Wikan 1994), without disregarding the effect of specific and explicit instructions for how to act and be on people's subsequent interactions.\footnote{There is in fact a substantive body of discourse-focused studies of instructional processes within workplaces which offer substantial insights into the linguistic interactions and meaning acquisition involved (see, for example, Gronn 1983; Gronn 1985, Puchett 1998, Tyler and Tyler 1998). Such language-in-use studies have informed my work here. But I am also attempting to capture how people learn what is organisationally acceptable for them to say and not say, which is where I tend to diverge in approach. For more anthropologically informed accounts of workplace instruction specifically treated as ethnographic events, see studies by Kunda (1992), Martin (1994) and Celkin (1998).} Being able to name things, to talk matters institutional, also requires an intimacy with nuanced and non-verbalised knowledges, where automatically sensing the contours of what not to say, of what can't be said and for being able to act without instruction, has all somehow become 'second nature.'

This is also the preoccupation of Michael Taussig (1999), who is concerned to evoke the 'more' in social life that defies codification but is no less intimately understood for being mute (see also Stewart 1996). We might understand this 'more' as the realm of the tacit and intuited, as life lived outside the ambit of the ability of words or reflection, either because it is so automatic and habitual, it has passed into non-reflection; or because it is what people intimately and intricately know without ever articulating directly (what linguistic anthropologists term, awkwardly, 'silent relations,' being the 'relations of a text to the unsaid and the unsayable' (Becker 1996: 143)). Tracking the unsaid and the unsayable requires closer ethnographic attention to the detail of the social contexts in which institutional speech events take place (see also Bauman 1977, Brenneis 1987, 1988, Gumperz and Cook-Gumperz 1982b, and Myers and Brenneis 1984). As Gumperz and Cook-Gumperz put it,

The very constraints under which individuals communicate favor the emergence of strategies governing what is to be put in words, how it is to be made salient, and what can be left unsaid. Over time, these strategies tend to be conventionalized and to become part of the standards by which effectiveness is judged. Such conventions can only be learned through face-to-face interaction. (Gumperz and Cook-Gumperz 1982a: 162)

The forcefulness of workshops

My second driving curiosity about the absorption and relaying of public health dispositions relates to this last point: the constraints under which health professionals communicate. In this chapter, I want to inquire into the form of institutional gatherings themselves, particularly workshops, which are at once both quotidian administrative events and the sites for fiery ideological battles over words and meanings, the gruelling intensity of which can obscure how conventionalised the combated analyses actually are. Specifically, I explore the significance of the tension-filled and
intellectually adversarial yet terribly polite circumstances in which institutional knowledges are produced, and the role of discord and polite restraint in the sedimentation of social knowledges of both cultural difference and the bureaucratic self. Here I pick up threads first signalled in Chapter Two: that is, the arduous task of learning the possibilities for situational creativity within extremely constrained speaking contexts.

My focus on workshops as a powerful form of bureaucratic immersion derives both from their sheer ubiquity (for at any given moment in the THS network, any number of workshops will be taking place); and from their forceful claim in shaping how people narrate events, problems, solutions, experiences, and written documents. Workshops are important because of the democratic and inclusive ways in which they permit and silence. They are by nature and design intensely participatory and emotionally draining. Participants must participate, and, as I will show, their deliberately structured and oppressively friendly inclusivity makes them almost impossible to disrupt with aberrant remarks or recalcitrant behaviour. In workplace gatherings, interruptions and criticisms, while they may surface old enmities or well-staked ideological cleavages, are quickly, if sometimes jerkily, re-colonised. More, because they are designed to appear as if they are ever-emergent and freely disclosing, the ways in which participants constrain, shape and silence each other through intersubjective co-monitoring is almost analytically invisible. It is frankly hard to bring to the surface the leaden weight of orthodoxy and the voluntary uptake of compulsory metonymic associations in situations which encourage, and in fact often seem fractured by, discordant lobbying, debate, questioning, emotive reflexivity, collective discussion and intense participation.

In all such THS gatherings, I argue, the emphasis is geared toward maintaining an appearance of collective decision making and participation, which works to draw participants into involving themselves in dialogues and processes with a for-the-moment-seriousness and intensity that they afterward might shake off, declaring it all to have been a waste of time and a painful repetition of stuff they’ve heard and done many times before. Which, given the ubiquity of forms of collective analysis in THS, and the conventions these democratic processes enjoin participants into producing, no doubt they have.

The discussion that follows concentrates on these two clusters of interest—vocabularies (what can and can’t, is and isn’t said) and the forcefulness of workshop processes—together with a third, which relates to the problems that are created out of what to do about the problem of Aboriginal people, almost always a feature of the exchanges taking place in workshops, group discussions, meetings, seminars and conferences in THS.

118 Surprisingly, given their dominance as a mode of interacting in many contemporary organisations, workshops are almost completely untheorised within the anthropological canon. Helen Schwartzman’s work on meetings remains one of the few serious anthropological treatments of similar sorts of gatherings in a welfare orientated organisation (see Schwartzman 1989).
Ethnography as social device

On this last point, I aim to show how traces of anthropological knowledges interface THS talkwork practices, presenting firstly as conventions of fact and solution, and secondly, as the basis for displays of intimate knowledge about the Other. For this I need to show how notions of public health professionalism in THS are structured around understandings of what it means to be (iconographically) educated and middle class and what it means to be (iconographically) Aboriginal and disempowered. The classifications upon which many expert health judgements are made rest on this foundational, constantly replenished, division.

Now this may seem a rather obvious outcome of the fact that Aboriginal health is what most public health professionals in THS are employed to work on. But, as I will show, here and in the chapters which follow, health professionals trade in a binary that pre-exists them, a binary where much of what comprises the intuitive knowledges about who Aboriginal and non-Aboriginal people are, about what divides and defines them and us, is acquired from a wider stock of understandings, which anthropologists have of course helped formulate (Beckett 1988, Cowlishaw 1990a, Langton 1993, Lattas 1993, Morris 1988b, Povinelli 1999, 2001, Tyler 1994). In the hands of cross-cultural educators and old field hands, anthropological truisms are used to manage the enthusiasms and initial perceptions of new fieldworkers by assisting them to interpret their early field experiences in certain ways. In other words, with anthropologised knowledges as authorising capital, newcomers are helped to adopt the particularities of ‘how we view things around here.’

Now, for anthropologists, the most outstanding initial feature is how fixed and definitive their often more tentative, provisional and disputed knowledges can become upon conversion into forms of bureaucratic discourse. So where, for example, an anthropologist like Basil Sansom might make a complex argument about how Aboriginal people use words as currency\textsuperscript{19}, in its circulation as codified cultural fact in THS, a stark identity difference is presented as a definitive rule to act by: Aboriginal people do not like to be asked direct questions, so be advised to approach issues in a gingerly, round-about fashion. As one cross-cultural manual puts it:

Aboriginal people generally put a high value on being non-confrontational in every-day life....Verbal directness is not only considered discourteous, in some circumstances, it can (sic) viewed as either aggressive provocation or belligerence.....Get advice and/or assistance from senior health workers (Devitt 1995:7)\textsuperscript{120}

\textsuperscript{19} As Sansom argues it, the evasion of answering direct questions with the disclaimers ‘dunno’ or ‘can’t say’ are not so much statements of ignorance or non-cognisance or even reluctance but rather, are evidence of the questioned person disclaiming his or her competence to speak about the subject at hand, regardless of whether or not the matter is ‘known’ (Sansom 1980: 21). That is, a person may know the subject but not choose to, or may feel herself not to be the rightful one to transmit. The capacity to promulgate knowledge of events or people is collectively licensed, policed by intersubjective scrutiny and minute counter-practices, as rejections and rejoinders (see also Povinelli 1993a, von Sturmer 1981). Shared expectations about who can speak about what and when they can do so are signalised and negotiated as part of interaction itself, within densely meaningful and politically marked encounters.

\textsuperscript{120} The fuller exegesis reads: ‘Direct, systematic questioning is generally considered an inappropriate and rather discourteous way to acquire information. The more senior the person, the less appropriate is direct questioning. But much information on individual health must be elicited through asking a series of questions. Although people may appreciate that this practice is unavoidable, it does not make it any more comfortable. Fostering a calm, relaxed atmosphere and posing clear, positively framed questions will contribute greatly to the accuracy of the information. Get advice and/or assistance from senior health workers’ (Devitt 1995: 7).
But it is not only that crude anthropologisms become instruments of institutional socialisation, which is a small part of the point. THS actors are being trained to be anthropological in their modus operandi, because understanding Aboriginal people sufficiently well that they can be recruited to support and adopt health initiatives is the name of the public health game. In addition, correctness about Aboriginal issues, backed by the authenticity of one’s own ethnographic experiences, the ‘being there’ factor, is a powerful instrument for establishing an expert reputation within THS. In thus making an interpersonal resource out of classifications of cultural alterity, bureaucrats join anthropological theorists in conscripting the conceptual and phenomenological aspects of ethnographic experience into professional social capital, at the same time that one’s ethnographic persona becomes a role to be managed through correct rules of engagement.

Learning how to anthropologise one’s self presentation, like everything I have discussed to this point, is not resolved simply at the level of specific instruction about matters of cultural identity, although, as the orientation sessions detailed below reveal, instructional content clearly plays a part. In THS, ‘learning the ropes’ means learning to also handle and deploy the subtle, imaginative and tacit ways in which colleagues diagnose, treat and police each other’s ethnographic slippages and inadequacies, within a seemingly supportive and yet, it transpires, a highly coercive framework of industrial democracy and professional collegiality.

A small example will illustrate this transformation of ethnography into a precondition of bureaucratic practice and a phenomenon thereof.

In a large conference room, 640 kilometres away from Darwin in Nhulunbuy, all the East Arnhem Regional Office representatives of public health have gathered for a fortnightly coordination meeting. Like so many such gatherings before and after, the meeting is at once a routine, practical matter—health professionals need to coordinate their travel activities to reduce overlap and unnecessary expense—and, as we shall see, a powerful mix of subtle and blunt techniques of bureaucratic absorption. In this part of the meeting, the chair, in structural terms an equal peer of those assembled, is calling out the names of regional communities from Milingimbi to Umbakumba one-by-one, eliciting advice on the general tone of the community and commentary on visits, either planned or just transpired.

After two hours of recounting, we are finally down to the last community, Nhulunbuy itself. Xavier, a relative newcomer to the Territory, and respectfully silent to this point, mentions a community development committee he has been working on, and the name of an Aboriginal man who seems to be a particularly noteworthy committee member, ‘not Gatjil but someone other.’ A team member helpfully prompts with ‘Merrilin?’ but Xavier shakes his head, and clarifying, says ‘no, it was a man, not a woman.’ The others look at each other, lean back in their chairs, and guffaw. Releasing Xavier from his bewilderment, we are told Merrilin is a man, not a woman! Xavier, blushing, waves his hand dismissively in the air, ‘oh, whatever,’ he says quickly. Not willing to let the cultural faux-pas go by so easily, the Chair stills the room, facing the palm of his hand outward
to the assembly, thumb next to his face, elbow on the table, before saying in a deepened, laughter-halting tone: 'There is some important history for you to know about him. Last year, his son was caught drinking and driving and was told off. He [the son] went home and shot himself.'

His neck turning from red to white with the ignominy of being found so comprehensively ignorant, Xavier dropped his eyes to the table, crushed.

'Oh,' he quietly demurred.

It is clearly in such slender moments of humiliation that newcomers like Xavier learn, through the powerful tutelage of shaming, both the appropriate disposition of the novice and the kinds of grammar required to signal true familiarity with and competency to talk about Aboriginal people—how, in other words, to demonstrate you are someone in the know. A cascade of limits on how and what can be said buffets down on Xavier's bowed head as he learns an excruciating lesson in the poetics of (bureau-professional ethnographic) knowing.

Yet, just as importantly for learning, what unites Xavier to the group at his point of acutely felt excision, as he sits immersed in what we can only imagine to be an exquisite agony of momentary self-consciousness, his body jamming home messages of shame—saliva hurting to swallow, heart hammering, the sounds of the room as others continue talking echoing as hollow noises, far away and barely registered—beyond all this, what bonds him to others is being positioned to speak about Aborigines. Beyond the time-slowng, heightened sensory impact of his shaming, in other words, the meeting re-establishes an absolute distance between those who can know and those who are known as a means of constructing a measure of how much one knows (Fabian 1983, cf. Said 1985). More, it shows that to be in the know, one has to have command of key pieces of information. Knowing what confers authority, and what is irrelevant to that task, is what Xavier will quickly absorb, with his speed of learning accelerated by the acute professional fear of being shown to be ignorant, and any failure to absorb the lessons a signification of his inadequacies as someone who has 'what it takes' to deal with Aboriginal people.

As this small case study illustrates, upholding the existing analytic state of things in public health is simultaneously an explicit and an elusive process. It is not maintained, as crude theories of state power might have it, through acts of institutional brainwashing, but through seemingly provisional and emergent co-constructions such as these, where work narratives, facts, gossip, humour and mortification are constitutive elements of the assembly. Such talk work, and the texts devised out of such talk work, precede, shape and are reaffirmed by the embodied interactions health professionals have in more remote locations—when they hit 'the field.' Co-performed and interactive, bureau-professional forms of ethnography play a key role in THS shaping processes, not only as a form of expertise in figuring the native's point of view and how best to comport oneself in relation to that knowledge (on which more below), but as a critical element in the politics of silencing and display, of slighting and showing.
As I will further show, displays of understanding about what are taken to be Aboriginal understandings have other reverberations within the health bureaucracy. Snatches of putatively objective, ethnographically-acquired knowledge work to create a floating swirl of images, not even half-formed, around the foundational index of Us and Them. The significations do not need to be fixed to seem true—quite the opposite. Like categories of easternness or westernness in contemporary Germany, 'their symbolic values and semantico-referential properties (often glossed as 'meaning') are significantly malleable and shift according to the communicative contexts in which they are employed' (Boyer 2000: 465, original parenthesis). Merrilin, maybe the committee man, maybe not, father of a dead son anyways, a son made suicidal from being told off, by whom we don't need to know, for such a wee adolescent thing, drink driving. What do our panel members make of these fragments?

For the beginnings of an answer, I will now turn to the official THS induction process, where newcomers are immersed in the formal and informal logics of both the organisation and the problem of representing one's knowledge about Aborigines, in a concentrated adult education forum. In what follows, I begin by elaborating particular moments in a two week long orientation course designed for people supposedly new to regional health work, focusing on the therapeutic techniques suggested for managing discordant field experiences, and the differentiating messages about self and other that are formally conveyed in cross-cultural sessions. I then try to provide some sense of the ubiquity of workshops in THS beyond the orientation session, and of the forcefulness of such processes in both shaping and reinforcing how people behave. Finally, to answer the question of what we are truly learning about oursevles and Aboriginal people, I focus on how participants are told to handle a particularly problematic issue for health workers in the Territory; that of community violence. The chapter concludes with the argument that it is only by paying close attention to the internal politics of professional knowledge formation that we are able to account for the role people play in inter-subjectively soliciting the right ways of thinking from themselves and from each other.

How does one learn to be bureaucratically adroit in situations of permanent self-other critique, to the point where one's in-situ calibrations become so automatic and habitual, they pass into non-reflection? How do people absorb what it means to be 'occupationally ordinary' (Sacks 1984: 419) within workplace positions that are collectively acknowledged to be arduous, anarchic and extraordinary? Learning how to do bureaucratic things in THS, how to 'comply', I will argue, is the sum of playing and replaying conventions about self and other in endlessly creative variations.

**Here to learn**

As a result of a hard-won policy pushed by advocates tired of seeing new staff arriving in communities with no sense of what they should do nor of how they should do it, all newcomers to THS who plan to work in a regional office or in a community development capacity are required to undertake the THS Remote Area Orientation Course. In its current form, the program has been operating every three months since mid-1996, expanding a much shorter course that had once been exclusively available for new nurses.
I was oriented to work in Territory Health Services from a Darwin office as part of this ethnography at the end of March 1998. In the dot-pointed formulations of the program outline, read to us by a facilitator intent on drip feeding the points by strategically shielding the full overhead with a piece of paper, the orientation course aims to develop:

- Team Working
- Two way learning and cultural awareness
- Cross cultural partnerships (‘A key if we are going to work effectively out in the bush’ we are told)
- Primary health care
- Reflections on experiences (‘It is critical during the next two weeks that people share ideas and swap stories so we can learn from one another’)
- A realistic view (‘In 1998 the picture of Aboriginal health is not great, so we are trying to be as realistic as possible about what we can achieve and about what our limitations are.’)

(Orientation fieldnotes, 23 March 1998)

Day One, and Bob Spicer and Julie Nelson, our pastoral guides for the next fortnight, watch over their new batch of sixteen neophytes as we each settle at one of four hexagonal tables evenly separated in the artificially lit, former nursing-dorm common-room. Colourful posters featuring Aboriginal subjects at play and work adorn the walls, proclaiming ‘Reconciliation,’ ‘Bush Tucker’ and ‘Land is Life,’ their transfixed animations unable to lift the drab effect of the streaky pastel green linoleum floor and ancient beige wall paint that still marks this room as old hospital property.

We are assembled for a formal introduction to the Department and its expectations of our remote area health work with Aboriginal people; me, fraudulently, as ethnographer, others because as doctors, nurses, nutritionists and communicable disease specialists, they have real work to do. On each table, navy and black whiteboard markers jostle alongside a roll of blank white stickers. These fragile structures sit on top of information folders, headed ‘Let’s work together to fill the gaps,’ water-marked underneath with a honeycomb design and a bumble bee; a mnemonic, we will learn, for the holistic, coordinated approach we will need to remove the discrepant health status of Indigenous Australians.

Despite our novice status, our trainee-impulses have us cueing off each other to write our names in large print on the stickers, decorating our chests with the self-identification, small habitual actions without need of advance specification as we await the instructor’s first words. As our murmurs and movements still, an expectant silence marks the session’s beginning: ‘I think you all know that my name is Bob Spicer. Can we spend a moment now just introducing who we are—starting from this table.’

Another workshop will commence with a movement of small tables into a circular pattern, visibly rearranged out of their former grids, because we really want this session to be really informal, we all come with different areas of expertise, experiences, we wanted to set up an environment in which people feel free to share ideas’ (Public Health workshop, Nhulunbuy, February 2000). Rearranging tables and claims for informality are standard openings. Likewise, a ritual beginning to almost all collective gatherings in THS is a requirement to turn-take self-introductions, specifying ‘who you are and where you’re from’—implicitly understood to mean work titles and position descriptions and not other possible identities—a democratising routine ostensibly aimed at increasing the efficacy of the networking function of workshops by ‘breaking the ice’ at the outset but which also reinforce the voluntary adoption of depersonalising tactics in committed health work (see discussion, Chapter Six).
House rules are specified—or rather, in the first of a series of inveiglings which enjoin participants in the labour of participation (Goffman 1971), house rules are co-formulated. 'Give each other room to move and space to make comments.' Bob's co-presenter Julie begins, sweeping her eyes over the audience. 'Is that okay, is that reasonable?' (nods and murmured uh-huhs). 'If anyone here has mobile phones or beepers, can you explain how you are going to manage them for others?' Katrina, a doctor positioned at my table, the one who will later in the course display her love of unripe cheeky plums, says she will take herself outside and answer any calls out of hearing. 'Be punctual' (pause) 'Anything else anybody? Does that sound reasonable?' (no disagreement). 'The last thing is the evaluation sheets. We will be handing these out each day and it is really important that you fill them in honestly—we know everyone groans about evaluation but we regard this program as unfinished—we are always working on it to improve it and make it of real use for people so we really need your feedback, okay? We will be giving you a summary at the end of the two weeks on what you reckon, okay?'

And so it went, some small rituals to begin our institutional ritual\footnote{For work which takes the notion of ritual in organisations as the starting point for anthropological analysis, finding the trace of the primitive exotic in the institutionally familiar, see Durrerberger (1987) and Trice (1984).} of the penultimate anthropological ritual, the initiation ceremony, not so much a triumph of disorder to remold initiates into new forms of being (Turner 1982b: 42-48) as an immersion in gentle tedium, where rules will be honoured in the breach: there are latecomers every day, certain presenters will not show, key questions are not answered, and at every table there is at least one dominating speaker silencing others. Not that any of this will be reported in our daily evaluation sheets, for the type of honesty required of us concerns not such recalcitrant observations, but 'constructive' summaries of what we learnt and which session worked best. Already there is much that we know about what not to show and what merits a note in these unfettered accounts of our learning.

By Day Five, we've endured a long first week of the THS Remote Area Orientation boot-camp. We have toured the hospital, including the Cowdy Ward for mental health patients, and we've hunted for mud crabs and mangrove worms and eaten gritty damper at Shoal Bay. We have received visits from a bewildering number of THS program representatives, each of whom has enjoined us to the listings of the multiple phone numbers and position titles in their respective work areas, urging the criticality of networking and coordination to the effectiveness of our function. The once empty spaces in our introductory kits now bulge with essential contacts and program descriptions, admitting us to the staggering interdependencies, the entainment of like and proliferating institutional forms we are urged to work within and against, creating virtual communication lines to supplement official information flows. It will be our own fault if we keep ourselves in the dark:

There is a capacity for moving things through the organisation—you just have to know what they are and how to do it. The other reason why it is good to know the structure, to have structure in the first place, is to have clear direction and lines of responsibilities. Everybody has a right to information about who they are in the system and who they report to. People have a right to be managed. But the structures
do not eliminate the peer support and communication lines between people. Use them. ...There should be some mechanism for you to find out what is going on - if you ever find yourself operating in a void, complain loudly and do something about it. There's no excuse for being a mushroom.

(Senior Manager, Orientation fieldnotes, 23 March 1998).

Representatives from Health House, twenty minutes drive and a world of abstract managerial principles away, have taken us through the Corporate Plan and its five key strategic directions, stressing health's business realities. Interestingly enough, Strategy 21, the policy sea-change to come in only a few months time, is not foreshadowed in our introduction to key management priorities. Government service provider dominance, soon to be represented as an anachronistic mode of organisation for THS, here still innocently marks us as unique. Unlike other jurisdictions which have extensive private and not-for-profit corporations defraying the direct cost to Government of health service provision, in THS, the managers tell us, we are spread more thinly.

When people come to the Territory, they bring with them an idea that health is the summation of individual episodes of care and that your job is to provide excellent quality within your realm of expertise. It is a reasonable point-of-view when you are well-resourced and have good infrastructure and other service groups [are] around to support you. But a different scenario exists up here. Services are spread more thinly and clients are more needy and it-it requires stepping back and trying to organise services for clients in a more systematic way. To think in a more systems-oriented way requires thinking about yourself and where you are coming from and why. It requires thinking differently. You either directly service clients or provide services to those that do. Everyone falls into one or another category—no ifs, buts or maybes. Either way your job is to do the best you can.

(Senior Manager, Orientation fieldnotes, 23 March 1998)

Continuing the service responsibility thematic, we have been urged to strive continuously to seek ways of doing more with less; to see Aboriginal people as our clients who deserve a quality customer service; and to simultaneously view ourselves as the most important resources the organisation has. Promoting 'creative energy and productivity in our workplace' is critical, managers assure, because

Without being trite, the assets THS has is in people's heads. To revive some Marxist terminology, the means of production is in people's brains, not their hands—so we never know if they're on strike or not!

(Orientation fieldnotes, 23 March 1998)

Now, on the afternoon of Day Five, reiterating the orientation program's motif theme on the heroic qualities required for work in Aboriginal health, Bob Spicer is keen that we comprehend and thereby exercise greater control over our personal limitations, 'because you don't really know what's going on in [Aboriginal] communities and your desire to get something rolling isn't enough in itself. You have to deal with your lack of power.' Approaching the electronic whiteboard, Bob asks that we 'look now at why we would want to do this work, what draws us to it, what are the 'Good Things' and what are the 'Challenges'?
The session generates a lot of discussion amongst people now comfortable with each other and with the rhythm of our workshop interactions. As people speak, Bob captures their observations in bullet points on the whiteboard. Responding to the initial call for good things, one participant suggests:

‘Hopping onto the plane and leaving Darwin behind always gives me a good feeling—it’s just the total opposite to the eastern part of Australia, you’re not fighting the traffic, the timeframes are so much more relaxed, you go through magnificent landscapes.’

Bob captions on the whiteboard, in the column headed ‘Good Things’:

- leaving town

Then onto the negatives:

‘The split from service delivery makes research difficult and the antipathies between THS service providers—well, it just makes me tired.’

Bob writes:

- fatigue

‘I feel frustrated being seen as a service deliverer, as a doctor first, there only to see sick people—all I see are people with puss, with sores. As a visitor I cannot spend time with people working on more chronic issues.’

Bob writes:

- inability to work up programs

And the trauma for the families is unreal. I take it out on my kids. I found it really, really hard. ...I would come back from field trips when I first started and I was so frustrated and depressed at the levels of sickness and feeling powerless to deal with it, depressed that I was not affecting anything. And I would take it out on my kids, abuse them for being so privileged. I really coped very badly, I couldn’t talk to my husband for at least the first hour after I got back. I would have to take myself out of the house, go for a walk, go to the gym ... It was so hard.’

‘I would agree with that. It took me at least a day to get over bush trips here—and I have never had that experience in any of the places I have worked—not even Africa’

Bob writes:

- lack of de-briefing opportunities,

and then takes the opportunity to elaborate the point:

‘You can’t lay it on your family—the amount of illness and death—you come home, you’re tired from going out bush, and your partner can’t bear your load. But the department is not going to solve it for you—you have to. So what are some strategies?’
A participant obliges with a handy coping hint:

'On a personal level, at Umbakumba, amongst the teachers we forged really strong relationships. And now I think that is important too.'

Bob writes 'need to network.'

<table>
<thead>
<tr>
<th><strong>Good things</strong></th>
<th><strong>Challenges</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>enjoy challenge</td>
<td>fatigue</td>
</tr>
<tr>
<td>big learning experience</td>
<td>lack of continuity</td>
</tr>
<tr>
<td>learning about Aboriginal culture</td>
<td>inability to work up programs</td>
</tr>
<tr>
<td>no nine-to-five routine</td>
<td>workload</td>
</tr>
<tr>
<td>the people</td>
<td>lack of power</td>
</tr>
<tr>
<td>leaving town</td>
<td>not feeling valued</td>
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<tr>
<td>autonomy</td>
<td>isolation</td>
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<td></td>
<td>lack of opportunity for relationship development</td>
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<td></td>
<td>lack of time</td>
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<td></td>
<td>lack of debriefing opportunities</td>
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<tr>
<td></td>
<td>need to network</td>
</tr>
</tbody>
</table>

*Figure 11: Good Things and Challenges, Remote Area Health Orientation Course, March 1998.*
The point about dot points

Interestingly enough, while the condensations clearly missed the richness of what people were enunciating, it was equally clear that nobody much minded. The question-answer format orchestrated a satisfying consensus and drew upon an easy familiarity with reflexivity that is characteristic of health professionals. While one could speculate that a different facilitator may have handled the translations with greater verisimilitude, there was a neat ceremonial economy to the process. As I've noted elsewhere, there are pleasures to be gained from projecting the right responses within group situations, in receiving affirmation from others at the offering up of words that fit, that match the request for revelation with just the right degree of rectitude.

The reductionist recordings of the facilitator, like the infidelities of policy, are thus not really the point about dot-points, for in a sense, the workshop was the de-briefing session, admissions of failure tumbling one after the other, outranking by far the humble good things. The doctor's powerful articulation of powerlessness—so traumatised by her own failure she comes home to abuse her children for their good fortune—was not erased but affirmed through the process of synthesis. Even when the deletions shifted blame away from the structure of work to an idiosyncratic state, as when, with a deft semantic manipulation of the ambiguities in 'tired of' the contributor's problem transformed into 'fatigue', it was of no particular consternation. The speaking and sharing seemed powerful enough to lessen the importance of the actual wording. Here are experiences worth attending to, the whiteboard transmogrifications seemed to declare.

Re-represented and re-coded, the objectification of self-consciously formulated tales of distressing and uplifting experiences into dot-points enjoin felt idiosyncrasies to a generic state, firmly cementing our situational collectivity through a sense of shared adversity and small joys. Perhaps others are able to speak to their spouse upon return from community work, but we can all feel there is no-one to talk to—other than, of course, those who are in the same boat. In the familiar self-help genre of the support group and after a week of mixed activities together, in and out of hours, we felt warm, united and heroic. We also feel, subtly and without personal bruising, that it is up to us to foster the right attitude, not the organisation. It is a relaxed converting.

Now, let there be no doubt. As I will later show, remote area work can be extremely stressful and demanding, involving frequent and exhausting travel, tense liaison with particularly-placed Aboriginal and resident whites in communities, and ongoing battles over emphasis and approach with fellow bureaucrats in THS and other agencies. Public health remains the poor relation of clinical work and its practitioners cannot always summon the enthusiasm to cheerfully do more with less. Funding is never secure, and the pilot projects which demand such intense organisational savvy, verve and personal commitment to initiate are ever vulnerable to non-renewal. But, complex though it may already appear to be, an explanation which tends only to the therapeutic effect of bemoaning circumstances in the soft encounter of the group cannot account for the extraordinary investment in the form of the workshop public health practitioners
will commit even whilst complaining bitterly of their time-wasting irrelevance. And more to my immediate concern, it leaves aside the self-work the work of talk calls upon its formulators to attend and the intricate work involved in learning the narrative strategies which make an experience tellable in the first instance. The meticulous detail with which some emotional traumas can be recalled, while others remain hazy or lost to memory, reveals something of the culturally patterned perceptual hierarchies which determine what we do and don't register, and more, how we frame what we select from memory to different audiences. Thus the gasp we might make at Bob Spicer's metamorphosis of distress into a technique of intervention would be a misplaced incredulity, as if the confession is an authentic moment pitted against the inauthentic codification of the bullet-point, when the deceit of free disclosure lies precisely in its delicate preservation of tacitly understood perceptual constraints in the first instance.

Suffering for beliefs

Before his death, conversation analyst Harvey Sacks described the differential access to what he called 'entitlement experiences,' being the anthropologically familiar difference between being the person who was there (witnessing, encountering, feeling) and who therefore now has storytelling 'rights,' versus gaining vicarious access to another person's experience through their narration of it:

The idea is that in encountering an event, and encountering it as a witness or someone who in part suffered by it, one is entitled to an experience, whereas the sheer fact of having access to things in the world, for example, getting a story from another, is quite a different thing. (Sacks 1984: 424-5)

Entitlement experiences are to be distinguished from the circulation of snatches of information that may become part of the general stock of knowledge not only in their different distributional qualities 'It is extremely difficult to spread joy. It is extremely easy to spread information.' (426), but in the type of perceptual constraints embedded within their uptake and narratability. It's not as if, Sacks argues, that once a person has had an experience worth the telling (in chancing to see the tailings of a gruesome car accident whilst on their way home, he instances), they can do with it what they will. 'No. You have to form it up as the thing that it ordinarily is, and then mesh your experience with that' (426-7). That is, many unsaid interpretations and ways of feeling and responding to the experience are casually renounced in the condition of both encountering and telling that in turn mark the teller and the receiver as both ordinary (reasonable, appropriate and in proportion).

It would not be right to claim to have been destroyed to the point of madness from having witnessed in passing a car accident involving passengers, ambulance workers and lookers-on

123 See Hanson-Berman's account of meetings in her joint article with Helen Schwartzman for an extended discussion of the similar tendency to discount workplace meetings—negations which are as likely to occur within meetings as side-talk (and I would add, in such unspoken forms of communications as eye rolls and grimaces) as they will occur in meeting post-mortems and other after-the-fact accountings (Schwartzman and Berman 1994: 78-85).
who were all strangers to you, let's say—for it was, after all, just another wreck, an everyday sort of calamity. Nor would it be right for the person un-entitled to the visual experience who is likewise a stranger to the victims and helpers to claim great impact from just hearing the story about it from the original passerby, the 'just' reminding us of the depths of constraint imbuing the having of experiences. (This could be played with endlessly. It might, for instance, be appropriate to tell the tale of some one who witnessed a wreck that had nothing to do with them and was driven to madness as a result, but it would not do to be driven mad by the anecdote itself!) In other words, the narrative forms through which people learn to have and to relate their experiences are thoroughly social.124

It is important to take from this idea of an aesthetics of experience and reaction the sense that orthodoxy (another word for behaving and interpreting in the realm of the ordinary) is itself a phenomenon that requires investments of self and co-performed work to maintain. More than just disabusing us of the notion that the subject can ever really control or be the author of her own discourse, Sacks' sketch of the bindings on perception and narration highlights the active social role of agents in making experience intelligible and recognisable within the brackets of the reasonable.

I want to push Sacks' insights a bit further than perhaps he intended in a preliminary attempt to explain the speed with which public health grammars are adopted in THS. Recall, for a moment, some of the characteristic attributes of public health professionals. Besides being well-educated, they are used to having the worth of their inputs called into question by many protagonists, including those they want to help. Theirs is an antagonistic, quarrelsome kind of work. They are also adept in deploying the psychologised modalities of collaboration and confessional self-help advocated within both public health and contemporary human management theory as methods for coping with their abused positions.

In kinship with their mental health colleagues, they share the widespread view that verbalising painful or difficult events is an important step to personal recovery, that restorying oneself stops the individual from otherwise internalising troubles and progressively being affected by that suppression. Further, they build on the humanist assumption that felt experiences, most especially negative ones, are fully-self presenting, standing as unmediated explanations of themselves, as authentic accounts which are somehow free of artifice and ideology,125 and that expressing these in a supportive group context is its own form of therapy.

124 Drawing on Derrida, Iris Young makes a similar point when she argues that deeply personal experiences are discoursed in another mode (Young 1990: 10-12).

125 The inherent assumption that such tellings represent moments of truth, that this is when people are being their least performative, when they are manifesting their most authentic selves, is widespread in THS, perhaps because of the efficacy of confessions in establishing how people should act (see later discussion above). Yet, as Iris Young goes on to note, 'The assumption of a consciousness immediately present to itself, which can know itself and its contents with apodictic certainty unlike any knowledge of other things, is illusory. It exhibits what Derrida calls the metaphysics of presence, the idea of consciousness as self-originating, a metaphysics that is possible only by taking speech, or voice, as the model of thought, wherein one can deceive oneself that speaking and hearing oneself are simultaneous and unmediated. There is, however, no originary position of the subject with respect to language or the world; the absent always comes along with the present as a plural relation of difference and context at every instance of discourse' (Young 1990: 12; see also discussion by Joan Scott (1991).
The emotional forcefulness of many public health workshop encounters in fact helps give them the appearance of guilelessness, of being unperformed and transparent, as if what emerges are not imbued already with institutional and cultural values. But as I will show, these are the confessional entailments which intimate workshops are designed to draw out. In laying claim to the (indisputably genuine) experience of distress in the midst of a discussion about how should we take care of ourselves in order to do our work better (the invitation to list good things as well as the formulation of negatives as ‘challenges’ itself pressing forth the posture of productivity), the ardent public health professional simultaneously lays claim to her entitlement to suffer and to tell. At the same time, and this is critical, the process preserves and constructs the very ordinary (expected, orthodox) extraordinariness126 of the public health persona.

Extraordinary—unlike the enemy others who seem indifferent or hostile to Aboriginal suffering, these are people volunteering to operate in the near war zone of disease-ridden Aboriginal communities with their ‘busted-arse clinics that may as well be khaki tents with a red cross painted on’ (District Medical Officer, 1999). Loneliness, disillusionment, physical and emotional strain, even management vilification, could well result. But these formulations are themselves posed in recognisable registers—that is, they are ordinary, they seem reasonable in the circumstances. And it is here, I want to argue, here within the selection of hardships to relate (in the selected anecdote, in the proportionality of the emotions attested, in the sympathetic reception and confirming responses of others), it is here that the complex regulation of the romance of ‘the raw’ is accomplished. Or to use an older vocabulary, ‘even such pure subjectivity does not remain untouched by ideology’ (Rosaldo 1989: 43), bearing as it does the heavy interpretive weight of previous use. The trick is to recognise the heavy-handed stamp of the ordinary in constructions of the extraordinary public health professional. And further, that these constraints arise out of the close inspection and recuperation of failure within such free-flowing processes as confessions in a workshop, which, it will come to pass, is an equally regimented organisational form.

Not unreasonable in the circumstances. And what circumstances are these? Bob Spicer tells us it is something to be survived, ‘it’s hot country out there and you will need skills in how to hang in.’ Others testify to its thanklessness, its professional isolation, the continual need for optimism in the face of so little explicit progress, the need for longevity yet the impossibility of ever having enough time to build relationships, the fear of using the wrong processes or committing a wrong approach, and the ever-present danger of doing too much for, rather than with, Aboriginal people, thus exacerbating the dependency that is at the core of the failure to achieve true self-determination. On the final day, an occupational health specialist has even taken us through

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126 In his analysis of the depictions of terror in the rubber colonies of South America, Michael Taussig makes different use of the notion of the ordinariness of the extraordinary (Taussig 1987: 39). Taussig’s concern is more with the mundanities of daily life that emerged in reports of the atrocities that were being committed. There, in amongst tales of floggings and tortures, vicious mutilations, rapes, mass murders and executions, are tropes of rationality (rounding the numbers flogged, for instance) and asides of minor irritation, a comment, say, on the beastliness of the mosquitoes. My point above is that public health professionals create an aesthetic out of their practice as caring and delirious which, in its radicalness, is heavily procedural, actively crafted and tacitly expected. In public health discourse, emotional display is just as much a routinised, institutionally-informed posture as is the call for greater coordination. It is part of the work involved in presenting oneself as an entitled (ordinary) member of an extraordinary public health profession.
martial arts exercises in self-defence, how to break a stranglehold and such like, lest we are assaulted in our roles as isolated health personnel (see below). 

‘What other sorts of things might affect you out in the scrub?’  
‘Stress’  
‘Ross River Fever’  
‘Yes—actually this reminds me of another incident, in East Arnhem Land. I’d been out meeting with people all day and the nurse invited me to lunch but to get to her quarters we had to go through spear grass. Now this stuff was shoulder high and every part of my exposed skin was smothered in mozzies. It would have been a simple thing to keep that place safer. Anybody got any ideas of any others? Scabies, nits ... these are all compensable claims. Caravans are tinder boxes too—you can get these work safety issues addressed. Come to us in Occ. Health and Safety, don’t complain about it amongst yourselves, do something about it. And remember, aggression concerns everyone. The Department will support staff who choose to evacuate in fear of their lives.’ (Orientation fieldnotes, April 3 1998)

Leaving aside the puzzling question of whose aggression we are managing (another unsaid: the lurking eruptive threat of Aboriginal delinquency), these are amazing stories, a smorgasbord of hazards to whet the sense of extraordinary endeavour. Feeling frustrated and unable to talk to one’s non-comprehending kith and kin is certainly reasonable in the circumstances. As is wanting to do something about it.

Ah, and there is Bob Spicer, encouraging as always, urging us to view our problems in terms of their opportunities:

Bob  
When I first started [remote area public health work] I was visiting fifteen communities and I couldn’t develop relationships with people on a once-every-three-months basis. I couldn’t do what I knew needed to be done and I think, rather than thrash ourselves for the failure, it is important to know what our limitations are and work from there. Stress is a BIG issue—they stick us out there, and it’s the last we see of them—I don’t think that happens in THS so much anymore but stress is still a big issue for us to manage. So what can we do?

Dennis  
Develop relationships with people ideally.

Amanda  
That takes time.

Bob  
Is there any substitute for time?

Amanda  
I don’t think so.

I am grateful to Jon Marshall for pointing out that since, without much practice, martial arts will not be of much use in any such situation, the responsibility for coping is once again put back onto the field agent.
Bob: That's right. My feeling is there is no substitute for time. So we should be more relaxed about that, and know that in twelve months time, we'll know a bit more and be a bit more effective.

Jan: I take photos of myself doing things in different situations and of my family and show that to community people and tell stories about them [the photos] and then answer questions so people can see Jan having a life somewhere and what that might be about, you know? People love the photos too and it really helps I think.

Dennis: So we need to recognise what we can and can't achieve.

Jan: In a lot of the places you spend time with people who can be very negative about their jobs but not change themselves. My strategy is to avoid those people and think positively for myself. It is important to do things for yourself too, to look after yourself.

Amanda: I feel uncomfortable about talking about developing relationships with other people in order to get done what I needed to get done. It took time for me to get past my own cynicism about that, the sort of exploitativeness of it.

The self-ministering administrator

Teaching people to occupy themselves with themselves, to become permanently self-administering, tending to their own negativity and learning to verbalise or disclose the efforts involved, Foucault tells us, are essential to the task of subjects actively re-forming themselves in light of the mediations of experts, without much need of force or overt coercion (1982: 208-10, Foucault 1988: 49; cf. Burchell 1993, Foucault 1990). Health professionals confess, Foucault might say, in order to restore their distress into a productive self-discipline; exposing fractures the better to recuperate them. Thus even blaming the Agency (it will not help you, it dumps you out there, it's up to us), the instrumental logic is upheld, recalling the model of prison reform discourse Foucault describes as ultimately and from its very beginnings reinforcing the carceral society, with critiques being ever-assimilated to regenerative ends:

It should be noted that this monotonous critique of the prison always takes one of two directions: either that the prison was insufficiently corrective, ...or that in attempting to be corrective it lost its power as punishment ... The answer to these criticisms was invariably the same: the reintroduction of the invariable principles of penitentiary technique. For a century and a half the prison had always been offered as its own remedy: the reactivation of the penitentiary techniques as the only means of overcoming their perpetual failure; the realization of the corrective project as the only method of overcoming the impossibility of implementing it. (Foucault 1977: 265, 268) 128

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128 Describing the talk of development officials, Robertson likewise draws attention to the repeated laments concerning the failure of peasants to take up 'more efficient' communal agricultural methods: 'Officials everywhere tell tales of people who have manipulated Cooperative rules to their own advantage, by corruption, embezzlement or nepotism. It is they who are blamed for failure, not Cooperative organisation, and in a vicious spiral the antidote is sought in more detailed regulation and more "professional" management' (Robertson 1984: 198-9).
In the reductionist process of dot-pointing, it now appears, there is much being achieved in terms of learning how to do and say bureaucratic things. But what of the people we are wanting to help, the people for whom all this self-directed effort is being harnessed? What else are we specifically told to think and say about them, and just as importantly, what remains unsaid but just as effectively relayed?

**Bearing in mind**

No orientation program in a government agency which has Aboriginal governance as part of its core business could fail to specifically cover ‘working cross culturally’. In THS, the Aboriginal Cultural Awareness Program operates independently of the orientation course. It includes various stages, ranging from a one day ‘taster’ that is compulsory for all employees, through to a supervised four day bush camp in an Aboriginal community for the handful of employees who will be residing in communities. A specially modified program, led by Aboriginal facilitators, is included in the remote area orientation course, not as short as one day but not the full residential course either. Having repeatedly established how fraught community work is, in the second week of public health boot-camp, we now have two days to learn lessons on culture, the truisms about difference and cultural peculiarity which anthropology has made complex and yet prescriptive enough to become rules about self and other.

There are many things we are told we need to ‘just bear in mind.’ In a series of descriptions which seem to take us to surfaces alone, we’ve learnt (with just about exactly this much detail) that country is important; that land is sacred, and there are secret men’s and women’s ceremonies that consume people’s attention to the detriment of other priorities. We’ve learnt that ‘professional loitering’ is an official term used to describe a studied casualness both in bodily movement and concern for time that government health professionals should effect when working in Territory communities. We’re to avoid looking Aboriginal people directly in the eye, but to remove our sunglasses to ensure our own orbs are not obscured from a reciprocal black gaze. Women are to keep their knees covered with long hemlines, and select non-transparent apparel—but never trousers, lest this draws too much attention to sexual parts.

Bear in mind Aboriginal people will say yes just to please you and not to ask direct questions. That it is best not to consult with the people on pay day, as their concern for cash will outstrip any other. That kinship is of overriding importance and incorporates everyone, including health professionals, who may be ‘adopted into the system and given a skin name so that you can be fitted in’ (*fieldnotes*, 26 March 1998), incurring vague and unspecifiable yet ever possible and emergent reciprocal obligations. Bear in mind that Aborigines don’t turn up for health treatments with early symptoms because they have a higher tolerance for pain. That even their babies enact illness differently (cf. Chapter Five). That they will supplement the illness diagnoses of western science (which explain the how), with concepts of spirits and sorcery (which explain the why). And that the Aboriginal understanding of health is that ‘life equals death equals life,’ an anodyne
summary conferring on Aboriginal people the interconnected ontology public health advocates argue is necessary to create a more caring western curative system as well.  

The weightiness of these injunctions cannot be overstated. As descriptions of Aboriginality piled one on top of the other, there were sufficient variations on the common wisdoms for the cross-cultural sessions to assume a deeply thoughtful feel. Take, for example, the following spontaneous workshop discussion, as fellow orientees discussed the semantic implications of the meaning of the Alma Ata Declaration of 1978 (WHO 1978), a seminal document for public healthers:

Trish: ‘When they [W.H.O.] say it [primary health care] is based on ‘practical, scientifically sound practice’ I hope they don’t mean just that—because there are alternative ways of doing things that are valid within the [Aboriginal] culture.’

Rob: ‘For me ‘scientifically sound’ [quotation marks aerially signified with two pairs of fingers bending at the knuckles] means it is observable and shown to work, is believed to work, within a setting, that it has efficacy.’

Trish: ‘Can I comment? I’ve found in working with Aboriginal people that their ability to fit in our views is very good. At Bachelor College, I talk about germ theory and my students talk about being sung. And being sung explains why some people get germs and others do not. So both world views are incorporated.’

Rob: ‘It is critical that we undo the classic definition of science and accommodate different worldviews.’

Dave, a late arrival: ‘We haven’t used the word ‘holistic’ but in Africa, I would deal with malaria with my white medicine but people wanted to know who sent the mosquito. The traditional healers would sort that out and combined, the person got better.’

(THS Orientation Course Fieldnotes, 30 March 1998)

There is no conflict, professionals were told (and retell themselves), between their own, now-deemed-sterile scientific worldview, and the more deeply spiritual and profound Indigenous analysis which explains the ‘why me? why now?’ 129 Forgetting momentarily that ‘we’ do already have available a set of explanations which attributes the ‘why me?’ to the logically prior susceptibility borne of Aboriginal poverty and disease-causing practices (cf. Chapter Three), the attributions and associations overlaid onto self and other have tremendous recombinative

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129 The dot point comes from the National Aboriginal Health Strategy (National Aboriginal Health Strategy Working Party 1989: x), which in turn comes from a larger definition which has been circulated as ‘the broad view of Indigenous health.’ As promulgated by the National Aboriginal Health Strategy Working Party, and expanded by the National Aboriginal Community Controlled Health Organisation, health is not just the physical wellbeing of an individual, but the social, emotional, and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total wellbeing of their community. For a critique of such open-ended attributions from an anthropological perspective, see Maggie Brady’s paper ‘WHO Defines Health: Implications of Differing Definitions on Discourse and Practice in Aboriginal Health’ (Brady 1985).
possibilities. Throughout the orientation session, the associations and distinctions continued apace. A lecturer from Batchelor College, a tertiary training centre for adult Aborigines, concluded her presentation on the workplace training needs of Aboriginal Health Workers (ordinarily graduates from Batchelor) with what she clearly intended as a provocation:

The knowledge and power is deemed to belong to the non-Aboriginal professionals who are meant to teach the others. We should say to A.H.W.'s 'and what do you think? what do you think is happening?' Make your respect obvious—and Aboriginal Health Workers will be more productive, more interested and more involved.

*(Orientation fieldnotes, 30 March 1998)*

A concerned fellow participant queries, having learnt the importance of not directly questioning Aborigines: 'But isn't asking 'what do you think?' a bit confrontational?'

'There are different ways of doing it,' the lecturer reassured.

We can see in these double-bound commands a marker of the antagonism between one's nurturing of a sense of self as liberally decent and of the Other as also human and yet utterly different—but who can be operationalized through techniques of liberal decency. Here the novice, having learnt that the mark of cultural respect is not to ask directly, is extended a correcting admonition: Aborigines don't like to be questioned—but there are ways of doing it anyway. Note again that circumspection in the Aboriginal knowledge economy is not so much appreciated as part of wider and more complex dramaturgy but as a set of expressive codes that are more appearance than substance, that exist as part of an opaque world knowable through a set of abstract rules, codifiable into prescriptions for proper etiquette and strategies for negotiating. 'Not things-in-themselves but things-for-us' as Taussig has put it, (1987: 78). or, as John von Sturmer would say, a complex existential world is reduced to the 'dum-de-dum of the most pedestrian prose—'One hot day in October...’ (1989: 127).

At the same time, while it has perhaps been useful to show how anthropological theorising can become simplified for the purposes of bureaucratic pedagogy and instrumentality, this is in no way to the point. We should remind ourselves that knowing the rules for talking to Aborigines is meant to be instrumental. It is meant to serve as grounding for cracking open cultural opacity in order to talk health and management reason, to create alliances in case management and problem solving. And if these half-way approximations of Aboriginal life worlds fail to deliver what the health bureaucrat is ultimately seeking (a reliable, talkative, authoritative interlocutor), it can be rectified with a new approach. Make your respect obvious, with its (subtextual) promise of future reward. Manipulate by being sincere, while also, critically, maintaining a spirit of deferring helpfulness.

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130 The burden Aboriginal people bear as representatives of western idealism has been raised by a number of commentators, especially in relation to environmentalism and spiritualism. See, for an insightful analysis of the 'spiritualising of Aborigines' which speaks of the west's own alienations, Andrew Lattas' essay 'Primitivism, Nationalism and Individualism' (1992). Marcia Langton describes the additional pressure placed on Aboriginal people by other Aboriginal people to represent themselves in iconic terms in her essay on representations in film and media (Langton 1993).
Encourage a union of understandings to smooth the insertion of an intervention or project. Understand the possible syncretism between their and our otherwise utterly different world views in order to seamlessly graft the two together.  

The more critical feature is rather the context dependent fluidity of the distinctions about self and other within THS. Training and education workshops should certainly be seen as official indoctrination sites. They are, on the one hand, overly other-izing, creating an Ur-Aboriginal who can be safely generalized about. And on the other hand, such sessions also confer a completely practical instruction in cultural sensitivity, aimed at removing the gross transgressions in communication so often witnessed by ethnographers, many of whom have documented the excruciatingly misfired bureaucratic efforts (see, for instance Cowlishaw 1999, von Sturmer 1981, and in this ethnography, Chapters Six and Seven). Even so, they remain but a small part of the trade in truisms and experience which taken together form the knowledge economy of the health bureaucracy. Over and over, beyond these situations of direct inculcation, and with the least prompting, health professionals are able to pull from a rich stock of stories woven out of their own and other’s tales from the field and personal relationships, formulations about who Aboriginal people are and how tricky the work is.

I have been concerned to this point with establishing the formulation of anthropologised facts as one of my own ethnographic facts about the domain at hand, and in the next chapter will show how these rules about the other have far-reaching practical consequences. In what immediately follows, I want to return to my opening interest in how health professionals learn what to say, what not to say and when best to say things—to the fashioning of a bureaucratic self—by paying attention to the particular power exerted by workshop procedures as social forces in and of themselves. Here I want to build upon a linguistic portrait of the co-devised yet compressed patterning inherent within the turn-taking of interlocutory exchanges, to see how workshops exact consensus diagnoses in ways more powerful than indoctrination via the direct pedagogy of a training session could ever hope to effect.

131 The existence of an entire body of managerial publications on this very issue—making friends and influencing people—should be marked at this stage, although the deliberate formation of alliances through techniques of politeness and flattery are only partly to the conscious fore here. Instead, it is the maintenance of a confident outlook and optimism in the power of decency to make a better (more literate, more employable, more healthy) Aboriginal subject that is the project of greater note.

132 Confounding this is the way workshop-hardened bureaucrats will toughen the sentimentality of such homilies as ‘avoid direct questions’ or ‘take time to develop relationships’ by readily dismissing them as ‘motherhood statements,’ signalling through a derisive gendering both a certain intellectual nous and an acknowledgment that these are truths that everyone knows to say but which have a more complex and imperilled relationship to practice. This in turn recalls Zizek’s reformulation of Marx’s classic dictum on the thrall of ideology: from ‘they do not know it, but they are doing it’ to ‘they know very well how things really are, but still they are doing it as if they do not know’ (Zizek 1989: 32).

133 One of my reasons for wanting to pilot us away from dwelling overlong on the image-making embedded within instructions on Aboriginality, analytically fascinating as it may be, is my belief that helping professionals will construct the arduousness of their task (the occupational ordinariness of their extraordinariness) as part of staking a progressive political identity using the projected characteristics of any range of ‘needs’ groups (the elderly, the abused, the homeless, the disabled, etc.) that are to be assisted. It is to these core practices that I want to direct attention.
Manufacturing consensus

I have already noted how within public health a particular stress is placed on maintaining principles of stakeholder involvement and collaborative practices within all aspects of one's work. The obligation to maintain open, committed and participatory forums for analysing issues of all kinds and for many purposes (a text that needs to be prepared, a training program that needs to be developed, the devising of the training program itself, a public consultation to assess the needs of a given target group, so on and so forth) is invariably enacted through a workshop process. This is of no small consequence.

Let us take, for instance, the guidelines available within public health literature for the procedural practices, discursive techniques and interactional strategies best used to help people freely participate in consultative workshops. Here we have explicit how-to instructions for facilitators which are designed to help them solicit uninhibited critique on a topic from people who might otherwise be circumspect (note that it is already assumed the forum is a workshop):

The group leader puts on the wall a large sheet of butcher’s paper and divides it into 4 columns. In the left hand column he/she writes down 5 or 6 items which are aspects about the programme that the group wants to comment on. These should be agreed on before proceeding. ... The next column is headed up ‘positive comments’ or ‘good things’. The third column is headed up ‘negative comments’ or ‘bad things’ and the last column is titled ‘recommendations’ or ‘suggestions’. The reason for this framework comes from the experience that people are more likely to feel comfortable about giving negative feedback if they are given the chance to turn this criticism into a recommendation or something constructive. (Hawe, Degeling, and Hall 1991: 64)

Where these authors claim that honest criticism is liberated by clearing space for useful negativity in the fourth column, I want to argue that the compelling qualities of workshop participation stem from a more complex combination of forces. There is a straight-jacketing to open-endedness, a dictatorship within the consensus achieved out of ‘uninhibited’ workshop talk, that is made tangible in the unbearable pressure of the need for agreement exacted by the polite force of the gathering itself. This force goes beyond what is said to the scene of the relating and back again.

To begin with, there is the micro-power of the columns themselves in providing compelling models for the analytic style, type and look of the in-filling required. Imagine four labelled but empty columns on a whiteboard (or even the simpler two we’d faced in the orientation session). In the confines of the workshop, the seemingly neutral medium of the whiteboard transforms into an aesthetic object which ‘incessantly exercises a demand on the one who performs or observes it; [and] through this demand, it reveals a desire-to-be that somehow warrants its being’ (Dufrenne, 1987: 6). Empty columns not only beckon participation, they in fact demand and compel a (prefabricated, ordinary) response. The first notation sets the scene for every other, its style suggests the pattern to be followed. Then, joining the compulsion created by the accusatory emptiness of the columns which silently exhort inscription, there is the heaviness
of the facilitator's pauses within heavily time-monitored sessions to obtain a covenant before further movement to the next point can be made.

This kind of stylistic compulsion rendered by collective analysis is also described by American anthropologist Helen Schwartzman (1989, 1994), who argues that the necessity to build on what others say by referring to already established points and exchanging in like manner within group discussions is what makes meetings, like those of the Pintubi ‘polity’ described by Myers, ‘collaborations for the production of congeniality’ (Myers 1986b: 439). The person who wants to disrupt the whiteboarding process (by, say, refusing to fill in a column, or suggesting responses which are clearly at odds with the style of other suggestions) will either sense her solitude and be subdued, or will find her disruption only momentarily stalls proceedings. Dissent is quickly and subtly colonised.

And so we abide, we ‘conform’ one might say, to the point of resenting interruptions. During an orientation workshop session probing the issues surrounding the affordability and universality of primary health care, for instance, a participant scorned the rose-tinted listing of the desirable characteristics of good primary health care services that had appeared on an overhead.

'Where is primary health care being done properly in the NT?' he angrily demanded. 'I don't think I've seen all those things you've listed here anywhere! Where is it? This is a bloody joke!' (Orientation fieldnotes, 30 March 1998).

His outburst had an immediate, visceral impact on the group. Where previously participants had been open-faced and full of suggestions, now everyone looked disconsolate. As one, we dropped our eyes and stopped calling out whiteboard responses. In the uncomfortable silence that followed, one participant began gently strumming her fingers on the table while others started to fidget. As if sensing that the exercise had petered out, the facilitator then switched tack by illuminating a new overhead, saying as she swiftly moved that we needed 'something more practical to cheer us up.' With the silence thus recovered, we participated once more, happy to have group amiability and forward momentum restored, a transition catalysed by our absolute desire to proceed to a more satisfactory finish, to do what it takes to complete the exercise and to waste no more time.

Even 'angry' professional confrontations can have a sanitised, pre-choreographed feel to them. Indeed, at public health events which feature Aboriginal health employees, along with ritual acknowledgements thanking traditional owners for their permission to hold this session on their country (were they asked? can they say no? do they care?), it is almost obligatory for an indigenous advocate to berate participants about the disgraceful lack of Aboriginal representation, whether it be in terms of the lack of Aborigines at the gathering itself, or, as a more general point, the dominating number of professional positions that are occupied by whites and paid for with 'black dollars' (see Chapter Eight). It is just as expected—it is ordinary and is thus an equally constitutive
element of the process—for the audience to temporarily fold in on themselves, momentarily cowed so as to display their assent to the verdict, with the drubbing and the contrition both in turn verifying the all-round sense that the burden being carried is indeed a thankless one.

**Self-sustaining**

But consent does not always bounce off dissent. Let me make another (non-orientation) case in point, one in which bureaucratic conceptualisations have become both easy to think and easy to say by experienced institutional actors. In the year 2000, two highly paid consultants from South Australia were commissioned to review the effectiveness of those Aboriginal hearing services that are jointly funded through the education and health departments. Several pre-contextualising points can be noted here. Having talked to carefully chosen representatives in community schools and clinics, the evaluators are now ‘consulting’ with senior health and education program managers about their preliminary findings. Being close to finalising their report they have arranged a workshop to present their draft recommendations to the senior managers for interim endorsement and fine-tuning.

From the consultants’ point of view, they have already negotiated meanings with factionally divided policy officers, service providers and researchers from government and non-government organisations throughout the Territory. The report’s draft wording thus already contains many trade-offs and amendments. In contrast, the managers in the room, who are familiar with the fractured history of hearing services, and were sufficiently convinced about the importance of it as an issue to support an external evaluation, are now expecting the consultants to tell them how to fix a service delivery field well-known for its internecine battles. They regard this as constituting the singular purpose for the evaluation and the main reason ‘outsiders’ were commissioned to do it in the first instance.

It is a bitter disappointment for many then, when, previewing their investigation of the coordination problems, the consultants proudly inform the assembled managers, with all the confidence of a profound revelation:

> There is a lack of coordination of visits to remote communities in many situations—most people don’t know who else is involved, what services are available and who to contact.

*(Fieldnotes, September 2000)*

In fact, they’d already pre-formatted the diagnosis of ‘lack of coordination’ as a caption point for the draft executive summary, photocopied for group analysis and included amongst the workshop papers. Yet, while the managers muttered to each other across tables about paying a high consultancy price for such an unnecessary restatement of the problems, continuing their acerbic criticisms of the consultants’ patronising and money-wasting platitudes in tea breaks and post-workshop debriefs, the workshop itself was characterised by the language of policy, with high-minded statements of goodwill and marked displays of professional consensus.
Is this a cut and dried case of complicity? Or is it also the confluence of institutional structure and phenomenal effect in a neat little nutshell? In the ever-widening spheres of self and other awareness within THS, I am arguing, the categories and procedures for doing bureaucratic things are in part learnt by pressures internal to the gathering itself, which also contains within it infinite opportunities for instructing allcomers in the operant conceptual schemas of their particular setting.

As part of their final report, the consultants want to present an action plan and a vision statement because, they say, they are not going to have their report join others gathering dust on the shelves. No, this is going to be action-oriented: 'Ear disease is the single-most preventable health issue affecting the poor learning of Aboriginal kids in school, so we want to make this report count.'

With one consultant poised by a whiteboard, the group as a whole are asked 'what are some of the words that would need to go in the vision statement?' 'It is a difficult problem, we have,' they go on to stress, 'for there is a tendency to think 'it's all too hard.' So let's focus on the opportunities because there are things that can be done. And remember, nobody can do it by themselves, we really need to act together.' And in so saying, their remarks are not only designed to elicit remedies but establish as precondition for participation the morally-binding need to be collaborative.

'I guess I would like the word 'innovative' in there' someone suggests, breaking the ice and setting the scene. Our hardworking banalities trip off our tongues.

Flexible.
Community control.
Successful.
Acceptable to all the stakeholders.
Equity.
Practical—with reality checks built in.
Collaborative—because if we don't know where everyone is coming from, we won't work together.
Partnerships.
Can we have culturally aware? What about culturally appropriate? Respect? Does 'inclusivity' cover that?
Resources?—it needs to be adequately resourced. It comes into equity.
I think it is really important that we have 'clearly defined roles and responsibilities.'
I think another good one is 'awareness of remote communities.'
The services shouldn't be one-off—'sustainable.'
What about 'multi-disciplinary'?
Going back to 'culturally aware,' a new word I heard the other day was competence—'cultural competence.' It really brings in the need for effect.
Embedded within these doctrinal formulations are depths of encounter where we’ve learnt, time after time, to project correctly, to articulate in bulleted mode using the right kinds of worthwhile associations (Aborigines > Partnerships > Cultural awareness/appropriateness/competence). We contribute as experienced professionals, not as novices in an orientation session needing to give elaborate spiels that require further condensation by the facilitator, but as old-hands at the abstractions required.

Yet in the same moment that our adeptness in the summary modes of diagnosing problems of Aboriginal service provision is revealed, our highly fettered language is one which refuses certain analyses. Circular and self-justifying, the alternatives to further institutional exposure for Aboriginal people are effectively narrowed down. While systematic doubt about what we are doing is mandatory, a radical questioning of our entitlement to do anything, to be there in the first place, or of the radical inability of interventionist explanation to undo its existential, conditioning externality (see Chapter Seven), is not sustainable. Such unthought concepts hang suspended in a wordless vacuum: they are inexplicable in terms of interventionist apperception. Improvement and greater stakeholder inclusion are always possible, as outsider critiques of our gaps and shortcomings also seem at such pains to remind us. Coordinated hearing services are necessary because the children suffer disproportionate hearing problems, which negatively affects their schooling outcomes. Education is a taken for granted good because it gives Aboriginal people a greater range of choice, employability and responsibility. Lack of coordination cries out for its institutional counterpart in more coordination. More coordination requires meetings, workshops, information sharing. Information sharing must have as its preceding action a diagnostic consensus about what needs to be shared, a consensus forged out a coordination process such as this, with masters of bureaucratic recital giving their inputs through consultation. And information sharing needs its corollary—a translation of professional intents into culturally appropriate/aware/competent formats (see also following chapter).

It is a dutiful offering up of expected metonymic entailments in the free-fall guise of spontaneous suggestion. Participants will walk out, blaming consultants for what they recognise to be stale diagnoses, when all the time the consultants are simply playing a part in a series of institutional iterations which serve to reproduce a shared and greater whole. How good the consultants may or may not have been is irrelevant: these participants have already learnt the key words and phrases which, as Tyler and Tyler note of professional training sessions in family therapy, function as ‘mnemonic indices to both theory and practice’ (Tyler and Tyler 1986: 240). Their ‘holophrastic utterances’ (ibid.) assign meanings as they loosen tongues, they declare a consensus desire not just to act but to act responsibly and earnestly, without truly questioning our right to act or the accuracy of these listings of actions in relation to effect on the ground, let alone the fetishistic attribution of agency to such images of action as the report and its vision statements, all without anyone personally taking responsibility for any of the ‘outcomes’
Further, because the form of the workshop itself, like meetings, requires such attentive work from co-participants, it becomes action itself, as both Annelise Riles and Helen Schwartzman have separately noted (Riles 2000: 143-5, 171-4, Schwartzman 1989). The 'action plan' the consultants will create out of their workshop consultations for the evaluation of Aboriginal hearing services, complete with its carefully worded vision statement, will not operate simply as an interim tool for the better coordination of health sector effort but rather, because it ordinates the heavy work of coordinating and collaborating in its very formulation, it will feel like a large chunk of the work is already done. In other words, the work of formulating the work that still needs to be done is itself an endpoint—and therein lies its powerful appeal as a repetitive form of analytical and declarative work, despite peoples' irritation with the ritual process. As Riles points out, the challenge for anthropologists is to understand the effectiveness of participating to the sense of having created 'external' action; or, to use her words, 'the effectiveness of the form in generating the effect of effectiveness' (Riles 2000: 172).

It is in these moments that bureaucratic naming simplifies and does complex things, homogenises and sets complex processes in train. Talking about the actions one should take to better assist target groups becomes synonymous with already doing things on behalf of and for, which, when combined with the corporeal effect of doing workshops on participants themselves (invariably exhausting, intense exercises in co-monitored articulations), feels like such hard work, it becomes the work that has to be done. Hence, perhaps, its multitudinous recurrence as a form of group activity within and between all THS locations and as a medium for collective gatherings between THS players and their many others (institutional actors and/or target groups).

And as with talk of sex, the master concepts of Aboriginal health discourse are replete with evasions (Foucault 1990: 53). Another whiteboard session (this one from the orientation course but it could be anywhere, anytime) asks us to collectively analyse and discuss the following (capitals in original):

1. How do other health care professionals SUPPORT the role of the AHW\textsuperscript{134}?
2. When can these professional roles HINDER the role of the AHW?
3. What can be done to IMPROVE the collaboration with AHWs?

It is a typical narrative structure that, in beginning with quasi-enigmas (questions that suggest answers, prolix or dot-pointed, are both known and knowable), reinforces both the allure of disclosure, and the promise—delayed momentarily by the pause in question (2) dedicated to admissions of possible inadequacy—of resolution. That is, the questions themselves are already answers. They do not allow, say, a condition of permanent ignorance, endless unanswerability, or even closure, finally, no reason to act, for do so would forfeit the purpose. It is confidently assumed that inadequacies pre-exist the query, that we already know how to formulate what to do about
them, that our knowledge needs careful re-assembly for practice to be influenced through acts of re-educated good will, and that talking about it is the means for fixing our knowledge into a collective self-consciousness that itself breeds good/better effect to meet ever-burgeoning depths of client need and system inadequacy. And clearly, talking about things certainly does have effects.

It is through talking that specially chosen words and their ability to effect things are imputed their magical ability to 'make a difference on the ground.' It is through talk work that professionals create shared grammars of complaint and diagnosis in parades of collective analysis amidst continual coaching in techniques of recuperating failure into the need to do more of the same.

This draws us closer to our destination, but before then, let me insert another workshop session, involving orientation participants now fluent in the cooperative dialogue of role plays and whiteboard discussions.

**One last thing to learn**

In the final days of our two week orientation, we are getting into the nuts and bolts of working with Aborigines in remote areas, no longer as a series of injunctions about the nature of Aboriginal culture but more (and hereafter in every form of workplace encounter where entitlement anecdotes are swapped by experienced players) by way of parables, which, as Tyler and Tyler note, effect the magic of getting people to infer for themselves the general point, 'to see the rule being invoked even though it is never explicitly stated in any of the examples...creating a sense of how to go on without being able to say how to go on' (1986: 247).

The venue is now very different. We are in the restaurant area of the Chengis Khan, a seedy hotel on one of the main drives into the Darwin CBD. The dining tables had been stacked to one side of the room. Lingering traces of old cigarette smoke course through the tired air-conditioning system and the dusty remains of plastic Christmas decorations are still in sad evidence, here at the onset of April. Several of the non-Darwin based staff who are in town for the orientation course have been staying in the hotel, perhaps explaining its choice as venue—although the group is now smaller, an attrition Bob Spicer says he naturally expects at the end of every course. A nurse, Cheryl Bailey, introduced to us as a woman of lengthy experience 'out bush,' has come to talk about the new clinical practice guidelines, a presentation for which she gives pre-prepared overheads and handouts. Embellishing her description of the intense consultative work involved in preparing the new guidelines, establishing proof of their validity as good advice, Cheryl also inserts as anecdotal asides, instructive recollections of her experiences as a neophyte nurse:

> We're nurses, and we're new, and we're working in a cross cultural environment, confronting your own ethnocentricities and you learn about the community's structure in an emergency situation—not the best way, but sometimes the only way.

*(Orientation fieldnotes, 3 April 1998)*
Cheryl’s own emergency epiphany, she now relates, came when she was trying to lift a patient onto an ambulance trolley to be evacuated out by air. Unable to, she asked the on-duty Aboriginal Health Worker, a hefty male who was standing nearby, for some assistance—but was ignored. She repeated the request. He remained silent. Repeating it again, he left the room altogether, leaving her thinking ‘Great! Now what?’ Within a few minutes another person thankfully turned up and assisted. Later, at the airstrip, patient safely on the plane, the refusing Health Worker reappeared to explain that the inert patient in need of moving had been his brother, whom he could not touch. Cheryl remarked ‘I had no idea! But I learned a very important message that day. There’s a reason for everything. You just might not know it at the time. Remember that.’

There are double enigmas here—kinship connections that are barely comprehended yet understood as powerfully inhibiting customary practices—reminding us again, if we needed reminding, of the mysterious inexplicability of Aboriginal people lurking beyond the dot-pointed summaries of their culture; an instance of what Merleau-Ponty described as the tendency to congeal insurmountable difference into our (non) understanding of ‘elementary societies’ (Merleau-Ponty 1964: 115). In the encapsulated and yet endlessly provisional knowledge forms of THS, there is a reason for everything, even that which lies beyond our immediate reason.

And in the vexing relation between what is said and what is not, public health professionals are also taught to decipher their perceptions of Aboriginal disorder in relation to what is forbidden to think. As for that, the violence we are briefly trained to defend ourselves from, together with ill-health, homicide and suicide rates, alcoholism, vandalism and other category forms of destructive behaviour, are explained diagnostically as to do with various forms of deprivation experience, denuding it of any intrinsic performative or causal character (cf. Feldman 1991: 19-21, Pearson 2001). As Gary Robinson notes of such absolving standpoints in Australian anthropological analyses, ‘in these logics, Aboriginal actions cease to be actions by Aborigines and are treated as effects of external ‘non-Aboriginal’ causes’ (Robinson 1997: 123). To which I would add, with now customary insistence, that what appears in the form of social scientific critique (of the external forces which explain aberrance), parallels the analysis performed within policy and welfare practice in the spirit of reform as social issues are combed for points of strategic intervention.

Violence, Feldman argues, is frequently treated as a surface effect of a deeper and exterior origin—an origin which in governmental analytics invites a welfare intervention. In the ever-fanned optimism of public health, resistant or eruptive behaviours are squeezed into forms of curable (or at least, administerable) pathology, again reiterated through the co-mingling of direct instruction, anecdotal interplay, institutional and more generally still, liberal-humanist ways of building sense that public health actors are immersed within, subjectively and objectively.

It is of no small consequence that the timing of the lessons on self-defence comes at the very end of two week’s worth of immersion in eulogising summaries of Aboriginal cultural traditions and techniques for taming uncertainty with the uplifting prose of supportive networking and
community development. Practicing karate had not been listed on our orientation agenda. My bulging kit has nothing to indicate we are going to learn what to do if (a black) someone were to come at us with a knife and threaten to rape, maim or rob. Or rather, it was listed, in bureaucratised terms of inoffence, with words meant to mean more than what they say in the midst of their literal innocuousness. I refer in particular to point III:

<table>
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<tr>
<th>OCCUPATIONAL HEALTH &amp; SAFETY FOR REMOTE AREA HEALTH PROVIDERS</th>
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<tbody>
<tr>
<td>PRIMARY AIM OF ORIENTATION</td>
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<tr>
<td>To provide new staff to remote area health with an introduction to relevant occupational health and safety issues, protocols, strategies, and training opportunities.</td>
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<td></td>
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<tr>
<td>KEY OBJECTIVES</td>
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<td>To achieve the core aim the following objectives will form the basis of the session:-</td>
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<tr>
<td>I. Ensure awareness of occupational health &amp; safety issues within remote communities and mechanisms by which to address them</td>
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<td>II. Ensure awareness of the THS Policy and Code of Practice on Safety in Remote Areas and understand its contents</td>
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<td>III. Introduce participants to the topics of critical incident stress, the general management of stress, and the management of aggression in the remote area workplace</td>
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<tr>
<td>IV. Provide participants with strategies and protocols for the occupational and health topics outlined above.</td>
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'How do people get to feel threatened in their work,' we are asked, safely back in workshop mode after the physicality of practicing sharp arm and kicking motions to block imaginary assaults:

'Well, the use of weapons makes it pretty clear—spears and guns'

'Equipment left outside the clinic will be broken or left on the doorstep'

'Old staff will refuse to recognise that you are there, there's no validation for new staff—it's a system of bastardisation'

'Threats to disemploy you—like 'you'll be out of a job, you white cunt', or 'you're here to do what we say', 'we won't let your partner stay,' things like that.'
Out of such abbreviated selections of the startling, which demarcates the initiated from those who have yet to encounter, emerges a cryptic whiteboard list of threats ripe for workshop transformation into pseudo-strategies (which, having no authority as official policy formulations, can only be seen as simulator exercises in diagnosis and suggested repair). An abbreviated portrait of the brutality of Aboriginal community life is first inserted into our imaginings of Aboriginal alterity and then returned as pragmatic accounts amenable to community development action:

spears
guns
threats
punch
fuel (fire bomb)
non-verbal
passive aggression
loud verbals
sexual aggression—from rape to annoying remarks
accidental aggression—‘posturing without intent’

‘What are we going to do about it? Let’s look at why first. What are some of the reasons for aggression?’ (and note how quickly we have learnt to abbreviate the symptom analysis for the purposes of whiteboarding).

‘They drink’
On the board: alcohol and other drugs

‘Tolerance—they have low trust levels’
On the board: low trust

‘The fact that they don’t like the work that you do’
type of work

‘Forms of mental illness can be manifest as aggression’
mental illness

‘low self-esteem’
low self-esteem

‘domestic unhappiness or violence’
domestic problems

‘people who are chronically or acutely stressed’
low self esteem

‘people who aren’t well, who are in pain’
ill-health
'You’re white; you’re the wrong culture'

wrong culture

'Cultural misunderstandings—things that are perceived as rudenesses'
cultural misunderstandings

And cutely, from me, 'Different perceptions about what violence and its need for suppression might mean—not everyone thinks it is something to be feared or avoided,' drawing a redirecting affirmation from a co-participant, a mental health worker.

'Yes, it becomes a vicious cycle doesn't it? Violence becomes an accepted and expected part of the culture.'

On the board: vicious cycle

'How can we break it?'

I later tried to imagine what kind of response would have been given if someone had confessed to experiences of terror, fear and isolation in suburban Darwin. Would the Department promise to evacuate staff then? But I already know the answer, not just because the policy applies to remote area personnel alone, with its default exclusion of the suburbs. The picture of the lone clinic and the embattled health professional in the harsh outback is conceptually reliant on its counterpoint image of franchise-designed brick houses, where security screens, police patrols, professionally landscaped gardens and neatly subdivided suburbs with newly guttered bitumen roads, give the promise of well-ordered sanctity. Violence needs to be considered as exceptional and out there, not an equally routine element of suburban and institutionalised life. It must be presented as that which happens, unscheduled and uninvited, in an-other place, on the periphery and in situations of marginality.

There are many things we are not saying here, when finally we are discussing an issue which seems by its very nature (violence, eruptive physical threat, suspicion and fear) to suspend the need for coded talk. But no, even now, participants carefully formulate sermonising caption points from the span of the allowed and the not said. Terror has to have both a home and a cause—and not just any old causal analysis will do. It must be treatable and even preventable—given the right collaborative diagnosis and sensitive approach. By extension, but left unsaid, we might ignite the black man’s anger and have his knife against our throats, if the right protocols are not observed and the true underlying causes not properly understood and acted upon, for what is known of the other can quickly revert into a thin surface obscuring a mysterious and unpredictable, even repugnant, depth (Taussig 1999: 5).135

135 Needless to say, violence against nurses happens, and with increasing frequency. If local media reports and staff complaints are any indication. It is the ways we are being taught to frame both an expectation of violence and transform violence into blameless acts by pitiable victims who are thus, by analytical fiat, in even greater need of our sympathy and help that I am highlighting here. But for a more functional accounts of violence and remote area nursing, see Fisher et al. (1995).
Conclusion: dot point vicious cycle

I feel we have gone full circle in the closed loops of our own vicious cycle, from the codes for expanding contact with Aboriginal people through being sensitively engaged, through to techniques in warding off yet assimilating violence to our soft welfare logics. Neither are more right or wrong than each other but are two extremes of the same continuum that ultimately preserves the separateness of the domain of otherness to be operated on, even as we are urged to merge in the name of better cross-cultural practice, keeping our own normative practices safe from harsh scrutiny as we learn to self-reflect. But of course it is not a closed loop, but is fed by many insistences. The models of behaviour and intelligibility advocated by ‘the new public health’ in its guise as a discrete and progressive discipline of academic knowledge for one (see Lupton 1995). The manifold interpretive devices of a post-colonial enlightenment culture for another (Cowlishaw 1998).

Despite this heterogeneity of forebears, I’ve risked belabouring the localised vignettes and risked being guilty of over-dependence on the spoken and the anecdotal when my avowed interest is on the ineffable bits that language leaves in the shadows (cf. Stewart 1996: 69-72). Yet in THS, it remains the case that anecdotes and classifications are the stuff of everyday transaction and pedagogical recirculation and that these are forged out of what can and can not be said. It is the case that acquiring the (ineffable) public health practices of concealment, revelation and self-editing, even the pre-formatting of encounters yet to be had, can be located in the seemingly unmediated interchanges of professional reflexivity. Swapping tales, authoritatively from an instructor’s virtual pulpit in front of a whiteboard, or as the collegial constructions of a coordination meeting, in the enforced democracy of a butcher’s paper or whiteboard exercise, in de-briefing gossip, purposively or unintentionally according to context, re-produces the tacit knowledge one must acquire to have an eye for the look of a thing, an ear for its sound.

These are self-feeding knowledge practices which consume their own representations, becoming the copies without originals Baudrillard saw as more real than the real (Baudrillard 1988). Public health professionals and bureaucrats more generally would call it building on what others have learned. So where I would acknowledge the danger of representing the immersion processes of public health as all a matter of closed loop exchanges within workplace gatherings, I would also stress the ubiquity of such gatherings and their centrality to the refining of a storied health professional who is knowledgeable in the key terms and meaning-rich categories that are interactively (re)made available for (re)ordering public health experiences and learning how not to founder, in the field or in the workshop. In turn, the techniques of the workshop create a storied self who can descend into the projected abjection of Aboriginal communities and return, aided by the elegant manners (Aboriginal people are this, so treat them like that then restore yourself like this) imbibed in the trade in truisms and displays of entitlement or ‘being there’ experiences. The continual sharing of experiences within public health (and wider bureaucratic) practice is thus not just an airing of anxiety in order to be purged, but is also an exercise in returning self- and
system-criticism to its proper administrative place, whilst learning and transacting in the signal terms with which to declare sovereign competence over cross-cultural mystery, itself a source of inter-subjective rivalry in the endless replay of contests for credibility. Public health workshops work to assemble diverse and at times warring health professionals together within a rigidly democratic cauldron which politely and solicitously fuses small antagonisms into the form of a coalition. More, these constitutive modes of interaction become models of the methods to be used when participants in turn consult with their others, especially in communities, with our/their ‘potential, expected, elicited, elastic group response(s)’ (Robinson 1995: 326), remaining ever bound to the broad-minded constraints of the form.

In following pages, we will see how the generation of scandal through statistics operates, like workshop-induced reflexivity, to reinvest our existing repertoire of practices and ways of diagnosing with new urgency. And how the objectifying practices of abstraction and enumeration within epidemiology once again suggest that Aboriginal people are coextensive with ourselves and yet remain ever revertable into points of knowable difference and unknowable opacity (there’s a reason for everything, you just mightn’t know it). Ironically, our brief lesson on martial arts will turn out to be a curious reversal of a more general phenomena whereby Aboriginal people are desensualised by the statistics which prove them to be desolate and downtrodden. Where usually the anonymously unwell Aboriginal body is denied any sentience through the flattened framing of morbidity, mortality and socio-economic data, the lesson here is that they are also easily re-animated as violent beings.

More than anything else the orientation has confirmed the negotiation of cultural difference is fraught indeed. A total schema for apprehending the frightening space between us and them has been signed, sealed and delivered, with its rules for respectful dialogue and lessons in self-defence. Further, as Xavier’s early lesson in humiliation clearly revealed, when professionals carry over their codified cross-cultural education into workplaces and direct encounters, the permanent threat of not getting one’s demonstrations right in front of one’s own peers, and the equally permanent need to be seen as liked by Aborigines, forms a relentless performance pressure which sees people scrutinising each other’s statements for transgressions (and folkloric tidbits). Professional gatherings of all kinds affirm the self-consciousness which people carry within themselves into encounters with Aboriginal people, armed with iconic abstractions to help them through. Being acutely sensitised at all times to possible error, professionals must hedge toward banality—not just in their wording, but, as I will go on to show, in their self-representation—as a direct result of their absorption of, their incorporation of, the corporation.
Chapter Five

Manufacturing

Between the Pen and the Paperwork
Chapter Five

Manufacturing

There is something irrational here at the bottom of the inevitable

Gabriel Tarde (1962: x)

There is something irrational here at the bottom of the inevitable. Tarde declared, voicing his wonder at the contingency of forms of existence, the ‘worlds of life and matter, as well as of that in society’ in which ‘the actual seems to be a mere fragment of the potential’ (ibid.), where the chance unfoldings of history represent only a sliver of all the possibilities that might have been.

Writing in the 1890s, Tarde had set himself a magnificent task: explaining the nature of social transmission itself. How does social knowledge travel, he pondered, so that people in one place pick up and relay the debates, wants and ideas started in another, reducing our sense of historical contingency in the process? In the age before the saturation effect of global telecommunications were able to muscle in on the space of answer, it was an interesting query. And in formulating his response, Tarde set himself another task: to emulate within the humanities what scholars had achieved in the natural science—announcements of the fundamental and universal laws governing the transmission of knowledge, a physics of information transfer.

His answer, how do ideas travel, was in essence simple, and in fact repeated by anthropologists in other guises. Tarde called it the ‘Laws of Imitation’ and argued that ‘inventions’ (any kind of innovation or perceived improvement, however slight) tend to propagate themselves through self-spreading contagions of imitation. As the novel things (e.g. explanations, mechanisms, techniques, words, language) travel, or rather, areimitated, they will hit and miss different reception sites, initially felt to be private and isolated: a person hungry for just such an idea over here, another resistant to it over there, with both reception and resistance operating as assimilations of a co-dependent kind. Reformulated by the independent subjectivities of the ‘copiers’ or adaptees, perhaps even rearranged beyond recognition, the novel origins of the adopted item may well be forgotten or not even noticed at the time of its incorporation. Indeed, should a massive enough uptake eventually take place, in sufficient numbers to become a social trend, Tarde argued the introduced item would become ‘so fully acclimatised ... as to become part and parcel of ... primitive customs’ (Tarde 1962: 297).

Given sufficient numbers, the general patterns to such local or subjective transmutations of incorporated material can also be discerned. Tarde argues these are identifiable as specific laws of refraction (traced, say, by linguists in showing the consistent and characteristic patterns

of language transformation whenever Latin falls under Spanish or Gaelic influences, for instance (ibid: 22)). Being disciplinary specific, the technical vocabularies applied to the specific genealogies of imitations makes it harder to see the general adaptation patterns that are being repeatedly reproduced. Yet every social thing, like every biological thing, he conjectured, has its ultimate origin in a single source from somewhere, perhaps even an invention from a long forgotten time ago, whose biographies could, he hypothesised, be followed in accordance with the disciplinary interests of established categories of knowledge.

In its own way a detailed railing against the investment of social critics in event histories, 'the vapid individualism which consists in explaining social changes as the caprices of great men' (2), under Tarde's laws of imitation, the novel could be voluntarily or coercively copied by others, alone or as a faddish sweep of change, its uptake a source of feverish agitation and violence competing against the resilience of previous uptakes or a strengthening proof of a tentative and privately held supposition, there to be overswept by other novelties or cemented into the customary. All inventions tend to 'propagate themselves through imitation in a geometrical progression, like waves of light and sound, or like animal or vegetal species' (22).

I begin with Tarde's concern to trace a physics of social transfer because it mirrors a concern I have in this chapter to trace the social activity of Aboriginal health statistics as they are authored, received and transmitted. Like Tarde, I will adopt from physics parallels I have observed between the forces health professionals ascribe to their knowledge forms, and their felt, visceral impact, in order to focus on how health facts are thought to act. I wish to consider an often overlooked aspect of the nature of statistical knowledge in relation to the stories that are scripted to explain Aboriginal ill-health: not how or who it objectifies, but rather, how facts are incorporated into the lives of the health professionals, who in turn attempt a reproduction of their understandings into the subjects who are the objects of the epidemiological horrors.

I am also concerned with the net effect that bureaucratic struggles with fact absorption and transmission has on the administrators and practitioners at the centre of the agonising, and it is here that, like Tarde, I move to a more generalised style of argument as I search for ways of capturing the high momentum stasis that creates the lived imperatives of this domain. But unlike Tarde, who was concerned with novelty and invention, my concern lies more with the absorption of 'new' knowledge forms. What effect does it have on participants, this chapter asks, when participants repeatedly hear, to the point of being able to easily recite the 'facts', the transformation of disability, suffering and dying into morbidity and mortality rates, and more, are expected to absorb these indicia as performance indicators of their own success and failure as committed citizens?

Borrowing metaphors from Brownian molecular motion theory, which describes the unceasing motion of something (say, a particle in water) that is being acted upon randomly by many difference forces, or rather, by forces which may hit from unpredictable directions but which
operate according to a calculable set of rules, I trace the iteration of Aboriginal health facts as they are heated and cooled (made scandalous or described in mundane exchanges), and the arbitrary yet patterned trajectories they then make as they jiggle between researchers, bureaucrats, public health professionals, Aboriginal communities and back again.

Before I move to make these admittedly abstract remarks more concrete, it needs noting at the outset that switching focus away from the people who carry the burden of disease and to the people who specify the dimensionality of the diseases classed as carried by others—the very function of this ethnography—is especially difficult to maintain here in the face of urgent bureaucratic and public health imperatives to respond to the crisis of Aboriginal ill-health, and to respond to it with great care and sensitivity.

The projections of overwhelming levels of disease emit a conceptual (moral, emotional and ideational) force which goes beyond that normally ascribed within critical theory to the subject effects of enumeration—such as, for instance, the biopolitics traced by Foucault. For when we encounter facts about Aboriginal ill-health, attention is automatically diverted to the absences of Aboriginal people, to what they don’t have and still need in order to be healthy. This is the conceptual power, the magical, magnetic pull, of the interpretive grid of public health. The repeat representation of disease and malfunction—with all disorders registered in higher proportions than the comparison non-Aboriginal population—fills the caring person with outrage that this could still be the case in a first world country. Accompanying this anger, one’s concentration is also caught by the representational practices of public health activists who aim to wield statistical knowledge in the direction of improvement, much like ‘the great Victorian social reformers’ whose ‘great fight for sanitation, backed by statistical enquiries, was the most important single amelioration of the epoch’ (Hacking 1991: 183-4, see also Porter 1999). That is to say, health professionals and concerned members of the public alike understandably enough respond to the facts that are assembled about Aboriginal ill-health, to the things that are made statistically visible, with a desire to use this information, ‘to act on it’, to create change. This is something every one agrees on, a compassionate and humanitarian response to serial evidence of poverty, sickness and despair. As liberal sympathisers we cannot help but view the taxonomies of racial inequality with deep consternation and heartfelt dismay and, as academic critics, by further looking to the problems posed by statistical classifications and other sets of representation in ordering how we conceptualise such issues in the first instance.

Being much closer to both the source of the statistical representations and the Aboriginal people who are the beset upon subjects of ill-health, this bureau-professionals take their consternation to the next level, into the realm of interventions and information sharing. And in their examinations of what actions they might make to bring the widely-desired changes about, ‘to turn things around’ as policy texts would have it, professionals join critics in pondering the cultural embeddedness of statistical formulations. Schooled as they are in post-modern critiques of the elitism of scientific knowledges, health professionals are conscious of the specialist nature of the algorithms which
feed epidemiological understandings, and of the historical specificity of such forms of knowledge, and wonder how they can take such complex, culturally-achieved, information to Aboriginal communities and have it make any sense, let alone get it to transcend its embedded knowledge-power differentials.

So far so good. Yet one of the problems I confront in this chapter is precisely why it is that health professionals' reflections about their problems of statistical translation and representation, including their critical reflections on the social facticity of facts and the cultural constructedness of their knowledge artefacts, exert such a stranglehold on their/our attention. My concern, like Tardé's, is essentially with issues of transmission and uptake. As in Chapter Four, I want to look at the ways in which professionals learn about the dimensions of the problems they have to solve and with what theories about self and other they order their task. But what seems so simple to say is much more difficult to execute. For what I encounter here is an exemplary instance of a problem I have periodically identified throughout this ethnography; that is, a moment where what health professionals have to say about their own activities anticipates the theoretical concerns of the social scientist in exquisite and blinding ways.

As I will show, health professionals do not conceptualise their tasks in a vacuum. They have complex and well-informed explanations at the ready for how they have arrived at their own forms of expertise and for how the industrialised world achieves its superior health status, and they have an equally complex sense of the politicised histories of both. Their explanations of such matters are sophisticated and learned. The explanations I've heard about the problems of science, of epidemiology and health expertise, show particular adeptness in social-scientifically informed pre-analysis and critique of these domains and how they are to be problematised. As Hervé Varenne notes in his discussion of why it is difficult to do ethnography of the professional middle class in the United States,

> there are everywhere signs that point us to a pre-analysis of America and how it should be qualified. People with rhetorical fluency are particularly adept at the production of texts, written or dramatically performed, that have so much the form that interpretative texts take that it can be very difficult to do the anthropological double take ... In fact, traditional ethnography, that is, ethnography that relies heavily on asking questions of informants, may be impossible to conduct in America, since the informants are so good at moving the attention of the interviewer away from the original ever toward 'the interpretation.'

(Varenne 1987: 370, emphasis added)

Paradoxically, the explanations which show such command of the scholarly critiques of scientific knowledge also work to distract ethnographic attention from how, in the everyday where theory merges with action, professionals in fact interactively absorb and then attempt to transmit health facts. So while I might insist on making the chief focus of my attention the native (bureaucratic and expert) theories of the role and participation of scientised knowledge into formulations of selfhood that are invoked by health professionals when they call attention to the best ways to
transmit their hard-won knowledge, one of the effects of native knowledge practices is that it sweeps all participants, including the ethnographer, into a focus on the effects and effectiveness of their translation attempts. By focusing on what health professionals are focusing on, we too are seduced by the imperative of their anxious efforts to educate or amend, and thus have our attention turned to the representative function of the textual and pictorial products being produced for this effort. The urge to critique the representational efforts of bureaucrats is irresistible, a sure sign of the ethnographer’s own institutionalised inhabitation and ‘pre-analysis’. The ethnographer’s critique of this representation effort, of the politics of translation if you will, then becomes yet another instance of the ways in which (‘outsider’) critical evaluation and (‘insider’) activist deconstruction combine to create their own impetus for renewed commitment to and replication of embedded forms of analysis and practice. It is an impossible binding.

This chapter then, is an attempt to show the phenomenological grip of the grim statistical portrait of Aboriginal morbidity and mortality on both anthropological and participant analysis, by also identifying its forceful claims in the moments where my hand, so to speak, is being compelled by the conceptual pressure of pre-given exegesis.

But first, let me begin with an example of how facts travel in THS.

We know but we don’t know

In previous chapters I have shown how, within Territory Health Services, as participants grapple with the intransigencies of ill health in the colonised Aboriginal populations of the Northern Territory, the question of what has to be done quickly comes to the fore. At any given moment in the THS network, health practitioners will be confronting the problem of how to enlist Aboriginal efforts to the urgent project of better sustaining their own health. There is a casually and relentlessly omnipresent portraiture of the gaps that must be closed if ever Aboriginal morbidity and mortality rates are to match those of the (by deed of Human Rights) universal healthy citizen. The challenge is how to return the otherwise stable ‘universal’ healthy person—here disrupted by the damaging vicissitudes of colonialism, poverty, loss of land, loss of culture, overcrowding, poor education, unemployment—back to a form of healthy order without further damaging Culture.

In lieu of endless citation I will represent this portraiture here in the form of a cross-sectional sampler. This barely gives a taste of the endless articulations to be found in pamphlets produced by advocacy groups, articles in health journals, conference proceedings, seminar presentations, Annual Reports, Special Reports, newspaper articles, academic texts, management data, costing analyses; anxious words and images shared and repeated in multitudinous encounters across and between health networks and beyond.

Those sections of Australia’s Aboriginal and Torres Strait Islander people for whom reliable statistics are available, have a lower life expectancy than for any other
indigenous minority within a first world country. On a world scale, adult mortality has improved dramatically in virtually every country, developing and developed—no matter what the disease pattern or the political system—so the failure to achieve similar gains in Australia's indigenous population calls for urgent and effective action.

*Aboriginal and Torres Strait Islander Health—A Submission from the Australian Medical Association* (Woolard et al. 1995: 2)

The proportion of mothers delivering preterm was consistently higher among Aboriginal mothers than non-Aboriginal mothers. ... The proportion of Aboriginal babies classified as low birthweight (less than 2,500 grams) fell throughout the decade from 15% in 1986 to 12.6% in 1995. It is still higher than the proportion of non-Aboriginal babies of low birthweight, which has remained steady at around six percent. There was an improvement in the survival rates of Aboriginal babies (as measured by the stillbirth, perinatal and infant mortality rates) but Aboriginal babies still have substantially higher mortality rates than non-Aboriginal babies.

*Trends in the health of mothers and babies, Northern Territory, 1986-95* (Markey et al. 1998: 1)

Australian Aborigines have experienced a rapid transition from a hunter/gatherer existence with a low fat, low calorie, high fiber diet to sedentary living with widespread poverty and unemployment, dependence on durable store-bought foods, pervasive cigarette smoking, and, for males at least, heavy drinking. Increasing rates of obesity, hypertension, and glucose intolerance have accompanied these changes, with the complications of cardiovascular disease and chronic renal failure. Adult mortality is >4 times that of other Australians and life expectancy for adults has actually fallen over the last 20 years in some areas. ... Although maternal and child health are gradually improving and infectious diseases are decreasing, these people are now experiencing all the manifestations of the maladaptive syndrome described above, accompanied by astounding rates of chronic renal disease and renal failure; from 1988 -1993, the annual incidence was ... 60 times that of other Australians.

*Diabetes and Impaired Glucose Tolerance in an Aboriginal community in the Northern Territory of Australia* (Hoy et al. 1996: 44)

In the last year I have really begun to wonder about how I am going to cope. I am really clinging on by my fingernails and some weeks are worse than others. I am at a low ebb right now and have begun applying for other jobs. If we can get the houses functional there will be a dramatic improvement in people's health. I really believe that. Skin disease, respiratory illness, and gastro-enteritis are the lead hospitalisation items—70% can be fixed through amenities. It is not their kids so they [the managers] don't care, that's what I think. They have silicon chips inside their heads that blinker them. I asked [a health manager], would you live in a house up here without a fridge, without a washing machine? Of course not! I am tempted to leave.

*Male remote area public health professional, Nhulunbuy, since departed (fieldnotes, 23 February, 2000).*
It's paradise over there, just beautiful. But it stagers me the sickness, the squalor in the middle of paradise. I go there, and get up and watch the sun rise, the sea eagles circling overhead, it is magic, heavenly. And then I go into town ((grimace and pause))... I heard that the Tiwi people have the highest attempted suicide rate in the country, at least one a week. I think it is to do with the squalor, the lack of hope, the poverty. Nobody wants to live that way. Those young men know what they're missing, they're not stupid. They can see what they're missing on the TV. It just must be so hard. But I shouldn't get so depressed. The Tiwi people are determined to turn all this around and so I'm here to follow their lead.

_New female remote area public health professional, Darwin Rural, since departed (fieldnotes, 6 August 1998)_

Imagine now a darkened room, blinds drawn shut, witnessing in the hushed artificial darkness a PowerPoint conspectus transmitting the Epidemiology Unit's knowledge of Aboriginal disease categories, specially designed for inducting health professionals new to the Northern Territory.

The multi-hued information-dense tabulations embedded within the deep blue illuminations are interspersed with sombre commentary: 'Unusually, the female Aboriginal mortality rate is far worse than the male in all age groups'; or

_We are actually getting bigger infants, birth weight is increasing, but after one year of age the weights aren't sustained. In one community we've studied, every single baby under 12 months of age is evacuated out in an emergency condition at least once in the first year of life. Injuries aside, the high death rates in the 25-44 year old category are from poor childhood health. These remain third world conditions in a first world country._

_(fieldnotes, August 1998)._}

And on to the next visual, 'Like people in many developing countries, Indigenous people wage an unnoticed struggle against disease. Low birth weight and failure to thrive from malnutrition and under-nutrition is implicated in the onset of diabetes, heart disease and cancer later in life.'
Lights back on, a doctor in the audience asks what work is being done to explain why these rates are as they are. 'The data just says what happens, not why,' he points out. 'If Aboriginal people knew that the high rate of infant illness contributed to these high death rates, they'd be interested in acting on it. In public health generally, are there people working on this?'

'Yes' replies the presenter. 'We are aware of this. But we are really needing community specific data so we can sit down with groups and say this is what is happening for you mob here. But we are a few years off. We have new information systems being put in place but it will still take a few years. The populations are pretty fluid too and that creates its own problems.'

Now, as we have seen, this is not an uncommon set of narrative formulations within health talk. From opening depictions of direness to hope, back again to difficulty; out of overwhelming problem to the more that can be done, against the harshest of odds. The answer, with better data, is around the corner—but it will take time and be a densely problematic process. The research is never complete, the data have infinite gaps. The maternal and perinatal statistics cited in the sampler above, for instance, are based on the 'Northern Territory Midwives Collection,' a database maintained by the THS Epidemiology Unit. The database stores information collated from forms completed by midwives for every baby born in a public or private hospital, as well as registered home births (Markey et al. 1998:3). The midwives also record the mother's demographic signifiers, her health, pregnancy type, style of labour and nature of delivery. However, problems surround the recording of indigeneity for, despite a clear specification that all women should be asked whether or not they identify as an Aboriginal or Torres Strait Islander, it is said midwives feel embarrassed asking this question of those who do not have an immediately indigenous appearance—who lack the look. In-service programs are frequently recommended to alert midwives to the importance of data accuracy, and to instruct them in techniques for asking all women, no matter what they appear to be, to clarify their identity. In the meantime, the incomplete data collections have to be used with caution, and continuing effort must be dedicated to making the information more reliable.

'We are aware of this' the presenter had said, referring to the need to share information. New electronic information management systems are on their way, he had assured, which will speed

137 See, for a discussion of a similar issue in Victorian administrations, Robertson, Lumley, and Berg (1995).
138 Consider, for another example among a plentitude, the dilemmas of counting Aboriginal people for the census, a regular subject of both intense bureaucratic wrangling and annually updated official explications of its impossibilities (see Australian Bureau of Statistics 1996). Heroic efforts are required to overcome or at least mediate the difficulties. Preceding major data collection efforts are exhaustive processes of designing, testing, skirmishing, field piloting and dress rehearsals. 'Skirmishing' (taking the preliminary formulations outside of the ABS central office into other agencies) for Indigenous collections requires negotiation with such representative bodies as the Aboriginal and Torres Strait Islander Commission (ATSIC) and meetings with variously placed 'user advisory groups'. Aboriginal volunteers need to be recruited and trained, and more intense than usual effort made to 'clean' the data. If the survey instrument succeeds each initiation sequence, it is automatically considered to be more robust. Suffice to say, the confessions of difficulty serve to reinforce the possibility of methodological resolution whilst reinstating the incessantly provisional nature of the data collections, ensuring critique is synonymous with revitalisations of the same processes. (I would like to thank Professor Tony Barnes, Centre for Cooperative Research, Northern Territory, for his help in clarifying ABS procedures for me). See also Joseph Dumit's account of the different modalities of testing answers in the research that is yet to be done in Dumit, ‘How do to things with science: Facts as forces in an uncertain world,’ paper presented at Travelling Facts: Inscription - Materiality - Translation, Wissenschaftskolleg zu Berlin - Institute for Advance Study, Berlin. 12-13 July 2000 (Dumit 2000: 26).
up the rate of localised data collation and dissemination. But even with obligatory questioning from well-trained data recorders, accurate capture of elusive Aboriginal people will remain difficult in the face of their multiple identifiers and high levels of (morbidity-induced) mobility.139 ‘The populations are pretty fluid.’ Even the penultimate database alluded to by our presenter, the Community Care Information System, is not quite delivering on its promise of complete patient information. When decisions are reached about how to count the number of Aboriginal bodies as they move across the landscape; when alternate noms de plume can be readily called up in computer wizards for reliable cross-matching; when fibre-optic cables are laid to connect the remote area clinics together; or when satellite transmissions suffer less disruptions; when the proliferating data sets are better standardised and coordinated; when the material is meaningfully translated; when all Aboriginal patients with chronic diseases are put on case management plans; when the map of Aboriginal distinction perfectly overlays every available variable—when, we might say, all the secrets of Aboriginal ill-health have been revealed, digitalised and re-expressed—then we will be in a position to help Aborigines panic and react in a more informed manner.140

Flaws impel action

It is neither possible nor necessary to examine health system critiques of the inadequacies of their own statistical literature to bear this point of endless indeterminancy out; for it is not a hidden effect of epidemiological practice but on the surface, readily available and given over to a manifest discourse of agonised analysis. The scandalous depths of Aboriginal illness and premature death, preventable death, are encapsulated within an economy of measures that speak of pain, disease, dismemberment, fluids and poisoned systems in the barren terms of epidemiological rates. These summary terms are accompanied by a meta-commentary which signals statistical deficiencies even as the incidences and prevalences are elaborated. The material is always flawed, incomplete or not as accurate as one would prefer, and yet, that aside, what it does reveal is sufficiently alarming to warrant immediate and deeply concerned remedial attention.

The anxiety for health professionals does not of course end with an identification of data inadequacy, for there is always the additional problem of taking this mass of flawed but vitally important material into the Aboriginal domain. This throws up collateral problems. Knowing that objective, population-generic representations are subjectively meaningless to individual clients and communities, health professionals are also confronted with the dilemma of translation. How are we to translate this

139 A reference to explanations which rest on the need to attend funerals, to care for sick relatives or to seek tertiary treatments as causes of high mobility (see, for example, Taylor 1998). See also Nicolas Peterson, ‘An Expanding Aboriginal Domain: Mobility and the Initiating Journey’ (2000) for an ethnographic description of similar issues. In fact, Aboriginal population mobility stands as yet another motif of Aboriginal life which is known and not known at the same time. As one examination of ‘the problem’ explains, ‘Given the level of mobility detected in this community, the ability to make population projections using sophisticated modelling techniques is severely constrained by unforeseen population movements that do not exhibit predictable mobility patterns. One community may experience population emigration in one period followed by net population immigration in the next without any predictable reason. With 25% to 35% of the population being mobile within a one year period, it is difficult to estimate accurately the spatial distribution of this migration’ (Warchuker, Tjapangati, and Warman 2000: 448).

140 For an overview of the problematics of data collections from the point of view of statisticians, see the conference proceedings of the Australian Institute of Health and Welfare (1995).
difficult summary material into terms which make sense, which are real, are humanised and comprehensible, for the people whose actual sickness and death the data abstractly indexes?

A public health physician who has worked long and hard on sensitive ways of presenting death information, exploring the persuasion power of pie charts versus bar graphs amongst various Aboriginal groups,\textsuperscript{141} says one of his most frequently asked questions is 'do Aboriginal people know how unwell they are?' This, he reflects, is very difficult to answer:

Clearly some, especially in the health field, have heard the statistics. Others have not. Almost all Aboriginal people have personally experienced the death of one or more family members. But even so, many seem surprised by our presentation of mortality information (which) began by acknowledging the grief of individuals and explicitly linked statistical information with personal stories and local issues...The implication is that information can remain abstract, external and cold, or it can become internal and warmed by contact with emotional feelings and personal experiences.

(Weeramanthri undated: 7)

The solution, he feels, lies in the empowering effects of well-designed and meaningfully-presented information. Statistics that have been warmed, demystified, their tears returned and secret meanings rendered.

\textbf{Accounting}

At this level, accounting for both the preponderance of health information and for the conscientious attention paid to how best to circulate it, is relatively straightforward. For the sociologist Ulrich Beck (1992), risk consciousness is the defining feature of late modernity, where the production of more hazards has prompted high anxiety on a global stage. The modern subject is schooled in a style of continual reflexivity, imbued with 'the idea that more and more aspects of social life can be subject to strategic transformation and modification on the basis of new knowledge and the capacity to discursively interpret conduct' (Bunton and Burrows 1995: 208). Yet under informational capitalism, the structural conditions for reflexivity about causes and effects is unequally distributed (Lash 1994). Why do 'we' know about being healthy? Because we are structurally enabled to produce and consume the information, we know about the risks, and in a liberal politic, access to information equates with the power to act. It is a symptom of the ongoing existence of racist inequality in Australia that Aboriginal people are burdened by the premature death and illness captured in multiple enlistments of rates and figures, and it is a matter of social justice that they be truthfully informed of the outrage of their own unhealthiness. As Bob Connell puts it, 'One measure of how far we are from a just society in Australia and New Zealand is the evidence of systematic social inequalities in morbidity, mortality and health care access' (Connell, cited in Metcalfe 1993: 35).

\textsuperscript{141} The verdict is that pie charts are more effective (Weeramanthri undated). Note that this has since become widely cited research. A truism that is retold and reworked in other encounters between old' and 'new' health professionals. One relative newcomer told me one of her constant problems was having to revise the generic public health education media (posters and diagrams) about healthy foods to make it more suitable. She said: 'One of the problems is we constantly change the educational information - the pyramids are not appropriate. People relate better to round things - a lot of things are round - damper is round, stories are round, you sit around the camp fire in a circle, it makes sense.' (Field notes, 6 July 1998).
Pondering the route of traveling facts, bio-science ethnographer Joseph Dumit asks 'Who takes up facts? Who does not? How are they produced and distributed?' (1997: 83). Now, given our all-over dependence on categories of scientific knowledge for our lived sense of healthfulness, personhood and function (Haraway 1991, Martin 1994), it comes as no surprise if I gloss a bureaucratic answer as: it is 'we' who take up facts, it is Aboriginal people who are deemed not to do so, and it is to epidemiologists and public health professionals that we turn in Territory Health to produce the transformational knowledge that will fashion appropriately alarmed responses. What we see played out in the many internal pedagogic encounters within Territory Health Services is an infusing of a scientised knowledge, which (it is assumed) needs only be retold to be internalised, heated up to render its full scandalous import, appropriately translated to allow the reversals in unhealthy behaviours to flow.

But then again, as a representation of the native theories of factual transfer operating in this environment, such a simple one-to-one domino image of information transmission and uptake is more aspirational than actual, straightening out a more chaotic informatics phenomenon and a more complex conceptualisation of the stakes. It puts it too matter-of-factly, to imagine the pathway as a recitation of serious facts, their uptake by the health professionals, an attempted transmission to the subject objects, as all to do with a more-or-less simple matter of more-or-less complex translation. For translation, as Benjamin reminds us, is a mode, never a neutral transmitting device (Benjamin 1977).

**Authoring, Receiving and Transmitting**

Thinking about statistical groupings, Paul Rabinow makes the observation that individuals sharing certain traits or sets of traits can be grouped together in a way that not only decontextualises them from their social environment but also is non-subjective in a double sense: it is objectively arrived at, and does not apply to, a subject in anything like the older sense of the word (that is a suffering, meaningfully situated integrator of social, historical and bodily experiences). (Rabinow 1992: 243)

We moderns are all familiar with the desensitising power of statistics. But entering the world of public health professionals and epidemiologists, despite the sustained sense of outrage engendered in worried talk concerning what needs to be done to reduce the burden of disease carried by the population of Aboriginal bodies, there is curiously no visceral reality behind the depictions. While public health is fundamentally concerned with the most intimate aspects of bodily function and daily life (eating, sleeping, cleaning, procreating, caring, rearing), it has curiously little to say about questions of embodiment. Unlike, say, epic depictions of facsimic or mass starvation, it seems unnecessary to the creation of scandal for us to experience, vicariously or visually, a sense of what chronic disease might mean as felt phenomenon. Does taking a piss feel different if you have kidney disease? What does embodying every known risk factor from an early age feel like? (This last in a context where a key THS strategy document admits 'Aboriginal' and 'at risk' are synonyms, as in: 'Aboriginality' is a 'proxy' risk factor, identifying a group at high risk, most probably because of a number of associated factors linked to socio-economic disadvantage' (Weeramanthri et al. 1999: 21).
Chronic disease, known to be eventually debilitating and life terminating, is as it is: a stripped and straightened syndrome, not an embodied state. In public health, as Dorothy Broom has recently put it,

we deal with fundamental questions surrounding pain and suffering, life and death... (Yet) public health has almost completely banished the live body, whether sick or well—lost it between the microscopic molecule or genome, and the abstract macro of the population (2001: 5).

Just as curiously, the unwellness of Aboriginal people does not feature as an explanation for why projects fail. In the driven concern to avert blame from Aboriginal people, what might easily be deployed as a ready-made and conscientious explanatory device for the seeming intransigency, poor compliance and service-resistance of Aboriginal people—namely, their permanent states of fatigue or chronic unwellness—is strangely not availed. Deaths from the 'new' chronic diseases are, as medical anthropologist Nancy Scheper-Hughes notes, 'prolonged, painful, and both socially and psychologically troublesome, as one must observe the slow, yet irreversible loss of the body's capacities and functions as well as the diminution of one's social roles, social network and economic resources' (Scheper-Hughes 1992: 285). Yet the nauseating condition of being existentially aware of organs and internal functions as part-parcel of encroaching dis-ease, a suite of morbidity-related depletions, lethargies and alienations one could imagine operating on a number of levels, is rarely brought into view as part of what one must 'bear in mind' when talking to Aboriginal people about the public health measures they need to take to improve their health and well being. Dr Tarun Weeramanthri, a key architect of the THS Preventable Chronic Disease Strategy, and a professional with a deep commitment to philosophical and social scientific critique of public health and clinical practice, provides a typical summary as follows:

What makes chronic illness different from acute illness? In general, acute illness (such as common cold, infected skin lesion or injury) are characterised by an abrupt onset, limited duration and clear cause. Professionals knowledgeable about the disease can offer an accurate prognosis and cure is likely. In contrast, uncertainty pervades chronic illness management. For conditions such as diabetes or hypertension, the onset is often gradual (indeed the patient may be asymptomatic at time of diagnosis), the possible causes multiple with many far in the past, and the duration lifelong. Prognosis is uncertain, and cure impossible. .... In the NT, the rise in chronic diseases (diabetes, hypertension, heart disease, kidney failure and chronic airways disease) constitutes an enormous strategic challenge. (Weeramanthri 2001: 8).

Aboriginal disease has a 'phantom objectivity' (Taussig 1980b: 3, 1987: 4), not so much in the Marxian sense of having actual social and economic relations obscured to the commoditized body which mistakenly thinks it acts and exchanges autonomously, but in terms of having the political-economy connections brought to the surface over and above the (unimagined) falterings of the inflicted body (cf. Chapter Three). More curiously still, Aboriginal ill-health is not just vicariously disembodied for surveyors but is also seen to be disembodied for its carriers. Aboriginal people are a population who are 'young and very sick' but they do not necessarily know it (yet), as they suffer diseases that 'are relatively asymptomatic for prolonged phases' (Wright 1996: 5-6). The *THS Preventable Chronic Disease Strategy* starts from the premise that
Chronic diseases, by definition, do not arise overnight. Instead, they *develop silently over years* until something serious happens that forces a person to attend a health centre and *interventions are required in the silent period* long before the disease itself appears.\textsuperscript{142}

Even trained health professionals may not know it, as when remote area nurses diligently measure and record for the epidemiological register childhood growth patterns and are unable to see the stunting in the live-wire, energetic, frenetic little black bodies in front of their eyes (Ruben and Walker 1995). Here the visual image which does not have the *look* of disease, which lacks its performative dimension, is not sufficient to activate intervention.\textsuperscript{143}

### Performing unwellness

Liisa Malkki similarly describes intact Hutu refugees as unrecognisable to humanitarian aide administrators:

For the refugee...wounds speak louder than words. Wounds are accepted as objective evidence, as more reliable sources of knowledge than the words of the people on whose bodies those wounds are found. So the ideal construct, the 'real refugee,' was imagined as a particular kind of person: a victim whose judgement and reason had been compromised by his or her experiences. This was a tragic, and sometimes repulsive, figure who could only be deciphered and healed by professionals, and who was opaque even (or perhaps especially) to him- or herself (Malkki 1997a: 232—original emphasis).

As Malkki describes it, the narrative testimony of refugees specifying political violence could not be trusted in the absence of corporeal wounds; here "bodies could give a more reliable and relevant accounting than the refugees' 'stories'" (ibid). For the asymptomatic diseased bodies of Aboriginal people, a different rejecting takes place: not even their bodies cannot be trusted to tell an "immediately ascertainable"\textsuperscript{144} story. Their opacity must be made transparent through more skillful professional investigation and tutelage. Complicating this, health professionals, like the nurses who fail to witness childhood stunting properly, need to be told what to look for, assisted with new measuring instruments, practicums and appropriately presented information so they see the damage they can't see and which seems not to be felt in order to help Aboriginal people feel the damage they don't yet feel and about which, it is said, they have both insufficient knowledge and a cultural tendency to deny or tolerate their pain until it is too late.

Which raises a question: how do we get to know about it when they don't?\textsuperscript{145}


\textsuperscript{143} This is well-established as a syndrome in the sociology of medicine literature. Although the subject of extensive revision and critique, Talcott Parsons' classic original concept of the 'sick role' (Parsons 1951: ch.10) firmly established the idea that the sick person has to perform unwellness and pro-actively comply with the injunction to noticeably desire improvement to attain legitimacy as a genuinely sick person. In contemporary literature, post-Foucault, this notion has been expanded to cover a more continuous set of rights and duties: a shift Banton and Burrows capture in the term 'health roles' (Banton and Burrows 1995: 208). As they put it, we are (now) concerned with the development of a new form of governance, one that has moved well beyond the walls of the hospital and involves not just the physician and the patient, but a whole range of agencies dispersed throughout society requiring of the individual an extension of their concerns 'with body boundaries' and 'individual psychology' to 'lifestyle' more generally (ibid). For a thorough overview of the sociology of illness, see Gerhardt (1989).
Learning to see

At a practical level, and as a first cut answer, institutional induction in prevailing diagnostic regimens for seeing the unseen takes place, not surprisingly, in the credential-attaining education professionals undertake before employment and over again in the multiple training settings (workshops) THS has occurring in its network at any given moment in time. Here anecdotes are cut and spliced into scientised narratives to form the shared interpretive grid for understanding Aboriginal absences. Two illustrative snapshots give the picture.

Absorbing and Transmitting Scene One

It is Day Four of a week long remote area nurses’ in-service training session for the East Arnhem Region, held in the Nhulunbuy Hospital staff conference room, in the year 2000. This afternoon’s session is dedicated to discussing the Growth Assessment and Action program. In a suite of interventions across a continuum of tackling the seemingly well (prevention) to ameliorating the afflicted (best practice management), the program requires that all children will be monitored and their growth documented, with check points to trigger alarm carefully specified. New growth assessment books have been distributed in order to standardise the measurements for more efficient centralised data collection and analysis, with the whole program being hailed as an important intervention in the management and prevention of early childhood disease. (These protocols and practices are part of the Northern Territory Preventable Chronic Diseases Strategy, which is based on the widely-accepted premise that the antecedents for adult chronic disease are established in the antenatal and early childhood periods).

The emphasis on growth assessment followed by intervention derives from past clinical history. As I alluded above, at one stage it was found that community-based nurses were religiously documenting, but failing to intervene to correct, the shorter statures and slighter weights of Aboriginal children from the first year of life and throughout childhood, partly because the children seemed otherwise so abundantly energetic (Ruben and Walker 1995). Now, having duly collected the annual clinic returns data and returned it to epidemiologists in central office who have re-collated it for use back in the communities,146 integrating the latest advice on how to simplify complex material for Aboriginal comprehension, the nurses have to work out if the data has been translated sufficiently well to allow for good community feedback. In a conscientious aesthetic of cross-cultural simplification, minimal text is maximised in large print and vividly coloured drawings, while simplified diagrams replace the dense exegesis of an internal-use epidemiology report. 147

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144 See Allen Feldman on ‘the cult of the immediately ascertainable fact’ in western epistemology (Feldman 1994, 1997).
145 This is a more important question than may at first be obvious, given the dependence on a presenting patient-body for clinical diagnosis in ordinary contexts (see also discussion by Moi 2000).
146 We should briefly note that epidemiological reports proceed along the same negotiated route of inclusion, exclusion and normalisation described for policies and other institutional narratives in previous chapters.
147 The paramount concern with aesthetic layout as forms of achieving transparent meaning in development work is briefly explored by Annelise Riles, here commenting on a newsletter produced by the International Women’s Tribune Centre: “The newsletter consists of a series of cheerful, uplifting images of feminism and feminist activism that aim to counteract negative stereotypes of the women’s movement and to inspire women in the developing world to an activism of their own. It contained little text and few specifics; the principal contribution is the images” (Riles 2006: 132). Additional THS examples are described below and in following chapters.
As the remote area nurse with the longest tenure in the Arnhem region, it falls to Peg Anselm to lead her counterparts page by page through the latest Growth Assessment Action Reports.

Interacting with Peg are eight nurses who've already attempted to use the previous year's material in feedback sessions with Aboriginal Health Workers, workers who are frequently used as the standardised representatives of the (poorly literate) 'grass-roots' and thus are the yardstick (and often the endpoint) for 'community' feedback.

The nurses are cynical, they've seen it all before.

'This is about moving from interpreting the data to doing something about it,' rallies Peg, warming to her temporarily-assigned leadership role. 'The question of 'why bother?' is they're saying now that the first two years of life is really important for preventing chronic disease later on. So keep going guys--this really is important.'

So they keep going, combing through the revised layouts of this year's tabulated data in the light of their previous efforts at 'community feedback.' They describe what seemed to work and what did not in terms of creating Aboriginal interest and assess the merits of pie charts versus bar graphs, the use of people figures rather than numbers, of fluorescent lime-green and fire-truck red squares in a coloured grid as opposed to the more usual black and white or pastel colours, as various ways of depicting under- and over-nutrition rates. One nurse suggested that a table showing comparative statistics of the community in relation to the region in relation to the Northern Territory in relation to the rest of Australia should not be shown at all because it does not tell a positive story. Its lack of good news may potentially dispirit community members, risking further docility when activism is the desired reaction. (Like simplifying cross-cultural texts so as not to make people with poor literacy feel inadequate, health professionals commonly assume that their messages must be uplifting, emphasising positives and successes in order to be both inspirational and to counteract racist stereotypes of pathology.)

'People here get swamped in bad news all the time—we want them to feel better about themselves, not worse,' the nurse-critic cautioned, and Peg wrote her comments down, for 'feeding back' further up the line to the central office staff who would need to revise future community reports in response to these efforts (efforts which will eventually be described in future policy representations as 'community consultations').

Page by page analysis of the report continued.

'We see a dip at four to six months in growth and no take off again until the kids turn two and then they can forage for themselves.'

'It would be good to have everything on one sheet, using those primary colours.'

On the Central Office request that they consider means of somehow presenting the information to the community as a whole: 'We don't have any fantastic ideas about this part. You can't post it up
at the store or clinic without explanation. And you really need your Health Workers to take people through it.’

Another nurse: ‘Do you think your Health Workers really understand it?’

Peg responds, transplanting the genesis of the Growth Assessment and Action initiative (the lack of appropriate problem recognition amongst the vigilantly documenting nurses) to an ignorance Aboriginal Health Workers are now assumed to mimitically reflect:

Well, it’s really important that you sit down with them and talk them through it because they’re the ones most likely to tell others. I think it is good for people to get an idea of how many kids there are and what the consequences are. They know the kids are skinny but they see them running around all day and they eat at least one meal so [they think] what’s the problem?

(fieldnotes, 24 February 2000)

**Absorbing and Transmitting Scene Two**

‘A view from the other side,’ Jimmy Kneeler’s seminar presentation, is scheduled for the post-lunch slot in Block Four, a Stalinist-sounding name for the office quarters of health professionals who work in remote area communities from a Darwin base. It took the best part of an hour, his talk to a new batch of doctors and nurses, as part of their orientation in August 1998. He’d been looking to make this presentation on his remote area environmental health program more interesting with a greater use of visuals, after feedback on an earlier version that he’d talked too much. The numbers being oriented on this day aren’t many, eleven in all, plus me and Jimmy, yet all the chairs around the U-shaped tables have been taken and I sit at the rear, introduced as Jimmy’s guest observer. A senior manager who arrives to briefly act as M.C. introduces Jimmy as one of three ‘very experienced’ remote area workers the new THS employees will be hearing in the fullness of the afternoon.

Jimmy began by drawing a rough graph on the whiteboard, saying that world populations remained fairly static until quite recently.
Why the relatively sudden surge? Basically it boiled down to three things: sanitation, housing, and occupational health and safety. But what had these things improved? With the agricultural revolution, people were removed from their lands and forced to move into the cities, where they lived in unsanitary overcrowded slums. With the Industrial revolution came not only the need for a healthy workforce but also union organisation and a demand for food security.

My point is that underlying all these reforms were issues of social equity. That is really important to bear in mind for health because a lot of this (pointing to the graph) is not about affluence. Saudi Arabia is a very, very rich country but it still has high levels of infant mortality, quite probably because of the position of women in that country. And that is what I want to stress—it is a bigger picture than health.

(Fieldnotes, 16 August 1998)

He drew another graph, symbolising the history of TB's demise in the west:

![Graph](image)

For the decline before antibiotics, it was the same things that happened with the increased population. So we now know that better environment leads to better health—that can be taken as a given. In the Northern Territory, Aboriginal infant mortality has come down, but if you break it up, the drop has been in the hospital domain, because we can evacuate the kids to hospital and treat them there.

A woman from the audience spoke up, 'So that's still a bandaid thing isn't it?'

Basically yes. Those of you who are doctors and nurses you know that basically we treat communicable diseases and we're good at sending people to hospital, making them better and sending them home, but that in the community, the environmental conditions could be way better. But it would be a mistake to think we can just copy the patterns of 18th and 19th century Europe and reproduce that in Aboriginal communities. These were changes which were based on mass colonisation, on slavery, on extracting the wealth of other lands, minerals and all that, to build up places like London. Nor is it as simple as transferring what happens in the third world to a fourth world situation. Basically Aboriginal communities have no fiscal independence to start with, there's very little employment in communities and what is there, is usually government funded. I guess that's where our job in environmental health becomes a bit interesting.
Some members of the audience lean back in the chairs slightly and nod.

So what do people need to live healthy lives? There’s been some good work. About ten years ago, an anthropologist, a doctor and an architect got together and decided to answer this question. They worked out that there were these nine things...

Jimmy illuminated an overhead, showing the nine things pre-prioritised in order of their likely impact on health improvement:

1. Washing people
2. Washing clothes/bedding
3. Removing waste
4. Improving nutrition
5. Reducing crowding
6. Separating of dogs and children
7. Controlling dust
8. Temperature control
9. Reducing trauma

And continued his narrative:

and then they measured people’s ability to do these things and found that the hardware in houses was so dysfunctional, people couldn’t act on these basic things. Every three months they measured household capacity and they wrote down what they found in this book, [Jimmy holds up a copy of Housing for Health (Pholeros, Rainow, and Torzillo 1993)], which some of you may have seen. It says basically things aren’t working for three main reasons: poor design, poor construction and there is no repair and maintenance. They dispelled a lot of myths and showed that if you put functioning infrastructure in, people will use it. The breakdowns aren’t because of people wrecking houses, misuse, vandalism, not even from overcrowding but because the original construction is crappy, the designs are bad, and the materials aren’t built for longevity. The load on houses is much greater too.

The same mob did a washing machine survey in the centre [Central Australia] and found that the machines don’t deal with the really high levels of calcium you get in that country and with having heavy blankets full of dust. Those machines go for four or five hours per day but when you count the cycles, they break down at the same point machines in Alice [Springs] would—only that time comes around quicker in a community.

You’ve all probably heard the one about how Aboriginal people trash the floorboards for fire wood? I’ve heard it lots of times but in eight years I’ve never seen it. It’s really important to put these myths into perspective because some of you are only going to be here for a short while and then you will go south and, given your contact with Aboriginal people, you will speak with a certain authority and if you perpetuate the myths, then it just makes our job up here that much harder.
Anyway, the UPK mob (the authors of *Housing for Health*) copped a lot of criticism because their research was in a small community, a dry community, so they did it all again in Pormpuraaw in Northern Queensland and basically showed the same thing—functionality is the key.

Another overhead, with photographs of the Pormpuraaw houses.

The houses might not look pretty but the people can undertake healthy lifestyle practices. It's important for you guys as doctors or nurses, if a baby comes in with bad scabies and you say 'take home that baby and clean him up, you got to wash that baby,' that you don't just give the information but that you check if that the person is able to realistically do it. Is there a laundry tub, is there warm water, is there a plug?

One of the audience members, an Aboriginal man, humphed agreement and nodded vigorously at Jimmy's last remarks, sinking his chin onto his chest and folding his hands together across his paunch as he settled himself further into the chair.

'So how do you think that went?' I asked Jimmy afterward.

'I talked too much again' he said glumly.

**Inscription**

Thus far I have attempted to follow the routes of health fact exchange in talk about what has to be done and how, to get some sense of how the necessity to act is created out of the projected absence that health professionals begin with. Recall this is an absence operating at a number of levels:

- The diseases are not necessarily felt by their carriers
- The diseases are certainly not felt by their interpreters
- The information is always insufficient
- The information is insufficiently known

To which let us add the dominant explanatory schemas for why ill-health continues:

- The system response is insufficient
- Aboriginal people bear the burden of past wrongs and misunderstandings
- They are suffering what the West itself has already been through
- Education is lacking every which way.

Returning then to the porters who must carry the informational load into the Aboriginal domain, I want also to return to my opening curiosity about the visceral bond that is imagined to connect receivers and transmitters to the facts which have acted upon them. My question is how, in this world of stealthy disease, are health facts made visceral for their transmitters, who in turn hope to configure the same bio-effects within Aboriginal beings-in-the-world? But in fact, asked in this
way, I may unwittingly be forcing a digression into a treatise on the imbibing of western biopsychosocial habits from infancy on to explain how concepts of risk and acceptance of health facts are instantiated within a raft of mundane practices—from a dutiful care to combine ascorbic acid when taking iron tablets through to dish washing—a topic as infinite as that which it seeks to index. And because these questions quickly lead into others about the scientised nature of western learning itself, a vast and inexhaustible inquiry, let me quickly circumscribe my ambit. My quest can be rephrased, more simply, as what creates the scandal and hope that surrounds the telling of facts, in the apparent absence of affect? And further, what kind of 'sensory alterity' (Feldman 1997: 31) is imagined for Aboriginal people in schemes to repackage statistics in the name of internalisation? What I have in mind here is a reflection on what health professionals are in fact already knowing when they assume facts act, beyond viewing this faith as a version of a classic enlightenment vision of the power of scientific knowledge to compel solutions (cf. Latou and Woolgar 1986).

It needs to be said at this point that much attention has been paid in the literature to the role of science with its sense of the molecular, combined with a desire to control epidemic-prone and unruly populations, in setting the scene for the growth of public health and the numerical charting of patterns of illness (e.g. Bunton, Nettleton, and Burrows 1995, Lupton 1995, Lupton and Peterson 1996, Porter 1999). Yet, with brilliant exceptions (e.g. Downey and Dumit 1997, Martin 1994), in the main these analyses tend to imagine a world of ideas as discrete from, but locked in a tight embrace with, broad social conditions, and say very little about the interactive dimension of factual deployment, the pan-handling with which people are making sense of their worlds using the health facts before and within them. In this I agree with Nikolas Rose when he asserts, in frustration with impoverished theories of changing modes of cognition, that

social conditions are never active in human affairs as raw experiences but only in and through certain systems of meaning and value. Ideas are constitutively social in that they are formed and circulated within very material apparatuses for the production, delimitation and authorization of truth. It is perhaps time, once and for all, to cease to distinguish the intellectual from the social only to ask how they are related

(Rose 1991: 681).  

Like social scientists, health professionals may appear to pay little, or rather, pay pre-directed attention to how health facts found them in the first place, at the same time, they know they have been found. Facts have acted on them, both in terms of their own daily healthy lifestyle calibrations, and in terms of fuelling a zealous determination to share facts in the Aboriginal domain in the cause of betterment. That is to say, health professionals know that they know more than their clients about the biomedical causes and effects of disease and the associated

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149 This compares with Bruno Latour's determination to follow Tolstoy's lead and reinstate the many in history who are overwritten by a few eponymous figures: a Louis Pasteur here, a Bonaparte over there. As Latour puts it: 'The active society that makes up immense parts of bacteriology is not the same as the society used as a backdrop or a social context' for the history of science. Herein originates the misunderstanding between microsociologies of science and philosophies of science. Society has to be redefined in order to become usable in 'social' studies of science' (Latour 1988: 254, n 3)
recommendations on how to prevent, protect and treat. They know this to be a culturally-stylised and historically-specific expert form of knowledge. And they know they manifest their knowledge both through their own bodily habits and in their professional efforts to impart what they have learnt (and have had refined through professional development) by folding it into their knowledge of Aboriginal culture, the better to illuminate that which is killing people. The better yet if this can be done with due recognition of Aboriginal models of illness and causation, if the holistic indigenous systems of meaning and belief can be rightfully acknowledged and incorporated into the explanatory schema, and if Aboriginal people can be involved from the outset (cf. Kleinman 1981).

For instance, a complex theory of socialisation and personhood, of instantiated science and enchantment with the uncanny, sympathy for sentimentality and sense of culturally embedded history is clearly operating in combination in the following narrative by an environmental health officer, here describing her plans for hygiene work with Tiwi women on Bathurst Island.

It is very interesting working in a project like this. It's probably the most interesting work I've ever done. I'm having to learn how to talk about hygiene to a group of people who do not take bacteriology for granted.

When you and I were growing up our mothers sat us on their knee and told us not to pick our noses and eat it. 'Ooo, yucky' we were told when we went to pick up a discarded lolly from the floor; 'oo yuck' when we played with cat poo in the sand pit, so we grew up with it.

Some of it was old wives tales—I was told not to sit in the bath when I was menstruating—crazy isn't it?!—but some of it was based on germ theory, so we got it from the beginning.

(Fieldnotes, 6 August 1998)

Margaret plans to fix this imagined osmotic gap by, amongst other things, showing Aboriginal women microbes (bacteria, viruses and parasites) under microscopes; by taking comparative agar prints of people's hands before and after washing; and by cutting up some chicken on a kitchen bench and then swabbing the bench, swabbing the bench again after cleaning it with a dirty rag, and swabbing it once more after cleaning it more thoroughly with the right chemical agents:

The ambient temperature up here is perfect for incubating the agar plates so within three days they should be able to look at the microscope images. I love looking down there, it's a whole different world. The little creatures sometimes build shelters for themselves, little cones, and it's fierce as well. Larvae will prey on other larvae, it is quite hierarchical. Really fascinating....But most Aboriginal people are losing their eye sight by the time they are my age with diabetes, or trachomas, so we can't take it for granted that they'll be able to peer down a microscope. And the last thing we want to do is to shame anyone. Aboriginal people care a lot about shame. So I'm thinking of also enlarging the images onto a computer screen.

I've got lots of ideas really.

(ibid)
Margaret is not alone in thinking that social inscriptions in early childhood generate a psychical health-conscious interiority orienting the western subject for life. Nor, as I have shown, is she isolated in considering that whereas ‘we’ bump into facts about managing our health on a daily and unavoidable basis, whereas ‘our’ history and present infills with a flood of advice which help us act right, Aboriginal people do not have the same biographical exposure to help them discern the underlying causes of their own illnesses. We need to ‘bear in mind’ that theirs is instead a world where young children are indulged rather than chastised, one in which spirits visit people, there are sorcerers and healers, and a more holistic view of health obtains.

But in her plans for sharing information by being sensitive to local beliefs, Margaret is also blending in alternate cultural understandings. Shame figures prominently, firstly in her recollection of the disgusted maternal figure who installs through admonition a shame-making contempt for bodily products, banishing menstrual blood from the bath water, thus conferring a lifelong (healthy) respect for the invisible stealth of germs. And again in the reminder that Aboriginal people are acutely sensitive to shame. Note that this last incantation, a common enough injunction about Aboriginal cultural distinction, stands here not as a symbol of sharedness but as its inverse: a mysterious and singular attribute which must be carefully guarded against transgression. Yet the recognition of cultural difference that seems to be about a distinct form of being is just as quickly displaced by the widely shared notion of a universal response to the hyper-real images of the microscopic. It is assumed that, sensitively handled, everyone will be equally enlightened by the visual revelations. (In fact, my fieldnotes overflow with informant references to the use of microscopes as an information sharing strategy to compensate for the shared diagnosis that Aborigines suffer a lack of germ theory as a life-organising conceptual schema.)

It is interesting to compare Margaret’s commonly held faith in the microscope’s power to provoke a particularised form of enlightenment through revealing the concealed, with Emily Martin’s discovery of the excess of meanings different viewers bring to the surreal and wondrous

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150 Annette Hamilton’s important early work on child-rearing practices in Arnhem Land, Nature and Nature (1981), is used as a key text in public health training. In fact, later in the afternoon of the same nurses’ in-service session described above, two nutritionists delivered a session on maternal and child health, stressing the need to understand the different systems of nurture, using this classic ethnographic work as an authorising reference. The group were told that ‘in the past the indulgence system worked well, because the foods were healthy, but today it is another picture. How we bring up our children differs - we mould them from an early age, discipline them to eat and sleep at certain times, isolate them, and parents are judged on how well their children behave, whereas Aboriginal children are loved to death. Almost literally. We love our kids too but Aboriginal kids have affection lavished on them - they’re breastfed on demand, not weaned until three or four years of age and given everything they want. So we have to work within that.’ (Fieldnotes, 24 February 2000).

151 For a more detailed discussion of shame in terms of its structure/structuring effects; its role in Australian anthropology; and its place in Walpiri life, see Jennifer Biddle ‘Shame’ in Australian Feminist Studies (1997).

152 The health education work of the Aboriginal Resource Development Service (ARDs) - formerly the Uniting Church Mission - in East Arnhem Land is a case in point (see, for example, Trudgen 2000: 246). In their role as trainers contracted by THS to educate health professionals, as well as being community-based health advisers in their own right, the ARDS model has wide purchase as a ready strategy to be thought. As if to confirm this, I was recently given another reminder. Travelling to Sydney via Nhulunbuy and Cairns for a dissertation discussion in June 2001, my temporary companion on the adjoining seat was an adult educator from the Northern Territory University on route to Nhulunbuy and thence to Yirrkala to teach Aboriginal people how to cook. He told me there were many things Aborigines do not know about hygiene. His partner in the course, a fellow chef named Steve, had taken a swab sample from participants’ thumbs on a previous visit and would this time reveal to the people how the agar plates were now overfilling with bacteria ‘so that they can see why they have to wash their hands and wear hairnets.’ (Fieldnotes, back of an airline sick bag, 22 June 2001).
images produced by cells under electron micrographs. For Martin’s American subjects, instead of inculcating a correct classification of these images of the intra-organic, viewers experienced deepening forms of wonder and perplexity, resulting in anything but closure (Martin 1994: 167-182). The super-enlargements evoked all kinds of associations, even with an authority figure present to suggest a particular interpretation. The one factor uniting her informants’ wildly diverse interpretations of the electronically-derived scale reversal of human cells magnified onto a screen, Martin tells us, was their acute displacement:

as depictions of the body, micrographs show microscopic entities radically decontextualized from the context of the body...the depictions...could be anything at all, from jellyfish in the ocean deep, to star wars in outer space. (ibid.: 179)

So much for guaranteeing phobic hygiene mentality out of a form of sur/realist revelation which, it appears, readily translates into deeper forms of mystery, even for the biologically pre-saturated population of English-speaking Americans! (cf. Taussig 1999: 66).

The health professional’s faith in the efficacy of showings of germs (and other health facts) to prompt life-transforming edification is partly a matter of emptying science of its cultural meanings, of seeing microscopic and statistical representations alike as capturing that which lies ‘underneath’ and ‘out there’, preceding cultural interference. But this ‘seeing’ is itself another form of bodily knowing. At one level, Margaret’s own enchantment with the marvelous activities of little creatures speaks eloquently of the theories of factual transfer and uptake operating amongst health professionals. These are germs with unique cultural and structural forms, an esoterica which can be converted back into factualised sense for Margaret in terms of her own training in the science informing environmental health. But this pre-absorbed ability to objectify the links between an otherwise random visual spectacle and an intellectual, moral and physical set of apprehensions is stripped of its heavy heritage and reduced to a straight osmosis between the visual and the interior.

The information items that are classified as vital for sharing somehow shed their history as the products of expert mediations and perceptual training, to become things in themselves with transparent moral import. By converting information of professional derivation into educative material to be translated, professionals reclassify the social origins of their own data. The revelation which depends for its explanatory power on an over-determining understanding of how it all ‘really works’—on, that is, an institutionalised ability to narrow down manifold perceptual registrations to end up with the overriding causal flow—has its embedded acts of repeated schooling and instantiation taken away, with the image itself assuming an inherent capacity to impel the correct correlations, provided of course, an accessible and sensitive explanatory narrative accompanies the imagery. Here it is the mesmerizing effects of miniturisation which will clarify the connection between germs, domestic cleaning habits, and bodily health. Elsewhere, in the endless circling around how to re-embodi scientific knowledge, it is pie-charts (not bar graphs), green and red (not pastel), large print (not too much text), or perhaps a sensitive use of Aboriginal drawing techniques to translate health meanings. One poster that seems to have followed me everywhere shows a positive-to-negative black and white simulation of the
iconicised East Arnhem x-ray line style. It depicts a cross-section of a strangely elongated and hugely pregnant woman inhaling deeply on a cigarette, her baby also perforce smoking as it lies trapped in utero, its curled body pressed against the crossed-hatched boxes of the mother’s incubating vertebrae.

But the women might not be able to see things clearly because their eyes are diseased. The opacity which momentarily rests in the statistics—a simpler, friendlier way of putting things needs to be found—rests truly in the eyes of the beholder. In fact they are all diseased; they are, to recall the words of one remote area doctor, ‘dying like flies’ and in the Annual Report of a medical research faculty, buried in a sink of germs (MSHR 1995: 12). If only they knew it. To which I could add other interpretations: if only they could match their gaze with ours. If only we could find the right way to make them understand. If only they could match their perception with our own pre-ordered vision, to see the little morality play of germs revealed as invisible agents of disease and modify their behaviours accordingly, merging old mystifications with new ones.

The problems of translation

It needs emphasising that Margaret’s is one of many, many attempts to anchor specific diagnostic connections between otherwise unlike phenomena in order that Aboriginal people are able to lead healthful lives. For Margaret, the task is to create a bridge between invisible germs on a bench to gastrointestinal disorders, between stomach purges and vulnerability to other infections, repeat infections to organ damage, organ damage to the onset of chronic disease in adulthood and so on. Or, to take another chain of unexpected interconnectedness, health professionals now suspect there to be a strong link between scabies, Group A Streptococcal skin infections (both previously thought benign), and progressive renal disease, creating a new challenge for education attempts (Atkins 2001, White, Hoy, and McCredie 2001). A minor skin irritation must now be made to signify potential organ failure.

But while there is acute and much-discussed sensitivity to the difficulties of giving a people who believe in sorcery a greater sense of scientific causality, the same slippage between assuming degrees of cultural difference and sameness evidenced by Margaret in her work operates at a more general level. Considering what health professionals tell each other to just ‘bear in mind,’ there are specific items that are widely-understood to be foreign to Aborigines (such as ‘germ theory’), others that might well be seen as foreign but are not, and again, acts of interpretation that are not fully perceived to be part of the cultural equation at all.

153 In this world of samenesses and distinctions, it is interesting to consider how contingent associations are made meaningful for those Aboriginal people who still live in storied, sentient countrysides, where rocks listen and it is a form of cleverness to associate ‘initially contrasting things’ (Povinelli 1993b: 683, cf. Povinelli 1995). As Basin Sansom describes it, ‘contingent associations are posted to link beings, places, manifestations, practices and the tracks that join the places of happenstance together. These associations of contingency have no formal necessity...The posted relationships are neither confirmed or even echoed in nature’ but are created in a narratology ‘that manifestly creates and celebrates immanence, establishes esoteric particularities of significance and above all, bespeaks the arbitrariness of the motivation of creation’ (Sansom 1995: 260-1). In such a world, the role of listening is a determinative one, as is the monitoring of irresponsible narratology. This could well be a description of public health concepts and how they come to be shared and upheld.
Firstly there's the way germs, statistical facts and other linkages (selectively) deemed to be core, have a truth independent of all conceptual choices. They simply need to be mapped (diagrammed or electronically demonstrated) to be believed. It is all a matter of rendition. Rayna Rapp puts it this way:

As many sociologists and historians of science and technology have pointed out, the objects of scientific and medical scrutiny must be rendered: they are rarely perceived or manipulated in their ‘natural’ state. It is their marking, scaling, and fixity as measurable, graphable images that enable them to be used for diagnosis, experimentation or intervention. The power of scientific images may, in large measure, be attributed to their mobile status: they condense and represent an argument about causality that can be moved around and deployed to normalize individual cases and theoretical points of view (Rapp 1997: 37).

But while prior knowledge of the subject matter to be translated is assumed to be culturally acquired, leaving professionals with the pragmatic difficulty of finding the right method for their representation, at another level, the referents to be translated are assumed to have a straightforward signification. The media that are used for the purposes of conveying the (foreign) information are similarly assumed to be culturally blank. Like whiteboards, posters, microscopic slides and the like are assumed to be neutral, or at least inherently transcultural surfaces upon which the more difficult concepts must be translated into comprehensible images and narratology. The receiver's interpretive possibilities may need to be restricted, in order to anchor the right meanings in place, and the images and texts presented may initially miss their mark and need to be revised—better translations may need to be found—but fundamentally, the surfaces upon which health facts are written or viewed are not problematic in themselves. These are universally effective pedagogical devices.

Then there are the perceptual and bodily practices that are being beckoned to by the translations which are intended to inspire an incorporated understanding of the requisites of being healthy. These again seem to be comprehended as having an on-again, off-again cultural overlay. Like the surfaces upon which educational content is portrayed, acts of perception and cognition are assumed to be universally the same. In fact, this rests at the core of the confident assumption that unhealthy behaviours derive in the first place from an ignorance that can be filled with well-put facts. Reifications abound. Not only is there an underlying assumption that Aboriginal people are a psychological facsimile of ourselves (Morris 1990: 85), but running through the quests to change behaviour are narrowed and simplified, even Aboriginalised, simulations of 'our' education. For instance, health educators systematically draw on a philosophic and sociological tradition which sees the body as a blank text to be marked, to in fact be constituted by, 'pedagogical, juridical, medical and economic texts, laws and practices' (Grosz 1994: 117). In other words, it is assumed that the pre-cultural body, anonymous and unadorned until socially imprinted, is universally able to acquire knowledge through childhood imbibing and ongoing tutelage. And under this general formula, the universally educatable subject can be addressed, can be hailed, through learning techniques and representational media that are likewise assumed to have standardised appeal: workshops and team learning exercises, texts with friendly visuals, posters drawn by Aboriginal
artists, data which are properly explained, germs which are exposed, cartoon diagrams which show how to implement. A universal ability to learn via a universal aesthetic and cognitive chemistry.

Recognising the culturally specific levels of abstraction already involved in representing the world in terms of rates, germs and hygiene habits, and thus the need to return the tears that cold statistics preclude, is one thing. What seems to remain available and yet unavailable to awareness, without suggesting non-deluded practice is either possible or necessary, is how dynamically scientised informatics interact with (western/professional) practices of self-fashioning. It seems that, accompanying the public health notion that cultural habits are learned, is a coinciding vision of socialisation as more or less a one hit wonder. In other words, within the sophisticated (culturally-specific) pre-diagnosis of how we come to know what we know, learning is at once credited as being something undertaken throughout one’s lifespan, only not as an intersubjective dynamic. By this I mean to refer to the combined activity of the peculiar and particular cultural mentality of the bureau-professional with the culturally available avalanche of information which sees us actively participating in the instantiation of health facts and relaying what we have learnt to each other (cf. Dumit 1997: 87-9, Dutton 1995, Lupton 1995, Turner 1996). A dynamic cultural saturation underlies our interactive relationship with the complex of medicalised and scientifically accredited information that is available at every possible scale, on matters of diet and lifestyle, disease prevention, death aversion and wellness maintenance. We constantly comb through a mass of information in the consumer world of factoids to make sense of and reinterpret ourselves and our worlds, feeding desires for beauty and bodily conquest and returning re-fashioned sensibilities for renewed scientific theorising, which in turn update previous ideas about what the modern organic being comprises, with it all feeding the iterative loops through which we are amending ourselves.\(^{154}\)

These more figurative dimensions of health information—the bottomless, subjective excesses contained within embodied uptakes of constantly updating and ever-available information—are not entirely fed or constituted by health theories and factual material. As many ethnographers who trace the social life of science in terms of how scientific and technological objects travel through the lifeworlds of ‘laypeople’ outside the laboratory are increasingly able to show, such knowledge forms are incorporated and reconfigured by subjects in unique and dynamic ways.\(^{155}\)

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154 Dumit puts it this way:
As objects of ‘human sciences’ we are the objects of facts. In this position, when facts address us by telling us about ourselves, we face the insistence of facts in a political or ethical way. On one hand, the insistence of facts catches us. We are caught in science in a series of different ways:
(1) via a need to respond to facts with facts, to refute science with more science. This is alongside attempts to ‘refuse the evidences’ of the way they are given to be seen (Rajchman: 79). We feel this insistence as a ‘but what if it is true that I am X?’
(2) via institutional demand. As bureaucracies, states and corporations legitimate and justify their decisions through scientific facts, we are compelled to respond in kind or accept their judgement.
(3) via our own truth to be made visible, our own body-symptoms verified as scientific traces. Here there is not a refutation of a claim, but an insistence of our own desire to be scientifically ‘confessed’. What I have called biotechnopower is a sense that the truth of our self, our nature, our sexuality, and our symptoms can be found in a test. (Dumit 2000: 37)

155 In addition to the collection by Downey and Dumit (Downey and Dumit 1997), see also articles in Lock et. al. Living and Working with the New Medical Technologies: Intersections of Inquiry (Lock, Young, and Cambrosio 2000), and Emily Martin’s earlier work, The Woman in the Body (1992 (1987)).
My point, and I think what bureau-professionals seem also to be saying, is that the bio-social subject of the consumerist west self-fashions from a scientistically-saturated perceptual orientation, which is not readily reducible to straight facts for ready translation nor to easy learning techniques for ready deployment. Or, to be far more precise, can be reduced to a task of translation, given the equally ready ease with which we reify our own as well as exotic epistemologies, reduce our own as well as other modes of being in the world, create some incommensurabilities and yet strangulate others.

This issue of assumed correspondences and equally assumed cultural specificities draws attention to the cultural intricacies of translation itself, a subject of remarkable philosophic inquiry in the hands of Walter Benjamin, who, in a translated and much quoted essay, made the point that translation as straight translation is impossible from the outset (Benjamin 1977). Drawn to a contemplation of the nature of translation by his own translation into German of the work by Baudelaire, Benjamin wrote of the life-after-life that translation breathes into a text. The translation is not so much a replica of a singular original as a perpetual renewal of interpretation and rendition that, akin with organic life forms, contains within itself the stamp of historical change, loss, maturation and an ongoing reinvention of connectivity with the present (see also Montgomery 2000). These interpretive movements through time occur not only in the language of the translator but in that of the original. In other words, language and meaning are not inert entities, frozen for all time, but are inherently motile and unstable, both as words (there being no pure equivalences between words in one language and words in another), and within the very sensibilities and denotations that individual language speakers bring to words. 'The task of the translator,' Benjamin wrote,

consists in finding that intended effect [Intention] upon the language into which he is translating which produces in it the echo of the original... to give ... a reverberation of the work in the alien one'.

(Benjamin 1977: 76)

Notions of fidelity are of no use here, for what is the translator being faithful to? 'In all language and linguistic creations there remains in addition to what can be conveyed something which cannot be communicated' (ibid: 79). Within THS public health practice, the 'something that cannot be communicated' is precisely what makes renditions of health information such a poor, pared down approximation of themselves, or in Benjamin's terms, a mere echo of the complexity and organically inhabited 'originals'.

To summarise: health professionals are very comfortable with the claim that scientific knowledge is socially produced. That is a cultural fact, like the health facts to be translated. Yet what this means exactly seems shrouded by a sociological knowing that is simultaneously a not knowing, where the core attributes that are understood as constituting our own socio-cultural uses and historical determinants of health knowledge are mapped onto equally abstracted fancies about what Aboriginal people lack and need to learn and see to be convinced, an issue I will confront again in remaining chapters.
Visceral statistics

Tracking the switches between an iconic sense of radically different sensory alterity and assumptions of cognitive sameness which buries Aboriginal and health professional existences alike within categories of absence and presence (as in they lack/we have germ theory, we lack/they have holism, we once lacked/they now lack hygienic living conditions), brings me full circle to the problem health professionals have diagnosed as a problem of information lack and gain. Where, in Malkki's world, it is 'physical, non-narrative evidence (which) assumes such astonishing power' in manifesting refugeeness (Malkki 1997a: 233), in THS, it is the pervasive narratives about what is wrong and what is to be done, made authoritative through symbolic calculations of the disembodied corporeality of Aboriginal disease patterns, which override the highly suspect physical testimony and lackluster uptake of health actions by Aboriginal people. Aboriginal people do not know how unwell they are in the silent period when there is still time to do something about their future acuity (if they did know, they would surely prevent their own disorders and live differently).

But in the face of this determined finding, very little is known about Aboriginal incorporation of statistics, which we might consider is a contradictory not knowing in the midst of the intense time, effort and resources expended on translation attempts, efforts which clearly presume a non-absorption of significant dimensions. And even this puzlement switches attention back to a speculation about Aboriginal absences, when it is the astonishing motivational power attributed to the statistical content that must be translated to achieve affective, metaphysical and life-organising effect which I am determined to be concerned with here. As I have argued, reducing a key public health task to one of information transfer presupposes the world of scientised facts, utterly contested and ever-emergent as they may be, to in fact constitute their own readily transferable and self-constituting capacity to engender behaviour change, if the right kind of media for transfer are availed. But what is this power, and why does it so well fire the bureau-professional imagination?

Let's assume that Aboriginal ill-health has been statistically encountered, at least by health professionals. In fact, let us see this statistical encounter not as an orderly transmission of facts in tutorial sessions but as an informational deluge, a swamping of data which points to its own infinity and scarcity at one and the same time, layer upon already-sedimented layer of already-analysed and over-documented material of which there is never enough and which is always uncertain. Picture how, within the health bureaucracy, and well beyond it, facts about the poor health of Aborigines come from random and arbitrary directions—dinner party conversations, breakthrough reports, corridor talk, policy documents, media articles, political speeches, academic papers or seminars, in aside descriptions of why a magnification of microscopic images is necessary, as mundane advice to use ti-tree oil or some other home remedy when visiting communities to avoid skin infections. Apologetic and condemnatory facts about Aboriginal decrepitude may erupt in the form of a scandalised re-recognition of racist
inequality with the latest groundbreaking release of health and well-being research. These are regularly recurring aghast re-discoveries which statistically prove that government efforts toward reconciliation are not working hard or fast enough, that the system continues to fail, that there are inequalities in resourcing and funding, that injustice still reigns.

In each case, the chaotic repetition and heterogeneous iteration and absorption of health facts, like all intersubjective moments, have their own specific density of encounter, and yet they retain a wider patterning, drawing on sombre registers of quantification (the particular constellations of phenomena that warrant measuring) and a culturally established 'trust in numbers' (Porter 1995). That is, each iteration contains within itself a deep cultural and historical underpinning which imbues statistical representations with the power of logic and comprehensibility, enabling not just the authoring of factual research within health but also its widespread acceptance as transparent representations of a more serious 'that' which it purports to explain.

The social life of health facts become denser still, if we add a more chrono-historical dimension to the laterally replicating movements, reference to which implies further 'fact-events' (Dumit 2000: 6). If I go back in time, I can trace the same concerns that Aboriginal people do not know the detail of their own pathology and/or what to do about it to the beginnings of colonial medicine in the Territory. Each historical moment would have its own structures of instantiation, which would need to be traced to honour the phenomenological dimension to health information multiplications or, if you will, to Tarde's contagions. Yet in the archival work undertaken for this ethnography, the core of the formulations (ideas about ill-health and social disorder and what to do about them) have shifted very little. Calls for community involvement and greater awareness, more research and better coordination abound and have done so for an extraordinarily long period. Amongst other effects, this contributes to participant feelings that things remain the same, despite the extensive re-analysis, renewed critique and ever widening sphere of interventions. In other words, despite the randomness of direction from which facts about indigenous morbidity, mortality and informational lack can come, it remains both and at the same time a chaotic informatics and a deterministic phenomenon, with a tremendous sameness characterising the history and style of our professional worry and diagnosis for urgent remedial action.

Take, for instance, a summary report depicting Aboriginal health twenty-five years ago:

The poor health of Aboriginal people is a matter for concern. ... comprehensive figures are not available, but it is known that in some areas Aboriginal babies die at a rate five times greater than other infants in the Australian population. ... Low incomes, poor housing conditions and lack of appropriate knowledge continue to affect the health of Aboriginal adults and children. (Australian Reference Service 1976: 11)

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156 In Joe Dumit's terms, 'a material history of modification... which in each situation effects one or more intercorporeal transformations' ('How to do things with science', p 6). See also Ian Hacking's account of the biographical depth of facts in his article 'How should we do the history of statistics?' (1991).
Or, for a moment of purely bureaucratic contemplation, consider the opening depictions by the Principal Education Adviser on Guidance and Special Education, Mr. Mark Smith, here summarising for the fledgling Executive of the newly independent Northern Territory Department of Education the policy implications of a harrowing report they'd received on the state of ‘physical handicapping and mental retardation within Aboriginal children in communities.’ The opening page of Smith’s summary paper begins with indicting extracts from the Commonwealth Department of Health’s 1977/78 Annual Report, setting the scene exactly as follows:

‘The more one studies the evolution of the Northern Territory, the more one is struck by its short period of development.’

‘The first Government Aboriginal school was not opened until 1951.’

‘...far too many Aboriginals live in grinding poverty with poor or non-existent water supplies and dangerous sanitary conditions. It is small wonder that babies brought up beneath the shelter of a piece of corrugated iron to fend off the blazing sun of the day and the sometimes sub-zero temperatures of the night have a high infant mortality rate, that intestinal parasites abound and infection is the commonest cause of morbidity and mortality.’

(Smith 1977: facing page)

Completing this facing page of alarming selections from the Commonwealth’s report, comes a searing portrait from a local, Dr Charles Gurd, then Director of Health in the Northern Territory:

Aboriginals live in an ‘Oliver Twist’ world of blinding poverty with 19th century demographic patterns of high birth rates, high population growth, high mortality rates both adult and infant, as well as high levels of illiteracy and unemployment and a high incidence of morbidity largely of an infectious nature. Trachoma, leprosy, tuberculosis, otitis media, bronchitis, pneumonia and gastro-enteritis are the order of the day. (Ibid.)

‘What more can the Department of Education do to face the situation?’ Smith asks his superior officers rhetorically, after carefully listing the extraordinary array of efforts already being taken. ‘The short answer is that on its own it can do little more than it is doing at present. ...[But] It may well be that in league with other Departmental agencies, greater success can be achieved than is being achieved now’ (Ibid.: 4). This promising coordination ‘would ultimately depend on the establishment of a departmental task force.’

Such a task force would have the task of:-
- establishing a data base through detailed research.
- establishing lines of interdepartmental communication.
- recommending more appropriate courses of action to departments and courses of action between departments.

(Smith 1977: 4, §4.1)
Fact impacts

If we imagine facts now as travelling and transmuting between encounters with interlocutors, as travelling like particles in heated animation, bombarding health professionals from indeterminate directions but operating according to a calculable set of rules\textsuperscript{157}; and further, if we imagine them as being able to be acted upon, heated up (deployed to create scandal\textsuperscript{158} or warmed to link to people's lives), or cooled down (the serious subject of serious epidemiological work, stripped of any post-modernist angst about the vagaries of the scientific method); then I am also now imagining health professionals as akin to the suspended particle, held in place by the equilibrium created by the bombardment. An equilibrium created by the fact that there seems to be no room to move (the ill health is so complex, and ultimately caused by unretractable colonisation itself) and yet still so very much to be done. Always there is scope for better management, more research, less turnover, more commitment, more resources, more action, more coordination, more planning and review, more learning, more dialogue, more partnerships, more data and more information transfer.

And while one can show how health facts travel within an unlimited series of intersubjective encounters beyond the health system, within everyday discussions and actions that are imbued with scientised knowledges, within THIS one must factor in the added virulence for health professionals of being closer to the epicentre of quotable epidemiological facts. As I have shown, health professionals inscribe wider informal and scientised knowledges about health, and about their own and Aboriginal cultural differences, in their daily workplace interactions. Wider environmental knowledges are refined and reaffirmed through their own skilled creation and selection of statistical data, which are in turn circulated within and without the bureaucracy (and other centres of authorising research) as expertly accredited information (cf. Boyer 2000).

The Brownian metaphor is mine, but it draws attention to the analyses health bureaucrats offer of their own inundation\textsuperscript{159}. Describing their own work, health professionals complain of feeling things are heating up, of the increasingly fast tempo (required) of their work, and of the rapidly accelerating overflow of things to know, read, keep abreast of, and participate in formulating. They pine for a time when the busyness stops and they can take stock and plan but they also say things are so dire, so critical, more and more action is required now. They strive for new approaches yet complain that nothing changes, things have been as they are for so long now, getting worse in fact, if indeed we turn to the facts. We've done/we're doing all we can, and yet, on

\textsuperscript{157} In addition to the required linkage to science as an authorising grounding for health facts (however indirectly stated), there are rules of fact talk, traced by Joseph Dumit in relation to the work of socio-linguist J.L. Austin (Dumit 2000) and also specified by Bruno Latour (Latour 1987). And, as I have shown, there is technical skill involved in producing factual reports (with rules specified in style guides for research reports); and ritual disclaimers/confessions concerning data inadequacy (its unrepresentativness, non-comprehensiveness, non-universality, poor-specificity, etc).

\textsuperscript{158} I am familiar with the rhetorical deployments of statistics having myself called upon epidemiologists and health researchers to deliver dramatic statistics to "heat up" a political speech or policy document.

\textsuperscript{159} There are other emic twists to Brownian metaphors in the use of chaos and fractals in financial analysis and management theory (cf. Chapter Two).
the horizon, around the corner, embedded within (select) program success stories and deliverable with (infinitely unachievable) perfection of the data, lies the good news that improvement is possible, if the more that can always be done could just be achieved with redirection of effort and the design of a better approach, or when it is achieved, sustained, and when it is sustained, updated, and when it is updated, made Aboriginal. Each time, the problem diagnosis breathes new life into the proliferating need to share information (coordinate) with each other and with the other.

And it is this avalanche of catastrophe and opportunity, rather than any breaching of the skin barrier, that animates health statistics and persuades health professionals that a key requirement of betterment is that Aboriginal people know how sick they are through an appropriately alarming rendition of the available statistics. On the one hand, 'we'll all be rooned', it is such a catastrophe; and on the other, let's get to it, there's still so much to be done.

The Department always seems to be putting out statistical documents and each time they say the same sort of thing. What's the point? I read them and I think 'ah yeah, so Aboriginal kids are fucked, they've got everything; and adults are fucked too, they've got everything as well. I guess it's great to know but there's never enough attention paid to how we're going to do it.

*Male remote area public health professional, Darwin Rural, since departed (Fieldnotes, August 1998)*

I am here attempting to invert the notion that it is Aboriginal disease—passive and silent—that predates professional alarm, to say we worry ourselves sick about their sickness via other means. To my question of what leads professionals to embrace health statistics as a tool for creating new alarm, I have suggested it is because alarm has transfixed them via other trajectories. To rephrase this, the health statistics which do not speak for themselves (requiring, as they do, interactive societal steepage and interpretive training to be rendered), alarm health professionals because of the alarming infinities which they abstractly index. The very possibility of proliferating statistical refinements in the name of change and cure creates a dynamic stasis which exhausts and compels its knowers toward more of the same, which must ever be measured (evaluated and reported in the hope it has indeed changed and cured) to reveal and revitalise its own momentum. Gap analyses index a recursive need for more research, action, intervention and data management. The well-designed pie-chart aimed at achieving the alchemy of Aboriginal transformation through apprehension is, in short, a culturally stylised abstraction of our own governing imperfections, and as we are moved to act or feel defeated, so shall they be.

Ordinarily, it is the virulence of facts that are the focus, with intense effort allocated to creating ever more persuasive forms with which to speed up their infectiousness within the Aboriginal population. Yet consideration of the physical velocity of their embodiment in the form of the worried health professional, who is held in suspended animation by the sheer force of the factual emissions they are in part responsible for generating, makes it possible to answer how, in situations of corporeal absence, the imaginary mirror of health information reflected back to Aborigines is attributed such motivational power. Facts about Aboriginal health have such
attraction as objects of knowledge. I am arguing, because of their visceral relation to our own bodies, their (poorly understood) salience for our own experiencing of the world. Our own fascination is held to fascinate others, and not for the first time.

Finally, what to make of the absence of sensory imaginings in discourses of disease? It is a logical omission really. A socio-logical explanation would point to the saturation training health professionals have received in the disembodied and barely sensuous tropes of intellectualist methods of accounting for the world, the Hegelian separation of ‘the intelligible from the sensible’ (Stoller 1989: 25), which medical practices are particularly and frequently chastised for. Then there is the enduring force of Cartesian dualism which, as Drew Leder argues, phenomenologically makes such good sense (Leder 1990). We tend to remember our bodies in moments of sickness and distress, physical dysfunction or dismemberment, or when certain functional needs (hunger, thirst, fatigue) assert themselves, when our hands shake as performance anxiety takes hold or when we accidentally slice a thumb to have thumb’s humble taken-for-granted use in our everyday repeatedly brought to a sensitive fore. These moments of dys-appearance, so-named to remind us that such physiological reawakenings are associated with troublesome states, are an attentional inversion of the alter state of the body, when it disappears from unfocused consciousness, when we comfortably inhabit ourselves without having our corporeality surfacing as explicit grounds for doing and being.

The two words, writes Leder, ‘dys-appearance and disappearance have an antonymic significance’

It is precisely because the normal and healthy body largely disappears that direct experience of the body is skewed towards times of dysfunction. These phenomenological modes are mutually implicatory, as can be seen in relation both to the body surface and the visceral depths. ... Self-forgetting is thus intrinsic to body function. (Ibid: 86)

It is this, he says, which explains the enduring significance of Cartesian dualism, for Cartesianism is a life-world epistemology, a mechanistic doctrine derived from an empirical real where it is precisely ‘because the body is a tacit and self-concealing structure (that) the rational mind can come to seem disembodied’ (Ibid). It is a metaphysics born from how we experience the world theorised as rules for how we should therefore live it if we are to be higher order thinkers. In like manner, it is precisely because of the associated tendency to re-member and thematize the body at times of error, disease and death, because of the assertive connectedness between corporeality and dysfunction, ‘the body is seen not only as Other to the self, but as a definite threat to knowledge, virtue, or continued life. Dualism thus reifies the absences and divergences that always haunt our embodied being’ (108).

160 Leder is quick to add that there are limitless pleasurable, painless or neutral means of returning to body awareness (‘I revel in the strength of my body during a race and the glow of well-being and relaxation that follows...I check a passing mirror to see how I look...In meditation I set aside times where I carefully follow my breath’ (p.91)) but argues these modalities do not exert the same strength of experiential demand and sensory intensity as dys-appearances, intensities which in turn have skewed our cultural reading of the body toward the negative.
Dualism carries within itself a phenomenology which is hidden by the nature of the subject matter theorised—much like the viscerality of Aboriginal health portraits whose trapped animation we grasp but obscure in our assumption that such portraits capture Aboriginal social relations, not our own animism, and thus have the edifying properties necessary for increasing their embodied awareness. The lack of speculation about the possible disruptive effects of chronic pain and episodic illness on how Aboriginals inhabit their days can likewise be explained as making good phenomenological sense. It is not just, or not only just, that there is a trained tendency within health sciences toward objectification. In the very experiencing of abstract thought and formulation, as the body disappears into its own functioning as exquisite intellectualist worry transcends one's own sense of physicality, questions of felt corporeality are instinctively put to one side. The very cultural and economic status of the bureau-professional also confers the affluent comfort of bodily absence, even when the problematic organic operations of black bodies are the subject at hand. A sleight of mind over matter. Moreover, in the humanist imagining that all people are not only psychological but also visceral carbon copies of ourselves, Aboriginal people are able to be portrayed as riddled with disease and yet as living and moving through the world with the same bodily dis/dysappearances as those traced by Leder. That is, the corporeality which is backgrounderd for the intellectualising professional, is likewise unthought as relevant for stories explaining either Aboriginal affliction or their perceived acquiescence to their own poor health. The middle class norm of the disappearing body, in concert with the mechanistic drive to express our personal and social distress in psychological and scientific modes, rather than somatically, is overlooked as itself belonging to a deeply encultured inhabiting of the body, with our silent body language becoming, in an equally silent process of unacknowledged projection, the viscerality of everyone (cf. Scheper-Hughes 1992: 185).

Pursuing Leder's challenge one step further, to see the 'meaningful phenomenological core' at the heart of enduring metaphysical ideas, to appreciate what significant desires a pervasive sets of beliefs offers, what domain of evidences it may be satisfying, I will offer a final set of reasons for the curious omission of Aboriginal illness from the repertoire of liberally decent vindicatory explanations for their ongoing decline and apparently refractory lifestyles. A crucial uniting feature of the major sympathetic explanatory schemas available (to summarise greatly):

- the burden of Aboriginal ill-health is a legacy of western colonisation;
- the pathology of Aboriginal lifestyles testify to current government failure;

is the tremendous scope made available for intervention.

If Aboriginal people act like they do because of what was done to them in the past, then the action this behooves is clear: we must refuse to be like the oppressors of yesteryear (by being more inclusive, more culturally sensitive, more willing to recognise, respect and even avail cultural difference\[16]) in order to 'turn things around.' If past and current projects have limited impact because of administrative failings—such as under-resourcing, lack of system coordination, too many projects underway at any one time, poor staff preparation, insufficient data, failure of political will, inadequate community consultation and involvement, or failure to transfer expertise to create sustainability—then solutions are at hand.
In contrast, an analysis which syllogistically suggests that a part cause of continued ill-health is the lethargy and hermeneutic disinterest caused by ill-health, its case or otherwise not being my concern, such an analysis is refused a place because it entails no clear place for bureaucratic intervention. Its endless circularity, in denying room for expertly-advised improvement, in precluding opportunity for government-led community self-development, simply cannot be admitted. As bureaucrats do indeed say when rejecting analyses which fail to resolve their depictions of trouble with recommended avenues for government action, 'it leaves no room to move.' Or perhaps that should be, people need good news, not bad.
Chapter Six

Encountering

Between the Pen
and the Paperwork
Chapter Six

Encountering

In earlier chapters I’ve shown how public health workers are assisted in interpreting their field experiences and their knowledge objects in particular, pre-scripted ways. Here I will extend this concern to look more closely at what people encounter when they move away from contexts of thinking about their activity and how it should proceed to the living out of their own platitudes in practice.

My interests here are deliberately person-centred. This is both to counteract a tendency I’ve thus far exhibited to speak about THS knowledge practices in the abstract without giving any sense of the particular personalities involved, and, paradoxically, to show how particularly personal encounters with Aboriginal people are quintessentially experienced in the form of abstract typifications. To explain this, let me draw on the words of Hugh Brody, an anthropologist whose descriptions of white administrators in the Eastern Arctic of thirty years ago make for painfully familiar reading:

On those rare occasions when Whites and Eskimos do interact socially and casually, on occasions that are not formal and ordered by the conventions of work situations, most Whites are excruciatingly embarrassed. They do not know how to talk or what manner to adopt; they become nervous and self-conscious, they suffer from a painful shame and confusion. They exaggerate their gestures and raise their voices, showing in every aspect of their social being an acute and pervasive unease. ... In such encounters, Whites show an urgent desire to please and to be sure that the Eskimo feels liked and respected.

(Brody 1975: 75-6)

Amongst Eskimos, Whites simplify their English, talk more loudly, and seem desperate to communicate without insult. Yet amongst each other,

Whites are often competitive over the Eskimo’s affection. They frequently denigrate colleagues by saying, ‘The Eskimos don’t like him, you know.’ And they are anxious to hear from any Eskimo speakers news of whom the Eskimos may have criticized among themselves. In a general, perhaps metaphysical sense, Whites are obsequious to Eskimos: what the Eskimo says and believes about them is a matter of great importance. (ibid.)

Brody suggests the acute embarrassment and deep interest in whom the Eskimos may privately censure stems from the inability of Whites to encounter the local people as discrete individuals. Deprived of the comforting protocols of a work context, the rare occasions of one-on-one informal mingling ‘off-duty’ leaves the struggling White in a situation of total unfamiliarity: ‘there is no formula for handling it, no procedure whereby communication can be established, and little or no exchange between the two personalities involved’ (ibid: 77). Instead, the Whites see the Eskimo only as an abstraction, a generalised and polarised ideal type, formed out of a composite of
truisms that are authorised by those with the ethnographic command of 'being there' experiences. Iconic stories about who Eskimos are, or what Brody calls stereotypes, circulate amongst northern Whites through anecdotal routes undisturbed by the rules of social scientific verification. Indeed, he argues, considered alongside more reliable accounts of traditional Eskimo life, they must be judged to be inaccurate. But the teller of such stories does not attempt to judge accuracy, he is not concerned with the possibilities or niceties of objective validity; he has not studied books or articles. The stories and views expressed by northern Whites are the product of a living social context; they inform and are informed by it...although the views and judgements of social scientists and other students may be at odds with that context. (ibid: 79). 162

'Tales from the field' are retold and reworked from the yarns of other administrator-sojourners who vie with one another in having the most arduous adventures, the most extreme climate exposures and the most sustained cultural contact with which to claim true authenticity for their thoroughly local depictions.

It is astonishing how accurate a portrait this also is of health personnel encountering Aborigines in the Northern Territory, thirty years later, a different mix of people, an ocean, an equator, and a continent away. As with Brody's northern Whites, a striking characteristic of public health professionals in THS is their propensity to narrate tales of adventure and near disaster about times spent working with Aboriginal people, often to the appreciative delight of their friends and colleagues. I recall one Environmental Health Officer in this light with particular fondness (and a memory of gripping stomach muscles from sustained bouts of laughter). Mal Guinness's ability to tell self-deprecating and uproariously hilarious field tales made him delicious company, and his well-timed insertions could easily knock a more serious discussion sideways. He once boasted to me, with happy irreverence, that working with Aborigines made 'scoring' with left-leaning female backpackers so much the easier, given the political credibility his exotic remote area work automatically bestowed. At the same time, what he had to say proved he had encounters with Aborigines to relate, his irresistible humour making the competitive subtext of his inter-collegial displays of knowledge all the more palatable.

But for me, Brody's suggestion that stereotypes are to blame for the depersonalising of Eskimo-White encounters, while believable, falls short of a full explanation. Just as I've had a problem with the explanatory capacity of 'complicity' as a means of comprehending the binds of institutional action, so too I stall at the suggestion that the exquisite self-consciousness of whites in relation to Aborigines comes about because their heads are filled with 'stereotypes.' Such a mentalist

162 In THS, as I've shown, the interplay between academic text and formative talk is far more fluid, and, in contrast to Brody's description, there is a great concern with policing each other's 'being there' accounts of Aborigines for prescribed forms of accuracy, in part by using accredited research as verification and even as prelude to embodied encounters. I have also argued that social scientific claims and methods are not only harnessed to the task of authenticating stories, but in large measure the style of argumentation within public health deploys a similar conceptual framing to those worked within the academy. However, this does not detract from the similarities between Brody's descriptions and my own findings.
explanation leaves the phenomenological grip of patterned behaviours unexplained. As with the concept of 'complicity', it is the hold of 'stereotypes' when people are comporting themselves in the most ethical ways they can muster which remains to be reckoned with. It is the persistence of abstractions when the THS-trained fieldworker's vocabulary has been repeatedly scoured for hints of ethnocentrism, which requires closer scrutiny. How can a 'stereotype', such an emotionless concept, account for the burning figure of embarrassment Brody's description so recognisably captures? How does it explain the despondency of health professionals who feel their own lack of enthusiasm and doubt makes their rather uninspiring and moralistic messages even more insipid? The misery of feeling oneself to be inept?

What I am trying to do is make the notion of stereotype, or cultural abstraction, more grounded by describing some of its (funny and painful, stressful and pleasurable) lived-in properties, by looking more closely at institutional players grappling with the very issue of being non-prejudicial in the context of their professional lives. It is in the attempt to rid oneself of racial and cultural stereotypes, I will argue, that we can locate the breeding ground for the not-knowing, for the acute self-consciousness and ultimate lack of empathy in encounters that Brody has depicted so accurately. It is the deep commitment to the notion that Aboriginal people are culturally different, and culturally different in specifically enigmatic and potentially disruptive ways, that interrupts the process of engagement whereby one experiencing subject meets another and tendrils are sent out to probe and soften the edges of strangeness, there to build rapport and solidarity.

A more general problem I have with theories explaining 'culture conflict' in rationalistic terms, whether it be with theories of 'empowered practical prejudice' (Hage 1998: 36), biological, economic or more broadly still, forms of post-colonial determinism, is their tendency to redirect anthropological attention away from an appreciation of the micro-practices in which racialised interactions are lived out, reproduced and even resignified. Let me hasten to add that the explanations of Australian race relations which develop meta-narratives on welfare colonialism, Aboriginal activism and government policy orientations (Collmann 1979, Morris 1988b, cf. Paine 1977) provide vivid accounts of structural conditions of inequality as these operate across a variety of contexts and periods in time, and vital details of the systems of authoritative knowledge through which Aboriginal people are and have been catalogued, re-placed and intimately governed. But, like analyses which take policy determinations as phenomena which explain the lifeworlds of bureaucrats, such broad brush accounts can omit consideration of how inter-subjective encounters possess within themselves effects of their own which abut and construct the super-structural forces tracked by many social scientists.

An issue I've been grappling with throughout this ethnography is the importance of complementing analyses of 'representation' and 'objectification' of 'the other' with a dual interest in questioning how such constructions and mystifications interpenetrate with formations of the self. And so, in this chapter, I want to explore what Brody only mentions in passing: the fact that intersubjective relations between administrators and indigenous people so often takes place in the form of
two groups of people performing an iconicised representation of themselves played to their projections of the other, reconstituting each other as strangers in the process. This is not a passive process which happens to hapless participants caught in discourses not of their own making. People actively produce, perform and affectively constitute ‘socially-constructed’ abstractions. It is not so much the existence of mystification but the power of mystifications, and people’s agency in maintaining them, that concerns me here. Similarly, my aim is not to list the conditions under which ‘true’ knowledge can be acquired when stripped of their pre-framed elements (cf. Goffman 1974) but to catch the coincidence in time between perception and performance, to give the fleshiness to what I prefer to see, in recognition of the levels of agency involved, as intersubjective acts of framing.

That the interactions between Aboriginal and non-Aboriginal people in practice are distorted by the prior representations each has of the other has been noted by other commentators. In an important essay on new forms of Indigenous media, Marcia Langton makes the critical point that

the creation of ‘Aboriginality’ is not a fixed thing. It is created from our histories. It arises from the intersubjectivity of black and white in a dialogue ... ‘Aboriginality’ only has meaning when understood in terms of intersubjectivity, when both the Aboriginal and non-Aboriginal are subjects, not objects. (Langton 1993: 31-2, original emphasis)

With intersubjectivity as her determined starting point, Langton nonetheless finds that ‘the most dense relationship is not between actual people but between white Australians and the symbols created by their predecessors. Australians do not know and relate to Aboriginal people’ (ibid: 33). In other words, when Langton analyses what she calls ‘the signifying practices in Australian racism’ (32), like Brody she finds non-Aborigines are relating to fetishised categories of indigenous identity which refer to something other than the lived referent of the ‘numbo jumbo’ descriptions. The world of Aboriginal sociality and politics as it is mundanely lived remains ‘distant and shadowy’ (ibid.). In Povinelli’s words, the Aborigine of the modern liberal imagination is ‘never wherever an actual Aboriginal subject stands and speaks’ (Povinelli 1999: 34).

Langton’s analysis implies, however, that both the misapprehended Aborigines and the Euro-Australians interpreting them are otherwise naturalistic. It is the ideological smokescreens through which the one views the other which fosters continual misreadings. Get the textual representations which precede encounters right, she seems to suggest, and whites will be able to relate to blacks, and vice versa, without distortion. It is an idea that is clearly shared by THS trainers, who also proceed from the premise that cultural opacity and miscommunication stem from stereotypes, and rationalistically insist that, with the right tutelage, interpersonal action can be freed from all prejudicing conceptual schemas. Yet, pursuing Langton’s insistence about the importance of inter-subjectivity further, I would argue that Aboriginal and non-Aboriginal people alike are called on to navigate and inhabit a complex set of sign functions as they represent themselves to each other. Further, I would add that these have been developed intertextually, or rather, more inextricably, through a fusion of organisational, textual and bodily experiences.
The dot points that distill field experiences within workplaces also precede field experiences and give them shape. The consciousness that is continuously informed by institutional texts and talk enters the field partially membrane by a priori representations.

As I will show, here and in the following chapter, as a natural outcome of the many talk-work encounters that take place within the bureaucracy, health professionals reproduce their corporate habits in the field. At the same time, their corporatised membrane is not a perfect shielding. Like the human body which responds to the environment at the same time that it sustains its original integrity, the health professional’s institutionalised sense of self is permeable. Health professionals embody their workplace knowledges, but they are also made vulnerable by their desire to form relationships, to collaborate and assist. In the field, the professional’s body is both distinctly feeling in itself, often suffused with feelings of trepidation and acute uncertainty, and also playing out an institutionalised representation of the self to an idealisation of the other who is in all likelihood reciprocating a distortion. But professionals are not just playing to an Aboriginal counterpart who is likewise also posturing. Professionals are interpreting what is thus co-performed through the conceptual apparatus and pre-layerings of cross-cultural education and liberalised goodwill. They are then, with renewed authority, reinscribing the edicts about self and other within workplace gatherings (which, as we have seen, have their own performative demands for progressive self-representation) on the basis of their filtered apprehensions. Thus the seemingly insular surfeit of bureaucratic knowledge which re-elaborates how Aboriginality is to be understood in order to facilitate intervention points is not created in ignorance of real people but is generated out of and continuously interpreted in and through embodied encounters. This is what gives the reductions of self and other into impersonal categories and prescriptions a deeply personalised and motile salience.

A THS person who engages with Aboriginal people in the name of public health approaches the task (and interprets the flow of events) from a particularised community development perspective. At the same time, this person is acted on and configured by the form of activity or practice itself. They act and are acted upon simultaneously. It literally feels transactional, as a reciprocal exchange between individuals and cultural domains, and is reported that way (cf. Stewart 1996: 37). People talk of having been transformed by their work with Aboriginal people, even as this work is one which reinstates cardinal categories of identity and difference. One officer described to me how his hostile attitude toward his late father, who had been an alcoholic, had changed after working with blackfellas:

Like, no matter what sort of an asshole someone is, you know, my Aboriginal mates will say ‘yeah, but he is my uncle’ or whatever. It’s like those relationships mean much more than what sort of a person they are. So I really thought about that and put a much bigger effort into building some sort of understanding between myself and my father. And I’m glad I did you-know, because the fucken old codger went and died on me. It’s like [another public health officer] once said to me, and it’s true, that people come up here thinking they’re gunna change blackfellas and they just end up changing themselves.

(fieldnotes, 18 August 1998)
I will return to these issues again in the conclusion of this thesis, because the business of interacting through and being contoured out of the murk of abstractions is a phenomenon I think likewise occurs when anthropologists treat bureaucrats as entities other than themselves. Anthropologists refuse to share company with those state officials they would prefer to despise, and at the same time retain a romanticised, and thoroughly bureaucratised, concept of the power of their corrective ethnographic texts to improve post-colonial interactions. I also want to make it clear at this point that while I focus in on individuals, I am trying very hard to highlight the *typical* features of such engagements, without apportioning blame or praise to any particular practitioners, as if there are better or worse ways of dealing with Aborigines. This is despite knowing (as Brody also notes) that such evaluative judgments would be of deep interest to professionals as they arrange each other into hierarchies of who relates best (Brody, *op.cit.*: 73, 76). For this reason I have chosen in this chapter to give a closely contextualised story of myself as a fieldworker beginning her work amongst fieldworkers, as it is a story of my anguish also. My hope is that by immersing myself sufficiently in the mire I can better resist the pernicious (anthropologically-informed) desire to depict the ethnographic anguish of non-anthropologists sardonically, as the disingenuous guilt of people denying their role in continuing relations of oppression. The more difficult task is to represent the clear desire of health professionals to work jointly with Aboriginal people in accordance with principles of social justice and mutual dialogue, collaboration and empowered action, to convey the dignity of this ambition, whilst showing its continuities with institutional principles. As Dan Miller puts it, 'the intention is to force the reader to acknowledge the poignancy of the articulation between the smallest and the most immense facets of social experience' (Miller 1995: 10).

To begin with, I recount particular aspects of my first fieldwork forays into the places health professionals regard as *their* field sites; the 'remote' communities. By focusing on some of our initial movements, at times almost in slow motion, I try to build a sense of how suffused with potential all encounters between strangers are and yet how all strangers are not experienced as equally strange. At the same time, I also try to show that, as we 'professionally loiter' and 'just go with the flow', the actions we are undertaking on behalf of, with and for Aboriginal people are enacted in the margins of community life. As this Chapter and the next will show, visiting health professionals maintain their distance from the shifting micro-politics of everyday Aboriginal life, despite their repeated desire to build close relationships, and despite the importance of these relationships in the interpersonal micro-politics of the professional's own everyday worlds. In conclusion, I consider how it is that professionals can be deeply and personally affected by their 'disimpersonalised'¹⁶³ encounters with Aboriginal people. Drawing all this out entails examining the interchange between bureaucratic practices, cultural identity and subjectivity and their discursive, affective and practical impacts.

¹⁶³ The term is derived from Uumi Willan's word 'dis impersonating' (1994: 195, fn.11), from a thoughtful article on how forms of anthropological theorising and the quest for greater meaning tend to overtake what being alive is actually like (see also Chapter Eight). I am attracted to it as an adjective for its injection of the agency involved in such *excorporating* removals.
The cursed store

'Racial difference is often experienced as a distancing without regard to spatial proximity'

(Martin Alcoff 1999: 22)

Last year, the year 2000 at the time, remote area nutritionist Marlena Thomas was out at Numbulwar, a coastal community of Nunggubuyu people at the mouth of the Rose River in Eastern Arnhem Land.

Figure 13: Numbulwar
Marlena had been back to Numbulwar to talk to the store manager, as usual a white man, about the opportunities for implementing a new Food and Nutrition Policy which the need to rebuild a new store had given rise to. By this time, the old store had been cursed and subsequently closed down for at least two years, its doors permanently padlocked, all its stock, perishable and other, lost to rats and tropical decay, the refrigeration machinery rendered idle while its internal components quietly gridlocked with rust.

Marlena was working to meet a central office policy requirement set for all remote area nutritionists that by the year 2000, 80% of all community stores will have formal Food and Nutrition Policies in place, with the full complement of stores to come after that (Stronach, Mills, and Ryan undated). Marlena held another opinion. She was more than prepared to work with the store managers on what constitutes community development and health maximising practices—quality fresh products, visibly displayed, a policy of employing local people to work in the store, eventually to manage it, and so on—but she resented that 80% target for its clear conflict with the community development maxim of working with community people at their pace and on their priorities. Like at Numbulwar, she told me, there was one week when the normal store manager was temporarily replaced by Sharon, the local book-keeper, who had inadvertently forgotten to order in lollies. The people spent their money on other things, and business didn’t go down at all. So now, the manager ‘forgets’ every week. ‘And that’s how local policies should go—they should develop at the grass roots, even if it is opportunistic like that.’ She goes on: ‘I don’t know why we don’t just restrict the availability of unhealthy food in the first instance. But then we would be accused of doing things for people, of being too paternalistic.’

‘80% of this, 60% of that, 20% of the other,’ she railed,

These figures are arbitrary, somebody dreamt them up, they are not real. It is disempowering for somebody like me—what if I can’t reach that percentage? The reasons why are not of concern—there is never any context asked for. All they would look at is what I did or didn’t ‘achieve’, with a very narrow interpretation of what is to be counted, versus what someone in some other region, Katherine region say, achieved. And what if I do run around shoving [store] policies together? What about the relationship to change on the ground, to people’s behaviours? There would only be interest in our ability to match the set percentage improvements. And if I don’t, then [I can] expect a questioning of the resources I’ve been allocated.

(Fieldnotes, 22 February 2000).

When I first traveled to Numbulwar with Marlena, nearly two years before in July 1998, she was still new to her job, and while she was not as fiery about the ineptitude of central office policies, she was already mounting a critique of administrative inefficiency. We had earlier met, accidentally, during the orientation program in March that same year, where I was participating as an ethnographer and she as someone genuinely new to Territory Health Services. By chance we sat at the same hexagon table on the first day and in the way of habitual returns to original seatings, we shared the same workshop sessions over a dense fortnight of condensations and generalities impressed upon us as necessary knowledge for being good operators. She told me
then that she had twelve communities to look after and that her time was totally at the dictates of the community, because the nutrition program worked in a community development mode. But that there was also a lot of paperwork and organising of travel, office politics to navigate, many workshops and meetings to attend.

It is ridiculous—I go out only one, if I'm lucky two days a week and the rest of the time is either organising to go out or dealing with office gumph. There are so many inefficiencies. I have to get travel forms signed by Darwin office—it is very inefficient. And then because the nutrition program connects with so many other programs you know, you spend a lot of time trying to connect with other staff who are also doing bush work and are in transit themselves and very hard to catch. We are like ships in the corridor, you just by-pass each other coming and going, so trying to coordinate community visits—well it's just crazy. It's just a crazy system.

(Fieldnotes, 26 March 1998)

Sure enough, on my first visit with Marlena in her workplace, it took an inordinate amount of time to organise another seat so I could accompany her to Numbulwar for a fieldtrip within a fieldtrip, on the same light aircraft she was booked on. There were repeat phone calls from the travel clerk with advice that I would have to pay for a separate charter. Hang on, no, won't have to do that, I could go on the doctor's plane for free. Nope, I could go with Marlena on her flight instead. Actually, I could go one way with Marlena but unfortunately there'd be no return, unless a seat became available 'on spec,' in which case I would have to pay several hundred dollars in cash and on the spot to the pilot .... No wait, good news, it's all sorted, I can go both ways, for free, no problems, I would just have to help Marlena pick up medicines and pathology items from the hospital before six in the morning to take along.

Then Marlena told me to fax the Numbulwar Council with an explanation of what I was doing (as an anthropologist shadowing a health professional). It took at least an hour to get the wording right. It took at least another to get the fax through as the number was wrong, and tracking down someone who had the updated version snowballed into time-consuming detective work as I found list after list in office after office with the incorrect number. Yet on hearing about how many times the travel clerk had rung me with changes to the travel plans and how long it had taken me to send the explanatory fax, Marlena was delighted: 'Day one and you are already in the picture! So now you know!' She kept returning to this in a light-hearted kind of way and told others, tongue-in-cheek, that I was really seeing things how they actually happened. During the day several things had gone wrong for her as well. When we had returned from lunch the telephones were not working. her A:drive on the computer had been broken since the morning and now her printer was refusing to respond so she couldn't print the education material she had been intending to take to Numbulwar.

Opposite Groote Eylandt and so on a flight path, mainland Numbulwar becomes extremely difficult to access by road in the monsoon season, as the way in becomes intermittently impassable with floods. We were at the tail end of the dry season, but most administrators still travel by air, for the speed and convenience. Charter flights to Numbulwar are augmented by a weekly barge service that brings in fresh provisions, not only for the store but to fill the orders of resident professionals, who receive freight and grocery allowances, together with travel subsidies, to ease the burden of their isolation.
It became a theme of its own, the business of ‘so now you know’ and proved critical to eventually being treated as part of the furniture by others regional officers, as someone to yarn with over a cup of tea in the staff room; or to get to do a minor but time-consuming errand or two. And it allowed me to keep company with health professionals when they travelled to communities, to sit out long journeys in four wheel drives and light aircraft and retreat to our sleeping quarters for post-mortems at night. The following comments were typical:

It takes a thousand hours to unpack the car because someone else has left their junk in it, and then put all your stuff in there ... like I sort of think, I can get away by such and such a time but it never, ever seems to happen.... Like you ring up the clinic and say 'what do you want?' and they say we want this or something so you go there and get that all on. So there's all these bits and pieces you've gotta do. It's tiring, and that's before you start.

_(Environmental health officer, September 1998)_

‘You cut all this stuff out in a consultation session when we are asked how things might improve. We say ‘better coordination’ or ‘more realistic deadlines’ instead,’ an office worker in the East Arnhem regional office tea room told me, pleased with my interest in how things really worked, one of many such discussions over the sheer logistical hassle of doing bush work that I was to have over the coming months of hanging out with regional officers.

For the first few weeks before our trip to Numbulwar, I had stayed in Nhulunbuy, the administrative service centre for the East Arnhem region, sleeping in the three bedroom government-issued weatherboard home of another health professional, who, being away on study leave, had made his rare house available to Cathy, a Murri woman from Queensland, and more temporarily still, to me. I'd also met Cathy previously on the orientation course, with her then only three weeks into her new job as Aboriginal Health Promotion Officer. It was hard for her, she'd said, being an Aboriginal woman, because people seemed to constantly forget all this was new to her too. Everyone speaks clear English where she comes from, and they're light skinned: here she is astonished and proud to see 'real Aborigines, real tribal people', not just the odd dark one in amongst 'the caramel' like back home but great numbers of 'really black' blackfellas. Even so, she wasn't enjoying her work very much, it wasn't what she had been expecting, which was itself hard to put into words, but she just sat in an office most of the time, and since it was only a temporary job until August anyway, she occupied herself with looking for other positions and writing emails home.

In my meantime, I occupied myself with inveigling my way into the lives of the other officer workers, in the small public health outpost of THS, discovering the rivalries and cleavages between those who saw themselves as doers and those who saw themselves as facilitators, with both claiming superior results when it came to dealing with Aboriginal people. Tucked away behind the Nhulunbuy shopping complex, or rather, to one side of the bitumen tarmac fronting the shopping complex, the THS East Arnhem Community Health Centre Building is a dowdy two-story affair, coated on the outside with khaki-brown pebble-crete, the signature adornment of 1970s institutional architecture. The public health entrance is obscure, accessed through a recess in an alleyway, not facing the street and not well-signposted, up one flight of narrow stairs, taking
two turns, with room only for one person at a time, to confront an equally narrow rectangular grid of newly painted rooms, pearl-gray walls, a bluer gray enamel gloss edging the windows and doors. The effect is that of insistent geometricity: rectilinear rooms housing office staff down one side of a narrow hallway, office equipment, the air-conditioning plant and a kitchenette down the other, harmonised by the gray tones of the wall paint and laminated office furniture.

First encounters

My first visit to Numbulwar with Marlena in 1998 was to be her first visit there too, and took place on the second day that I was shadowing her. Like me, she was nervous, and we were full of over-eager bonhomie with each other, our strain to create a more relaxed mode of relating manifesting itself in excessive solicitude. We kept making small jokes, a strategy for masking our initial unfamiliarity, our newness and lack of ease with each other. It was a strain that carried over into our talk with 'Willy', the Aboriginal Aged Care Worker who came to pick us up from the airstrip using the health centre vehicle. He took us straight to the Visiting Officer's Quarters (the 'Vee Oh Kew'), hopping out of the vehicle to help us to open the high wire gate with its stiff padlock, joking as he forcefully pried the old lock apart that 'it takes a man.' We all laughed then. Willy, Marlena and I, with feigned gusto, our eyes surreptitiously darting off one another in what I felt to be an awkwardly desperate yet curiously alienating desire for friendship.

Our gear safely stashed and locked away, we climbed back into the large white Toyota four-wheel-drive and Willy drove us the 30 metre short run to the health centre, a square demountable building, about a metre off the ground, painted brown on the outside, with orange linoleum floors and light blue walls on the inside. It backed out onto a stunning view of the Rose River, framed by sand dunes and a few coconuts, tamarind trees from the Macassans still growing along the edges.\[165\]

\[165\] The phenomenon of Visiting Officer's Quarters is discussed again in the following chapter. In brief, they are duplex buildings available within all the larger East Arnhem communities for visiting administrative personnel.

\[166\] Maccassin trepangers are said to have planted the tamarind trees centuries ago (see Macknight 1976).
When we arrived, the clinic was closed for lunch. The nurses who greeted us at the side door introduced us to the two Aboriginal Health Workers, who shook our hands softly and looked down at the floor. They seemed keen to get past our phatic conversational amits and back to their own talk and I was glad when we moved outside, where Peg Andelwar, the community health nurse who had been liaising with Marlena to arrange this visit, joined us on the back steps with cups of tea, and spoke to Marlena about the store that was to be built.

Peg was keen to take advantage of community development funding that Marlena had available for sponsoring Aboriginal nutrition workers in communities, and enthusiastically listed all the tasks such a worker might be given to do in Numbulwar. With a new store about to be built, it was an opportune time to work on what the store should stock, how healthy food could be identified with stickers and posters drawing attention to good food choices, how they could have monthly themes (‘food suitable for diabetics’), and so on. As the sea breeze caught the coconut palm leaves in lazy rustles, the two got into animated exchange. Peg seemed very task-focused and kept moving beyond generalities into next steps and tactics. She would take the idea of a nutrition worker to the community, that afternoon she said, dropping her tilted hand with its half-pointed finger into a midpoint in the air as she spoke. We could talk to everyone at the meeting she was having with important community people about an anti-smoking program. That would be a good time to mention what could be done at the new store.

Cups of tea over, Peg took us on a walking tour of some of the streets. The houses were mostly made of weatherboard, some on stilts, others on the ground with rusting wire grilles covering the windows. Many were built on plain sand dunes with scant vegetation, while others were fenced and had spots of greenery—clusters of lemon grass, an odd coconut palm or eucalyptus tree. We eventually came to a stop outside the house of an elderly man called Barradginn, the inaugural Chair of the Health Council Peg had recently formed. We waited some time, long enough for the back of my neck to get sorely sunburned, but when Barradginn came out he was a sight worth waiting for. An old man stepping slowly with a walking frame, white as white neck-length hair wafting outwards in all directions, snowy chin stubble against his chocolate brown skin, one mesmerising eye a milky blue-ice curve, sporting a crisp new navy anti-smoking tee-shirt, KICK BUTT! QUIT boldly-lettered in white against the dark blue. He said hello to Marlena and me but then we all said little else, shuffling our feet and grinning. Peg explained who we were—Marlena's the new nutrition lady, Tess is a student—and confirmed that he would be at the health council meeting schedule for 2.30pm that afternoon, when Marlena would talk to them about good tucker.

On the walk back to the V.O.Q, Peg explained that Barradginn was a diabetic who had lost the front halves of both feet from ulcers and now was keen to make sure that younger people knew what he hadn't as a young man. ‘He tells me that if he had only known then what he does now he would still have his feet.’ This led to a discussion of ways of communicating health information to Aboriginal people. Peg stressed the material needed to be visually literal; people needed to be able to relate
what they saw to what they were being told. The anti-smoking posters which have more graphic representations (sponges squeezing black liquid representing tar from lungs for example) were more effective, she thought. Marlena commented that she had heard these were not very effective, that they turned people off, they were too negative. I suggested maybe it was just eastern seaboard sensibilities being repelled, and Peg commented that either way, it did not represent a true assessment of what worked up here. Our traffic in semi-factual anecdotes, including odd snippets about research or evaluations prefaced by 'I’ve read...' or 'They say...', continued all the way to the V.O.Q., where we parted company, agreeing to reconvene before the community meeting later that day. It was public health shop talk: endlessly fact sharing, relaxed and easily informative. (The extent to which institutionally-generated health facts are implicated in our collective and personal identities is suggested by their presence in such idle conversations. We swap and reinvest simultaneously.)

All this time, it was never clear to me what had happened to the cursed store—the reason for us being there—and what was happening now. What was left in it? What did it look like inside? What were the clan disputes about? Why had it been cursed? Who by? What reparatory work was being done to lift the curse? Or, was it not like that at all? Had the curse been left unchallenged on the assumption that whitefellas would reverentially accept the finality of a permanently cursed store, unquestionable in its deeply mysterious voodoo secrecy, and perhaps offer to build a new one? The curse, it seemed, was also exerting its magic on our powers of speculation and curiosity. I didn’t dare ask questions when others seemed not to be asking any either.

Over our lunch of sandwiches made with the food we’d brought with us by plane, I asked Marlena what she knew about the sorcery business. She admitted not much. People tended to be close lipped and there was clearly still trouble about it, she said. The store had been placed under such a strong curse that all its contents had been left inside, with meat still in the freezers and no electricity. The Sport and Recreation Hall (an elaborate sounding title for an elongated tin shed) was being used as the temporary store and one of the reasons Peg had urged Marlena to come out was to get nutrition on the agenda while planning for the new store was in its infant stages. In community development terms, this would mean introducing a store policy at the community’s pace, when they were ready for it. Then Marlena casually noted that the former school principal had also recently been evicted from the community—something to do with running the school canteen as a general takeaway and refusing to pay royalties to the traditional owner when this was demanded. It seems the school had itself been temporarily cursed a month before, apparently a preventative move taken by the Numbulwar Council President to stop a stronger and more permanent malediction landing on every part of the school and the land it was on, down to its very foundations. A new takeaway was to be opened in a disused small tin building, another reason for the nutritionist’s timely visit to Numbulwar with her shadowing anthropologist.

A bush school has been shut down by a curse amid claims the traditional owners demanded a royalty payment from the school tuckshop. Education Minister Peter Adamson confirmed yesterday the Numbulwar school principal had been asked to leave following the row ...

The 182 pupils and 40 staff have refused to return to school since a 'temporary curse' was placed on the school by Numbulwar Council President Lindsay Joshua last Tuesday.

A council spokesman said Mr Joshua was forced to invoke the curse to prevent the region's most senior custodian, Albert Rami, from invoking an 'irreversible curse.' The spokesman said: 'Had the big curse been put in place, no one would have ever returned to the school and the whole place—including the foundations—would have to be ripped up and taken away.'

He said the dispute began when principal Ian Gurnier 'publicly defied' the authority of Mr Rami, the Numbirindi people's ceremonial leader...


I had not seen Marlena asking any questions of Peg, of the Health Workers or of Barradginn about the whole dramatic affair of curses and evictions and was struck then about the seeming lack of interest in what I 'knew' (anthropologically) to be consuming issues of momentous micro-political importance within Aboriginal communities (see Reid 1983). It appeared to contradict the anthropological material, such as it is, on the intensity of white interest in and eternal gossip about Aboriginal behaviour (cf. Koster 1977). It seemed to me that our gossip as health personnel, whilst centering on Aboriginal issues, was following different routes, related to problem diagnosis, program opportunities, and points for intervention. We were not trying to piece together coherent narratives about what might be going on for people on a day to day basis, as perhaps I might if I were being differently anthropological, when like as not I'd have nothing to do with health professionals. Rather, we simply accepted strange events as happenings taking place on the periphery of, and yet needing to be incorporated into, the routine of our own activities. It seemed I was learning the severe limits to bureaucratic inquisitiveness and simultaneously, the silence which reinstates the opacity of Aboriginal Culture.
We stopped our sandwich discussion when Peg arrived at the V.O.Q door to tell us that the afternoon's community meeting was cancelled: the people had apparently gone fishing, so we'd be having that meeting tomorrow morning. Instead, there was time now to go to the town council office to meet with the council members. This was going with the flow.

Again, we drove the very short 50 metre distance to the Council Office in the Health Centre Toyota to find Barradginn waiting outside. The council turned out to comprise Steve, the town clerk, who was not there yet—hence the wait outside. Steve is a brown skinned fellow short of stature and rangy build, dressed to look like an outback man: faded jeans, cowboy belt, red-checked shirt, rough speech, a strong smell of tobacco and a confident roll to his hips as he swung out of the vehicle. His girlfriend, Linda, an Aboriginal woman, slim in newer jeans and a bright yellow singlet, long black straight hair, climbed out as well. She was attending the meeting as the proposed new manager of the soon-to-be opened takeaway.

Steve was carrying two cans of coke in one broad hand. 'Health food drink!' he called out provocatively. Sharon, a white woman of fair skin and demure manner, also joined us. We had met Sharon on the road earlier in the morning, when we were looking at the gardens on our way to see Barradginn. She had made a charming and unusual sight ambling slowly in her smart gear—a straw hat with sky blue band, tailored navy trousers, matched by a camisole top with a pretty floral pattern and a blue over-shirt to protect her pale skin from the sun. On the morning's walk she'd had a romance novel tucked between the index and forefingers of a well-manicured slim hand, and a wicker basket tucked in the crook of the opposite arm. Like an English maiden on route to a picnic, she was a real contrast to ruffle-haired Peg, brown as a berry with her skin exposed in her simple mission dress, to Marlena and myself with our completely untailored, loose-fitting cheap Indian cotton gear, standing as our own attempts to keep the withering tropical heat at bay. Since Sharon is the accountant and does the orders for the store, Peg was keen to ensure Marlena and Sharon had a chance to meet.

The meeting could now begin.

When, after Peg's explanation for why Marlena was in town and what the newly formed Health Council was trying to achieve, Marlena finally spoke, I was surprised at the stiff public health formality of her words. She did not say what she wanted to see happen in the community as she

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167 Town Councils are accurately described by Myers as institutions created by government in the 1960s, to represent "local Aboriginal communities to the branches of the Australian government" (Myers, 1986b: 433). In addition, they were envisioned by white Australians "as the authoritative and legislative representative of those communities...expected to help preserve order and regulate community life, to decide on how to deploy community resources, and to decide on employment" (ibid, see also Collmann 1979). Today they form an important part of call for all visiting professionals to Aboriginal community, with these visits often becoming the authorising 'community consultations' that were discussed in Chapter Two.

168 The business of travelling in four wheel drives over walkable distances deserves brief comment. While I did not explore it separately as an issue during fieldwork, it was a notable phenomenon, and others have since confirmed it is commonplace. Several reasons have been suggested to me, including the need to keep much coveted vehicles secure from vandalism and stealing and at the same time ensuring that the vehicle is under constant use so that it cannot be claimed for hunting or visiting country by Aboriginal co-workers. I would want to explore the issues beyond such means-ends explanations, however. It is truly peculiar. Having to heave in and out of large vehicles for short distances makes driving more exhausting than walking, indicating more is symbolically at stake than the preservation of ownership.
had with me but rather said things like 'it's important that the knowledge that I have about food business doesn't just stay in Marlena's head—it has to be community knowledge, the ideas have to come from the community,' and she evaded Steve's insistent prompts for specific tasks and actions. 'Well, what would you like to do?' he kept asking. 'When do you want to do that?' he'd prompt. At other times he simply dug for straightforward information: 'we would like a list of the sorts of things we should or shouldn't be using in the takeaway—can you provide us with something like that?'

Linda, the takeaway-manager-to-be, had been collecting recipes she wanted to try out from New Idea magazines and now put a bundle of cut-outs on the table for us to see. She quietly murmured 'milkshakes.' Steve nodded proudly and declared his girl Linda had a lot of good ideas. Marlena hemmed non-committally. After the meeting, Marlena said she was horrified at the suggestion of milkshakes. The machinery would be difficult to clean, the milk would have to be kept cold, the whole thing could be a real bacterial nightmare. She wanted to encourage the use of pre-packaged fruit juices and diet drinks but hadn't wanted to quash Linda's tentative enthusiasm or directly contradict Steve in public. She would talk with Linda alone and separately some time later.

Barradginn had remained quiet through the whole discussion, except when Marlena had pulled out 'The Store Book' from her hessian bag, a spiral bound and laminated set of photographs of stores and food displays, which he asked for by silently holding out his hand. While the others continued to speak he flicked through it, stopping at a full-scale photograph of fruit, vegetables and nuts, a bountiful still-life of healthy foods, to suddenly comment forcefully, stabbing the picture: 'This one, this one we want at the store now! We need this kind of tucker!' The others looked up, nodded and smiled, and allowed their discussion to divert to the Store Book and whether Steve could keep the glossy copy in Barradginn's hands for the full Council members to look at. Marlena said she could leave it with him for a short while and could certainly get them a smaller black and white version (A4 rather than A3), but she would have to go back to the Nhulunbuy office to see whether she had a spare of the large colour version Steve insisted they wanted. Later she told me that this had been an acute moment for her. She had felt ridiculous showcasing something which had so clearly been developed as a community tool but which she had also been told cost a lot of money to print in its high gloss form and was in short supply. She was tempted to just leave it with them and deal with the bureaucratic consequences later but that might mean a whole lot of other things would become difficult.

Still nothing was said of the padlocked store. I daydreamt, idly speculating whether maggots would still be alive or would it now just be snakes, rats and spiders?

'Had it been difficult working out who to address in that meeting today?' I asked Marlena as I cooked us both a scrappy meal out of tinned lentils, an onion and a capsicum later that night. It was, she responded. She had not known quite who her audience was, but in the end stuck with pitching it to Barradginn, who after all, represented what she was there for. It was too early to be rushing into promises and Steve did not represent the full council. She had not been able to
talk to Linda yet, whom Peg had hinted might be silenced by Steve's domineering manner. She needed to build relationships first, and get a better feel for the power networks operating here. Mid-sentence, loud music erupted close to our enclosure. Looking out, I saw the silhouette of kids dancing under the glare of the clinic spotlight to the beat of disco music. Marlena turned up our television in response, but even shutting all the louvres only lightly muffled the thumping. One green and one blue light had been suspended from the wooden beams holding up the corrugated roof of the Fifty Cent Building outside, an unwalled pergola structure so-named for its octagonal shape. Drab during the day, with a grotty cement floor and dogs lolling in the shade, right now, the silhouetted dancers and disco lights transformed the pergola into a vivid scene of rhythmic limbs knocking pure auditory adrenaline out of a tinny ghetto blaster.

Attempting to sleep against the disco sounds, I laid awake thinking about the kids and their dancing, experiencing what I felt to be a moment of real ethnographic limitation. Was the disco a spontaneous thing, did it happen often, or was it perhaps part of a well-intentioned welfare program, 'a drug-free' recreational alternative to promote 'adolescent self esteem' or some such? More importantly, what stopped us from going over and joining in? What was so inhibiting that we kept ourselves so well insulated inside the walls of the Vee Oh Kew? I realised I knew very little about anything that was going on, either out there or in here. But I was also aware of being here as someone wanting to know the community as visiting health professionals come to know it, and that seemed to entail being someone who doesn't inquire into things, but just assimilates disruptions, in this case a noise nuisance of the first order, as things that just happen, unexplained and inexplicable. And certainly not an opportunity for laughing and forming relationships with the kids, being foolish, exposed to their teasing, drinking their poisonous brew of fermented cordial and dancing into the night. So it was, on the next day, every white we met commented on the disruptive noise, the poor class of music, their lack of sleep, how it goes on all the time, and then how the kids don't attend school, how they fall asleep at their desks, something needs to be done, but the parents don't or can't control them, the kids just run amok all night and then they are useless during the day. We casually kicked the complaints about at odd moments throughout the day. But nothing was said of its possible place in community life.

Oranges and apples

The cursed store was near our outdoor convening place for the delayed community meeting the next morning. We were meeting in the Fifty Cent Building, once again banal in the day time light, coke cans and other debris the only hint of its moonshine alter-life. The cursed store sat there, on the other side of the road, a corrugated iron building with padlocked doors and kerosene drums blocking the entrance way, brooding in the growing warmth of the sun.

Some people were already assembled, well in time, talking in huddles; others, including Barraelgin, did not come until Peg arrived in the Health Centre Toyota. The members, about twenty in all, were mainly either children, or old. People stood, or sat on the ground, some few were seated on the odd number of plastic stack chairs scattered about. No young adult men attended, and only three young women, all with new babies. Any particular kinship patterns were
not entirely clear, and again, not really a subject of any post-meeting commentary. Peg, Marlena and I sat outside the structure on the sand, out in the sun, concerned to leave shaded space for the meeting members proper.

We had no idea where all the young men are. Yet, if this were Wadeye (Port Keats) on the eastern side of the Territory coastline, metonym for dysfunctionality in bureaucratic assignations, we would know to think they were all on the grog somewhere, or sitting out gaol sentences, neglecting their young children and almost equally as young wives, leaving it all up to the tired old grandmothers. We would know to think that welfare interventions were critical for teaching the too-young mothers how to parent and for building the self-esteem of the young men, so that they can feel less estranged from their own culture and suicide less frequently. We would know the terms with which to categorise Wadeye as an artificial community, formed for administrative convenience by assembling seven (nine or fifteen, depending on who does the telling) warring tribes together.

And if I were with anyone but Marlena, the fact that the old people outnumbered the young here at our meeting in the Numbulwar Fifty Cent Building would be turned into a factual tidbit at a future meeting of public health officers as part of bureaucratic trade talk about communities and their problems. But this is something I know Marlena will try to resist. Unusually for a public health worker, she is determined, as far as she possibly can, to shed the values and synopses others would give to her as fixed truths about Aboriginal people and places. In fact, when I returned two and a half years later, when she was already one of the longer serving white professionals in the region, she told me the very term 'cross cultural' was misleading in its inherent homogenising.

This term 'cross cultural'—we're looking at Aboriginals, forget the 'cultural' business, we're dealing with Aboriginals. There's a woman who was employed here to do a job because, based on work she'd done with Eskimos [laughs]. Don't get me onto that! And she couldn't cope, yet she was employed because she had that 'cross cultural experience' and, I mean, yeah sure, I've worked in Africa, I've worked with Aboriginal people in Redfern, but hey, I'm working with Aboriginal people here and they're vastly different. As is every culture in different contexts. ... I mean let's just put everybody who's not Balanda into one cultural grouping!

(Transcript, 25 February 2000)

Marlena had told me she wanted to come to Numbulwar to form an independent relationship with the community. Reading her predecessor's case notes, she had been struck by the clear insistence that Numbulwar was unsuited for nutrition interventions, that its internal politics made it impossibly problematic for successful community development work. She thought she should see for herself, and not accept the harsh pre-judgements. Yet, despite this desire not to be swayed by the prescriptive verdicts of others, a desire I share, at the same time, whether we like it or not, we will both later speak with the authority of 'being there,' an authority few fieldworkers

169 'Balanda' is a generic term for non-Aboriginal in Yolngu Matha and has become a commonly used term in public service parlance as well.
(health professional or anthropological) can resist invoking in the face of gross misrepresentations from ignorant others which compel our corrections. Like it or not, we will absorb and contribute to the interlinked significations which animate classificatory discourses. And it will later be hard for others to distinguish what we ourselves have witnessed in communities from what we've been told at one or more remove from Aboriginal lives, in case notes, casual talk, meetings or workshops, where so much depends on adept participation in the circulation of fragments and ‘factoids’ (cf. Dumit 1997).

Back at the Fifty Cent Building, Peg introduced Marlena to the assembly (obscurely, they proceeded to call her Cathy after that\(^{170}\)) and went through her agenda. An item about a doctor visiting from Sydney in the last week of August to look at kids with puss-filled ears; news on attempts to recruit a male GP to work residentially in Numbulwar; and a forewarning of the planned visit of another THS public health officer, coming soon for a week to talk to anyone who wanted help quitting the smokes, prompting a conversation about how many smokes that disabled girl on respite care was getting from her carers. ‘Six packs a day Peg, maybe more!’ someone interjected.

‘And them people looking after her they bin gettin gunja wit that respite money.’

‘Yo.’

And then hilarity as one woman imitated the wheelchair-bound girl in question, miming her spastically throwing a rock at her imaginary carers in aggravation at being deprived of her smokes.

People chuckled, repeated the joke and the exaggeratedly disabled throwing actions, chortled some more, then the discussion petered out.

Peg waited for a time, building a little space of silence before saying, solemnly, ‘And now we got a big question.’

Pause.

‘What question Peg?’

“We need to talk about getting good food into this town, how to make Numbulwar a place for good tucker, good food for skinny kids, or diabetics, to make everyone strong and healthy. Marlena there is a nutritionist and she is here to help us. So can everyone just take some time now to think of ideas for what we might do and then let’s talk’

After another pause, one of the older women suggested that a list could be given to the workers at the Women’s Centre, so they could know what sort of things they could cook for the old people. The Women’s Centre need a list from Cathy, the old woman said, stroking Marlena’s arm. Peg was not impressed with the deviation, suggesting perhaps Marlena could stop by the Women’s Centre later, but for now, what about the store? But the men thwarted Peg’s countermove by listing the

\(^{170}\) Reading this chapter, ‘Marlena’ told me Cathy was the name of her predecessor nutritionist.
healthy sorts of things that could be included in the old people’s menus, chanting words like ‘rice, chicken,’ ‘oranges and apples,’ as if reciting rote instructions.

‘Not too greasy, not too dry’ interjected Billy.

‘Green beans, carrots, lettuce, milk. Apple, damper. That baby ... wad its name now? ... Farex!’ said Peter.

‘Orange, potato, turtle,’ chimed Billy.

‘Yeah, turtle! Those old people bin need that meat and fat too. Yeah.’

Barradginn mischievously said the old women could do that, all that cooking, the men could go fishing, and a woman from the left called out ‘We’re diabetic here because we bin eating food la shop.’

‘Yo.’

Peg seized the opportunity: the shop was back on the agenda. ‘The women’s centre feed old people and that’s good but we need to think about how to feed everyone now.’

Someone called out ‘in that shop too, that big one.’

Peg: ‘Well, I’ve been talking to Marlena about how to get good food in the shop and she says we can think about setting the rules and have a workshop with the store workers, and the people who prepare food, at a meeting in the first week of September. Do you want to talk about that now Marlena?’

This was Marlena’s opportunity to present herself. (She had been silent up to this point, as indeed, had I). Marlena pulled out the laminated Store Book from her hessian bag. Resting it on her lap, tucked under her chin so that it opened outward, she explained ‘this book gives us ideas about things we can do when there is a new shop. On this side are pictures and this side, this writing here (pointing) gives suggestions about what can be done and who you can talk to, because Numbulwar doesn’t have to try to do everything on its own, there is help.’

Barradginn again gestured for the book and Marlena once again handed it over.

Peg: ‘One idea I’m thinking of, you know how we weigh the babies at the clinic? We could do that at the Women’s Centre and talk to the young women about nutrition and how to give those babies good food so they’re not skinny kids, because to grow up strong for culture and community you have to be strong as a baby.’

She was interrupted by the advent of a truck loaded with boxes and men on the back tray, bringing stores up from the barge into the area dedicated for the resurrected takeaway. The men were noisy, shouting at each other as they scraped heavy crates off the back of the truck, their racket overcoming the rumble of the truck motor left on to power the cassette music blasting from the cabin. Peg looked up at me as I scribbled notes, laughed drolly, and rolled her eyes: “Tess, you getting all this down?”

When the noise abated and people were less distracted, Peg resumed.
'One idea that Barradginn came up with yesterday for putting good food in the shop—you wanna tell them?' (turning to Barradginn).

Barradginn leant forward from his plastic chair. 'What I bin decide when they shop here they tell you this bin kill you. My decision to make you understand. Monday you can get him onefella, not two, not three will kill him. Just Monday, Wednesday, Friday, one packet won't. What you people think about that?'

A discussion in the local language erupted. There seemed to be some antagonism toward Barradginn’s proposal, which was to restrict cigarette purchases to one packet every second day, from the people grouped at the left, particularly from one late arrival, an old man in cowboy gear, a smart blue akubra hat, riding boots. The talk went on, with participants overlapping each other all at once, and Peg sat, watching us, us watching her, bemused whites left behind in the language mire. Barradginn erupted in English, asserting the need to balance people’s individual autonomy with collective restriction:

'Health Government say, we have a list, just one smoke! else government close'm that shop. Policy him say—like that poster, all types of poisons, ten thousand different ones [referring to a federal government issued anti-smoking poster stating the different chemicals in tobacco]. When you decide I takem to council tomorrow. You decide, those smokes, they put him underground but his choose, but one packet, okay, go around ask, people don't give. This stuff kill you. That's true. I'm no liar—I'm dreamin' that. You can order yourself, you can kill yourself. You gotta make the rule. I take la meeting tomorrow. I smoke, I gotta but him myself.'

Another woman called Flora spoke up, responding to the muttering Barradginn’s outburst had provoked from people sitting to his left. 'All that country that talkin all around now we low,' she said, gesticulating with hands high and low, then drawing a diagram of bar graphs in the sand. She was talking about morbidity and mortality rates. 'They show us now at Darwin Hospital... (moved into language ...reverted to English) 'for your health and your body.'

Barradginn, pointing to Mario, a little boy who had just wandered into Flora’s lap, 'Like Mario now—we gotta look after him properly way. Language, ceremony, culture, language. Tobacco bin made in America and Norway', not Aboriginal culture, its white culture allway just kill you .... (moved back into language) .... Bob Marley culture not for us, not for Australian people....(language) ... Think about this Monday, Wednesday, Friday can buy smoke .... (language)'

During one of the pauses, Peg suggested quietly to Barradginn that perhaps people could come to him at night to give him their decisions. Barradginn nodded and said to the others, 'you come see me tonight.' Peg wanted to move the discussion on. 'If we talk about nutrition at the school, what should we say?' Flora: 'old ways, bush tucker, new ways, gotta be both ways.'

'Yo' confirmed the old women beside her.

171 The Norway reference seemed bizarre until I later went into the store and discovered stacks of sardine tins with "MADE IN NORWAY" in large red print on the packaging and boxes.
Peg—‘There’s money for health promotion, if there’s young people around who could do things, maybe plant foods in top camp or water cooler in the shop. Think about young people who would really like to do some work and have ideas. Let me know okay?’ Nods.

She closed the meeting then, and we all went our separate ways: Marlena and I to visit the Women’s Centre, Peg back to the clinic, others to whatever activities they had in line for themselves. Peg later joined us in our V.O.Q where Marlena and I had cups of tea and Peg devoured our leftover lentils, cold from the fridge. We discussed the problems of staffing the Women’s Centre now that federal funding had been removed and how the community would prefer a white coordinator who could more easily avoid the humbug of kinship obligations and just run the place fairly. How the task of community development is to try and give expert information and suggestions, but also to allow sufficient space for people to form their own decisions. (As another public health worker put it to me, describing the need to sit back whilst being an expert resource, ‘we need to be on tap, not on top.’) Adult education is a real challenge out here, we agree, and in our amplification of this as a problem, we necessarily left unspoken the unstable mimesis demonstrated in today’s public meeting, where the chants about apples and oranges and bar graphs in the sand revealed a clear bilingualism in health facts.

Interrupted again by the blaring sounds of the disco in the dark of the later night, I helped hurriedly slide the windows shut and draw the curtains, as Marlene turned on the ancient air-conditioner in the Numbulwar Visiting Officer’s Quarters, its overworked rumbling a poor match for the insistent midnight thump of the ghetto-blaster booming from the fifty-cent building outside. Falling asleep to the repeat refrain of ‘JO-OHN-N-N-EEY, JO-OHN-N-N-EEEY, JO-OHN-N-N-EEY,’ an exuberant love jingle broadcast to the sand dunes, mangroves and mud flats of the Rose River, I am left to mull over the power of our silences. Our lack of speculation in some areas, yet clear and unarguable causal analyses in others (as in, whites are needed to justify administer principles of access and equity where blacks cannot), both feed a lacuna which refuses to yield to straightforward co-presencing. To the extent that silence is its own form of tacit communication, our incuriosity preserves Aboriginal strangeness within the fastness of our own routines. Avoidance keeps our normative schemes for assessing Aboriginal life intact: our judgements remain inferential and culturally-bound, totalising whilst partial and abstracted. Our silences speak about what we do not need to know in order that we may already know Aboriginal communities, uninterrupted.

**Translating**

It is an arresting image, that of the cursed store, requiring our silence for its potency. That it does not speak back is ultimately reassuring, at once affirming the merits of our exclusion from the everyday of Aboriginal social relations and at the same time further exoticising and mystifying them. It is through not knowing the quotidian detail of Aboriginal life, through not knowing the mundane micro-politics of sorcery and such like, it is through distance that we can maintain
our claim to cultural sensitivity and retain a sense of the mysterious depths hovering on the edge of our knowing. We are not attempting to change any of that deeply cultural stuff, only the burdensome deficits that have accrued under western influence. So it is that we will later be able to explain the conflicts of 'implementation' (for Marlena and Peg, of inclusively developing a store policy, but it could be about anything really), using irrefutable vocabularies about the need for time and non-dictatorial processes. We will deploy equally powerful rational explanations of the distress, dependency and low self-esteem that colonialism has incurred and which therefore necessitates our greater enthusiasm and commitment, and we will be intensely interested in showing our knowing about Aboriginal people for these purposes—all without moving beyond an essential instrumentalism in our actual interactions and thinking.

Such are the community development efforts that are dot-pointed in activity reports as irrefutable actions that have been or are still needing to be taken with, on behalf of and for Aboriginal people. Consider, for example, one such implementation plan, produced to document the actions required in community stores south-west of Katherine (Timber Creek, Bulla, Kalkarindji Yarralin, and Lajamanu), in which we see in Key Focus Areas 1 and 3 the formulation of similar tasks to those being pursued by Peg and Marlena.

**KEY FOCUS AREA 1: COMMUNITY STORES**

<table>
<thead>
<tr>
<th>Implementation Plan</th>
<th>Approx Cost</th>
<th>Performance Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Store Workers Project</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Community meeting to inform that funding has been secured and to identify workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Commence training, development of resources and evaluation tools</td>
<td>$24244</td>
<td>- Workers identified</td>
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<tr>
<td>- Negotiate food supply modifications</td>
<td></td>
<td>- Completion of course modules</td>
</tr>
<tr>
<td>- Report completion and dissemination of results</td>
<td></td>
<td>- Attainment of competencies for Cert 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Number of nutrition promotion activities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Number of people participating in nutrition promotion activities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Core food consumption</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Vegetable and fruit consumption</td>
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</tbody>
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**KEY FOCUS AREA 3: COMMUNITY NUTRITION WORKERS**

<table>
<thead>
<tr>
<th>Implementation Plan</th>
<th>Approx Cost</th>
<th>Performance Indicators</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Meet with interested women to discuss job description, wages, hours, support structures/plan</td>
<td></td>
<td>- Meeting held</td>
</tr>
<tr>
<td>- Commence training</td>
<td></td>
<td>- Workers employed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Course modules completed</td>
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<tr>
<td></td>
<td></td>
<td>- Attainment of Cert 1 competencies</td>
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*Figure 16: Extracts from Nutrition Action Plan 2001 (THS, unpublished work document).*

It all seems so purposeful, so blithely confident, when actions are re-presented in a grid, when the experiential dimensions so casually omitted by the dot-points are able to belie the uncertain in-worldly circumstances of community work. But can dot-points and silences contain everything? What of the physical and emotional discomforts, embarrassments and distastes which cannot be immediately accommodated within such rational public health framings? Where do they go?
Suppression

In an essay critiquing the assumptions of a health promotion campaign run amongst the coal miners of the Hunter Valley, anthropologist Andrew Metcalfe has observed:

'while many social workers are aware of the various radical critiques of social work practice, much less reflexivity seems to be among workers pursuing preventive approaches to health issues, especially if the issues do not set off political warning bells by crossing lines of clear phenotypical or linguistic difference' (Metcalfe 1993: 31).

Drawing on Foucault, Metcalfe argues that public health promoters universalise a body that wants to be acted upon. In their concern to prevent the inequality of preventable chronic disease that seems so unfairly concentrated in lower socio-economic population groups, health promoters assume and project a subjectivity that covets a health-consciousness. Accordingly, the actions of coal miners who resist being turned into anxious calorie counters, who insist instead on their beer and fish and chips, are discounted as the deficit behaviours of those lacking the means and knowledge to behave differently.

Clearly there are many parallels in Aboriginal health, including a desire borne of unarguable goodwill and statistical compulsion to view recalcitrant black behaviours as symptomatic of an ongoing social injustice that can and must be remedied with renewed commitment to their 'development' and 'capacity-building'. But I want to take issue with Metcalfe's implication that the political beacon of 'clear phenotypical or linguistic differences' is sufficient to alert public health workers to the lived meanings of cultural alterity. Or that professional reflexivity is a guarantee of very much either. For while, as I have demonstrated, it is clearly the case that health professionals take great delight in showcasing their particular knowledge-mix of Aboriginal Culture, an explanation which suggests this is a politically sanitised response to the contemporary demand that obvious cultural differences are registered, whilst not exactly wrong, is certainly insufficient.

Unlike academic scholars who seem only recently to have discovered whiteness as a racialised embodiment that is carried in a whole suite of culturally-imbued habitual postures (in spoken and tacit interactions, gestures, listening habits and facial expressions, perceptual orientations, manner and stance), health professionals and liberal administrators in the Northern Territory have been race-conscious for quite some time. They have encountered and reaffirmed their self-consciousness about racial identity in a number of ways.

In previous chapters I discussed the confrontational exposures to racial awareness that take place in professional development and workplace gatherings, and how the need to appear as if one is always across of-the-moment issues, including information about Aboriginal people and places, is a constant performance pressure. I've added to this the objectivist accounts of racial difference which are indexed in census accounts of unemployment rates and job prospects, land and home ownership patterns, imprisonment and crime; in every epidemiological account of morbidity and mortality; in every general sociological account of the impact of liberal power on a subaltern
group: and in every meta-narrative on the history of colonisation in Australia. Amongst other effects, all these assert race as a key marker of material difference between white and black. They serve as objective reminders of the continued salience of racial phenomena in the everyday of post-colonial life. Thus, even whilst bureaucrats have attempted to erase ‘race’ from their texts by removing racialised terminology from their written and formal language, preferring such seemingly neutral demarcations as cross-cultural, urban and remote, Indigenous and non-Indigenous, it is nonetheless continually reasserted into the professional’s everyday consciousness as a matter of pressing concern (cf. Butler 1997, Cowlshaw 1998).

Beyond all this, there is also, I suggest, a consciousness of one’s white privilege which comes from a more fundamental experience of confronting the spectre of epidermal difference in the flesh. There is a subjective ‘more’ which continues to elude the semantic refinements of policy texts and is carried in the self-conscious bodies of white health professionals into the field. The disequilibrium many health professionals admit to feeling when they meet Aboriginal people can only be spoken in private, secure moments of shared reflection and mutual empathy. This is when friends might tell me how their sense of personal sanctity was threatened by a scab-encrusted-mutt-of-a-dog rubbing itself against their leg; and I in turn admit to not wanting to use the butter I’ve watched just such a dog licking. And they tell me how distressing it can be when they’re hailed in a town supermarket by someone they know out bush, now drunk and incoherent, aggressively demanding and threatening to the rest of the family. How secretly anxious one man felt when a black friend, his adopted brother, picked up his newborn white baby for kisses and cuddles and he inwardly thought ‘fu-u-ck’ but refused to let himself look alarmed as he watched that scabies-infested skin with its smattering of streptococcal sores rub up against the silken chubby smoothness of his most new and dear. Or how another wanted to give up after spending month after exhausting month consulting widely for a project, cajoling and pleading with Aboriginal people to contribute and participate, only to be belligerently told by the same mob she’d not consulted sufficiently and was simply out to exploit them. Or when fieldworkers try, day in, day out, to ‘get something up’ and it all comes to naught when their own energy wanes after too many setbacks; and how hard it is to proceed when they do not receive any facial or verbal cues from seemingly impassive black faces that any of what they do is even being heard, let alone understood. As this new public health doctor put it to me, as we left an evening workshop which focused on ways of improving Aboriginal adherence to treatment programs:

I’d say the most important issue is to have patients taking control of their own disease. In remote communities it is really difficult to have two-way full and frank conversations with Aboriginal people, even with the Aboriginal Health Worker there translating for you. .... Having the Health Worker there doesn’t really make a difference because you don’t know how much they understand of what you are saying and how well they are translating it. I find with the older patients, especially women, that they just sit there and don’t offer you anything at all, their facial expressions stay the same. Everything, they sit there and don’t look at you, they don’t say a single word and then they get up and go. It is disheartening.

(Fieldnotes, February 2000, Nhulunbuy)
In quiet and empathetic safety they speak of the strain of being eternally polite, of being 'beggars at the table of sociality' (Bauman 2001: 218), trying to be their most right-on selves by suppressing what they well know to be bourgeois anxieties and donning a more rugged attitude to bodily pollution and personal hygiene. There is a consuming strain to being diplomatic, standing in awe of Aboriginal colleagues operating in semi-professional positions as project and community liaison officers, hyper-privileging their contributions and presence and yet judging behind backs—unable to relax into the innocuous duplicity of their otherwise ordinary bad mouthing of each other because race, everywhere denied, exaggerates the interpersonal sensitivities. Double layers of self-awareness suspend naturalism in the vexed presence of race that has been signed as oppressed. Bureaucrats have had their habitual body postures thoroughly critiqued by well-meaning expositions on the nature of Indigenous cultural distinction and the extent of bureaucratic intrusion, with the result that their ordinary ways of being in the world, known to be arbitrary and power-laden, become forced and denatured. The frustration, the weariness and disappointment, the unease and repression, and most especially, the emotional and bodily disgust, these feelings may stem from stereotypes, but they are much more than that. As this public health worker put it to me:

There is a tension in withholding or suppressing your own cultural horror when you go out bush. I would come back just absolutely rooted. It is not only that you are trying to be careful about what you say and how you say it and what the messages need to be, which is fraught enough, but—You-know—I used to sit there and have to pretend that the horrible, scabby, mangy dog which was rubbering up against me as I was sitting down talking to people wasn't filling me with absolute horror while in the meantime being handed a baby that pukes up on you and you smile and pretend nothing is happening in the name of cultural sensitivity. If I was in my home I'd leap up and get something to clean the puke and I'd shoosh the dog away. So I'd come home, absolutely rooted and open the door to find Steve [her husband] had just let the kids go wild. There'd be toys in the hallway, dishes piled high in the sink, kids tired from being left to go feral and the only thing I could do was go straight to the sink and start cleaning because there was no way I could relax without some order. You come from chaos to chaos. Steve would say 'hey, you just walked past me! I'm here too you know!' and I'd say 'I can't stand this, I have to have some order!' We eventually got a cleaning lady and I know it sounds like a joke but I still say, to this day—although Steve says I'm exaggerating, I'm not—that that lady saved our marriage! She literally saved our marriage!

(Fieldnotes, 10 August 1998)

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172 This deserves brief comment. Bureaucrats who deal with Aboriginal issues fall over themselves to use the most correct terminology in relation to contemporary Aboriginal identity politics, for instance by insisting on the term 'Indigenous' as opposed to 'Aboriginal' as the latter is said to exclude Torres Strait Islanders. It is also very important never to imply that people who do not lead 'traditional' lifestyles (however ill-defined) are lesser indigenes. That upholding these constructs requires active self-policing and some degree of strain is revealed in the gleeful with which bureaucrats pronounce on himats that institutionally-placed Aborigines are scorned by the real blue-bloods of Aboriginality, remote community people. A recent rumour, circulated with a full relishing of its deliciousness, was that the Anicen Landers from Galwingu had taken to calling all sojourners "Baland" (meaning whitefellas), including the brown-skinneed Aborigines (alternatively, 'half-castes', 'coloured' 'yellow-fellas or 'urban blacks') who in public service agencies occupy key brokerage roles as liaison officers and coordinators. Even bureaucrats who treat the Aboriginal colleagues they work alongside in programs with extreme deference and respect revelled in the anecdote. It was a momentary release, in which the work of suspending a widely shared but rarely spoken distrust of people who powerfully claim Aboriginality but seem to lack customary knowledge, could itself be temporarily suspended.
Things might be thought but seldom, and if then, very guardedly said. As we have previously seen, if health professionals perchance do confess to feelings of frustration, to experiences of ‘cultural horror’ in one of their many group sessions, the work of being ordinary demands that these will be in the form of careful worded admissions which reinstate the extraordinariness and ultimate do-ability of their tasks. The more fraught dimensions of encountering will remain hidden from view. In fact, I have never heard such formulations as ‘I hate mangy dogs’ or ‘I can’t stand the constantly running snot in kids’ noses’ ever so straightforwardly put in any public forum. Instead, as part of learning about public health success stories, suitable approaches and thusly, the vocabulary for re-coding one’s own anxieties as those of an-other, participants would quickly learn, for instance, that curing dogs of their skin diseases, despite its essential irrelevance to human health outcomes (in that most canine diseases are canine specific), is a critically important community development task. Action is justified on the basis that dealing with dogs is an important entrée for forming relationships with Aboriginal people: if dog-loving community people can see us doing a good job with their animals, they will trust us to deal with the harder issues much closer to home ( Territory Health Services 1999a: 2.32-2.34).

Truly negative emotions and visceral responses are suppressed, because admitting them not only runs the risk of being seen as (peculiarly and idiosyncratically) unable, but makes people feel themselves to be as racist as everyone else, when a key aspect of the public health presence, purpose, pleasure and satisfaction, lies in its politically rehabilitative intent. But the point I really want to draw attention to is that this terribly private business of confessing discomfort is in fact a most social phenomenon, dependent as it is on the presence of like-minded witnesses (Biddle 1997: 227). For, by being unmentionable (that is, entirely admissible but only in hushed tones and amongst like-minded friends), the private admissions assume the veracity and authority of a confessed, secret truth and as such, serve to reinforce the shared sense of sacrifice and ordeal which bonds public health professionals together. It is also seductive for the ethnographer, beguiled by the seeming candour of the ‘I shouldn't be telling you this, but...’ confidences of their informants, to believe they are getting to deeper, more truthful levels of information, when all along these secrets are ever-present as public secrets, known, shared, and meant to be (m)uttered (cf. Foucault 1990, Taussig 1999). All along our getting through the façade with each other was meant to happen, an expected (ordinary) moment in the privately engineered creation of the extraordinariness of public health endeavours.

173 A public health rejoinder to this would be that dogs act as vectors for human contagion, particularly by eating and stepping in human faeces and then playing with children and walking through food preparation areas (see, for example, Pluleros, Rainow, and Torzillo 1983: 9).

174 I am aware that this concentration on professional perceptions suggests many questions regarding how Aboriginal people might be interpreting these same encounters. Whilst it does not affect the relevant points here, were the context to be widened, the fact that often Aboriginal people are extremely sensitive to and aware of the suppressed reactions of disgust would need to be explored. For more thorough accounts of Aboriginal reactions to bureaucrats and their meetings, how officials might be mocked but can’t be avoided, see in particular the ethnographic work of Toni Bauman (2001), Gillian Cowlishaw (1999) and Basil Sansom (1980, 1995).
Let's not delude ourselves about this matter of the private admission and its powers of disruption in the public formulations of public health either. Should there be some kind of emotional outpouring, a collective display of people's felt senses of risk and jeopardy in, say, a sensitively handled debriefing workshop, the task of the facilitator will be to help people 'get through it', to manage 'the situation' so participants can reproduce themselves in future helping acts. The group may well join in narrating tales of hardship, invited to attend to these aspects of their experiences by the compulsion introduced by other revelations, taking up each other's affective responses and reciprocating in kind as mutually supporting professionals are wont to do. But the expectation that these discordant tales will be restored to their proper order, with whiteboard and butcher's paper strategies developed for 'dealing with it', would frame the confessional space. Participant flailings would be quickly insulated by a rush of constructive analysis and the inclusive, supportive pressure of co-participants intent on smoothing 'challenges' into a restorative practice. Everyday and ordinary bureaucratic referencing would be restored with collectively formed narrative unifications which contract the possibilities of critically reflexive interpretation into remedies for future approaches. The work of talk would retranslate uncontrollable feelings into therapeutic dot-points recommending the need for better preparation of fieldworkers, more organised opportunities for networking, more time for project development and consultation, more institutional support for public health approaches as a whole, greater coordination of effort and so on.

There is a gap, a space created by the non-correspondence between the (countable, measurable, knowable) Aboriginal object of bureaucratic talk and rules for comportment, and the particular, subjective, lived-in experiences of racial ('cross-cultural') encounters, which health professionals are left to fill. And fill it they will. Professionals compensate for what they struggle to comprehend with all kinds of theories and explanations, silence included, juxtaposing personal viewpoints with accounts from others, anthropologised texts and bureaucratic guidelines, health facts and colonial histories—all of which point to continued Aboriginal misery and white responsibility as indisputable realities. Aborigines as individuals become impossible to meet except through acts of framing (cf. Wikan 1994: 185). An interactively re-sewn patchwork of rumour and depiction reproduces institutional knowledges over and over again in the very presence of the people about whom so much is said. The racialised awareness which is played out in (agonising) micro-interactions in the field, in mixtures of preconceived and improvised contacts, then feed back into and are integral to subsequent reflections and professional theorising, the sermonising caption points which attempt to redress future attempts to create good relationships and meaningful dialogue without burning oneself out in the process. Perception, which cannot be seen as racialised, has been affected. And interpretation is inseparable from perception.
Incorporating the corporation

But while this might explain how the organisation gets to repeat itself, it still leaves the phenomenological power of simplifications only partly explained, a problem I’ve repeatedly encountered throughout this ethnography. The obsequiousness noted by Brody and others, which makes public health workers so desperate to please and be liked, is a complex mix of colonial guilt and psychic projection. It is also, to put it very simply, an outcome of institutional embodiment, of our incorporation of the corporation. When whites are operating in Aboriginal communities, or in workplace events featuring Aboriginal participants, they are excessively keen to create a connection, ‘a relationship’, an ambition about which they are placed on an almost permanent workplace trial. To achieve the desired relating, they have first to overcome the wariness that all strangers or slightly acquainted people potentially exhibit with one another. More excruciatingly, the grounds for automatic connectedness, which visually and behaviourally similar people can at least take for granted, must also be transcended. This is not just about phenotypical sameness, which an earlier generation of race theorists, concerned to undercut racism by expounding the virtues of liberal tolerance with the argument that difference is really only skin deep, would have had it (eg. Benedict 1983). There is a microlanguage of racialised inhabitation that is expressed in gesture and glance and which is conveyed from body to like body in little acts of mundane and unverbalised mutual comprehension, which, whilst not static or unbending, at the very least facilitates companionable dialogue (cf. Goffman 1971).

In contrast, even when public health professionals visit Aborigines within spaces that are tacitly designated for joint use, their encounters are marked by a simultaneous withholding and involving, a vigilant watchfulness and excessively careful control of bodily movements. Further, professionals have to reach through the shrouded models of Aboriginality they’re mentally carrying, construed out of all that they’ve seen, heard and learnt before, to construct dialogue. But professionals are not simply interacting from the subjective state of their habitual white selves to the Aborigines they form out of ‘stories created by former colonists’ (Langton 1993: 33), which might be fraught enough. This is my point. When professionals and their Aboriginal interlocutors meet, it is as prefigured bodied: their own, and the ones they are employed to help change. They meet Aboriginal people not as they might meet each other, as strangers who are each individually potentially friend or foe, but as generic representatives of programs and advocates of approaches which aim to reorder the most intimate aspects of Aboriginal life, lives which are themselves understood as collective types. But while public health goes to the heart of how people eat, sleep, prepare food, keep house, rear children, have sex, order their time and finance their activities, the community development task is one which, like efforts to create


176 As this business of typing of Aboriginal people seems to me a well-understood phenomenon, (see, in addition to Langton, Anderson 1985., Johnson 1987, Lattas 1993, Morris 1988b, Myers 1994, and Povinelli 1999, Povinelli 2001), I make short work of it here, concentrating instead on how individual professionals participate in transforming themselves into collective types. Having said that, it remains a significant sub-theme of this present work that bureau-professionals project onto and measure Aboriginal communities against an idealised and iconicised model of their own best and worst features.

At the same time, and this really is a rarely spoken secret, it is the very modes of cultural alterity, the everyday rituals and mundane concerns through which individual people distinctively re-form their sociality, it is these ways of being in the world which administrators 'know' (without knowing) to be faulty and try to change by modeling (and carefully describing) supposedly neutral health-conferring practices. The extent of artifice in the process, even in situations of clear mismatch in the ways health professionals and their Aboriginal interlocutors perform the desired forms of 'community-led' diagnosis and response (one group calling out oranges and apples while the other maneuvers to have the look of community action around the development of a store policy), can not be explicitly recognised. When you stop to think about it, being able to screen so much of one's surrounds out of perceptual registration whilst being so intensely engaged is itself a magnificent testimony to bureaucratic learning and inhabitation (a point I will elaborate in remaining chapters).

Professionals are speaking and perceiving as representatives of their profession and administration, as well-intentioned community developers, and as ideal ambassadors of their culture's abstracted knowledge about health and well-being. On this last point it's as well to recall that public health professionals are relatively young (some are in their fortieths, most in their thirties and twenties), they represent both genders and alternate sexualities, are middle class and, by definition, tertiary-educated and fully employed. They are usually of sound health and lack intrusive physical disabilities. Some have taken lessons in Aboriginal languages—most commonly Yolgnu Matha for the East Arnhem region and less frequently, Kriol in the Katherine district and Murrin-Patha south-west of Darwin. Their jobs as Aboriginal-oriented public health personnel means that all have been exposed to various Aboriginal Studies texts and courses, either as part of their own further studies (towards a Masters degree in Public Health or Community Studies) or through the medley of formal and informal professional tutelage opportunities ongoing throughout the organisational network. Yet few public health professionals, if any, spend time in Aboriginal homes (see Chapter Seven), and their discipline-specific specialisms (as environmental health officers or people concerned with ear and eye health) will determine which Aboriginal people and organisational representatives they are most likely to come into contact with.

When extending the help of THS beyond the office workplace, professionals experience bush travel and anxiety-laden community work as nervous outsiders, intent on mobilising the efforts of Aboriginal inhabitants who often do not seem to want to know. Few claim any ability to fully overcome the self-conscious outsiderness that being positioned to wield interventions and give advice confers. Despite the bravado anecdotes within officer to officer talk-work that impute easy command of relaxed relating, few seem able to slipstream through the two-way power relations embedded within being dependent on Aboriginal consent and participation for their relating (cf. Bauman 2001).
Doing 'bush work' is considered both an honour and a burden. Symptomatic of this is the syndrome of 'burn out', an explanation for high turnover which has produced its own genre of prescriptive literature (eg. Edelwich 1980, Jones 1982, Maslach 1982). In practitioner formulations about the hazards of fieldwork, one hears many reasons for burn out, canvassing the shortcomings of government policies, the insufficient fieldworker support and preparation, the poor accommodation facilities, the family toll of time consuming travel, the physical arduousness, the high cost of remote area living, the isolation and lack of entertainment, and even, in the words of one fieldworker, the dominance of married couples in regional townships.  

Interestingly enough, there is seldom any analysis of where the ever-changing job holders go to next (equipped with the cultural capital of remote area experience), nor whether the rapid movement is restricted to regional office holders alone. High turnover is simply proof of burn-out. Yet out of my own fieldwork samples over four years from mid 1997, the following pertains:

- Of the sixteen different representatives of senior management that I originally negotiated my fieldwork access with and through, only one is in her original position. Of the remainder, four remain within THS in new positions (promotions or transfers at level to higher profile work roles) while the rest have moved entirely, either to other government departments (seven) or to new work overseas or interstate (four).

- All six trainers who facilitated our orientation session at various times have since moved.

- Of the sixteen fellow orientation participants, only one, Marlena, is in her original position.

- Finally, excluding officers from the Katherine region, of the twenty-three regionally based public health professionals I spent lengths of time with in the regional offices, nine are in their original positions, seven have moved to other positions within THS, one has retired, and the remainder have moved on.

In fact, out of the above small and of course, barely representative, bureaucratic slice, while the regional public health officers certainly faced turnover, they have also retained the greatest number of people in their original positions. Yet the mythologies surrounding high turnover as a symptom of burn out as an issue unique to work with Aboriginal people remains. It is another instance where empiricism is not necessary for proof of the truth. The equation: remote area work is beset with difficulties which leads to burn out which leads to high turnover, has solidified into a commonplace, while the high turnover that is equally, if not more true of senior management positions, on the rare occasions it is noted, is ascribed to the corporatised need for managers to constantly replenish their careers, to refuse stagnation by reinventing themselves on a frequent basis.

177 Some have additionally mentioned to me similar advantages to those which can emerge in workshops where there has been a tactical insistence on defining positives as a soliciting prelude for system reinforcing criticisms, such as 'freedom from central office interference', or 'the opportunity to travel to remote and beautiful parts of ourback Australia.' Less frequently, some will mention the financial benefits to earning wages where there is little to spend it on. Mal Guinnes, for example, told me his first investment property was purchased out of travel allowances and an unknown number of free flights interstate out of frequent flyer award points. These last types of admission were only ever made to me by people who had worked in regional office positions for some time and had since moved to completely different areas.

178 I am excluding the Katherine regional office from this assessment as my time there fell during the aftermath of widespread and catastrophic flooding in the area (February 1998) and the staffing, being an emergency situation, was aberrantly inflated.
I do not wish to make more of this than it deserves. Turnover is high everywhere in the Northern Territory, which is of course an impediment for all sorts of actions. My point is simply that there is a pattern to the talk about bush work, of which the romance of burnout is but a small part. Professionals greet their projections of Aboriginal neediness with models of themselves as iconic helpers, the repudiating converse of a silent alter-ego, the iconic oppressor. The contradictions are inscribed within the professional’s very body. Silence is a measure of a deep phenomenological inhabitation of institutionalised knowing even when, because encountering feels so subjectively demanding, it seems as if relationships really are being built, as if transformational encounters really are being had. In the field public health professionals act out an impersonalised representation of themselves. They become their program in spite of themselves. The mimesis which is ordinarily attributed to Aboriginal people as they are enjoined to create management regimes with an indigenous patina (Merlan 1998: 150) is not one-sided. Professionals introduce themselves to Aboriginal people in terms of their name, position title and program purpose. They retreat into their directives and project plans, but not without complaint. They mime the organisation in their representation of it. It is not only that Indigenous people seem so deeply mysterious which makes professionals in communities hyper-aware of being in a community, even when the encounters they have are so partial and disjointed. It is also, to paraphrase Taussig (1987: 78), our personality absence even in their presence, our deeply personal maintenance of impersonality, that wears people down.

**Conclusion**

In this chapter I have confronted a seeming paradox. Why, given the intense interest in Aborigines and in learning techniques for inducing cross-cultural familiarity and comfort, and the equally intense desire to have cross-cultural experiences worth the telling, is there relatively little effort to seek to know Aboriginal people in their lived actuality?

In remote area public health work, and not just in Numbulwar, I have argued there are odd silences and a curious lack of speculation about the everyday concerns of Aboriginal people. It would be less surprising to find an abundance of rumours and speculations about Aboriginal affairs in efforts to supplement what is not fully known with the fragments of second-guessing and supposition. After all, as I have shown, that is what so much administrative work is based on. But while there is endless interest in pin-pointing Aboriginal issues and cultural habits definitively, in no way does this entail crossing the borders that anthropologists bodily wade through. This is a key methodological difference between anthropological and health fieldworkers and important to note in the context of the very many overlaps between anthropology and things bureaucratic I have been at pains to identify throughout this ethnography. Although even here I feel compelled to quickly add a caution to this romantic image of the rapport-striking anthropologist and recall the haunting words of W.E.H. Stanner, who, reflecting on what earlier generations of anthropologists urgently and earnestly involved themselves in, similarly shows how an early distancing kept anthropologists aloof from everyday life as lived:
The young anthropologist ... wanted to understand what was then being called the 'functional system' of social life, how institutions help to maintain each other and contribute to the whole process of human society. We were beginning to speak about 'social structure', the system of enduring relations between persons and groups. Where a society was breaking down (as with most Aborigines) we thought it our task to salvage pieces of information and from them try to work out the traditional forms of social life. Such were my interests. They help to explain why an interest in 'living actuality' scarcely extended to the actual life conditions of the Aborigines, and why in referring to those conditions I did so in a sidelong way and in anything but a firebrand's words. But it will hardly do as sufficient explanation. What was missing was the idea that a major development of Aboriginal economic, social and political life from its broken down state was a thinkable possibility. How slow this idea came to all of us.

(Stanner 1968: 203-4, emphases added)

Our silences also implicate the extent to which we embody our institutionalised selves in an abstracted and idealised form of its own. We are clearly able to fall into relaxed communion with fellow institutional actors at a moment's notice, and in fact routinely seek one another out for this purpose, a pattern I observed repeatedly with other government personnel on subsequent field trips. Yet when health professionals encounter Aboriginal people, they move from normative inhabitation to a racialised self-awareness which manifests itself as hyper-civil behaviour. We are politely, reverentially silent in the face of sorcery, passively acquiescent when alien vocabularies lock us out, deferent and watchful in the presence of community people, using as non-threatening a language and bodily posture as we can possibly muster, committing to little except possible return visits and the supply of information materials—and later call it 'going at the community's pace'.

In this excruciating context of 'disimpersonation', it is useful to consider the advice from a document produced by the Department of Local Government (augmenting insistences given in many other settings, such as orientation sessions) to assist officials who may be visiting an Aboriginal community for the first time. Following such cautions that answers to questions should not be rushed as 'English is probably not their first language,' readers are reminded that 'As always you are representing 'the government' and will be assessed in that context. What you say is what 'the government' says' (Department of Local Government 2001: 2, citation marks in original). As such injunctions demonstrate, health professionals occupy a position already marked by the inscriptions of others. At one level, they are positioned as translators of an abstracted health knowledge which, whilst having a poor relation to the complexity of influences through which westerners actually attain good health, is nonetheless meant to represent the core items necessary for good health. Health professionals attempt to 'share' this iconic information in the most helpful yet non-prescriptive manner possible. As we have seen, caringly produced graphics and guidelines assist them in their task. But on another level, they must beware of exercising any false authoritativeness, as they cannot prescribe any actions of commitments without the intensive consultative and authorising footwork I've depicted throughout this ethnography.
These are the more obvious ways in which professionals clearly take their corporate settings with them into remote geographic settings. But I have also argued there is an institutionally authorised perceptual registry operating in black-white public health relations which powerfully determines individual experiences. Wanting desperately to help, but pre-prepared in an insistent tutelage on the depths of Aboriginal mystery, saturated with factual accounts which make sense of everything they may witness and hear through the benignly explaining rationalities of colonial depletion and economic scarcity, and repeatedly alerted to the possibility of upsetting Aboriginal sensibilities through a wrong look/dress or too-directly stated a dialogue, health professionals cannot help but stumble through interactions hamstrung by 'cultural sensitivity.' They become excessively self-aware, left not so much 'with no formula for handling [their unfamiliarity], no procedure whereby communication can be established' (Brody 1975: 77), but with an excess of procedures and formulaic rules, a surfeit which ensures their interactions are always already mediated by existing genres of interpretation. The incorporated self enters into a pre-problematised encounter with a projected other, against which the incorporated self is defined and returned back to interventionary logic. Creating stability in dot-pointed representations out of this truly fraught yet magnificently human context of service delivery is, I believe and will now go on to argue, a testimony in own right to the power of bureaucratic magic.
Part Three

Inhabiting the State

Between the Pen and the Paperwork
Chapter Seven

Mastery

Between the Pen and the Paperwork
Chapter Seven

Mastery

Emma
The fact that the Army worked out so well, it pulls you up short on assumptions. Because for me that would have been too full on, too regimented, all the things that everyone tells you not to be.

Tess
Where do you think those philosophies, of not being too regimented, not being this or that, blah-de-blah, come from?

Emma
I dunno. I think that's probably a response a bit to the way things used to be, I mean everyone's who, that whole mission sort of culture, what's happening now is I think almost a reaction to that.

Tess
Like a backlash?

Emma
Yeah. Almost. It's sort of like nobody likes to be connected to that, but there are some people who were brought up with that [mission culture] and who view that quite happily, you-know-what-I-mean? I think I sort of agree with the philosophy behind community development but a lot of it is really airy-fairy and based on talk and talk and talk, and people get damned well sick of all the talking.

Theoretically yeah, it's the best approach, but then in reality there's only so much talking. I'm talking in communities, they just want things to be improved, they don't necessarily want to talk about how. Because a lot of Aboriginal people say to me when I ask 'is that okay? is that okay if I do that?' they just look at me like I'm a maniac and just say 'yeah, of course you can do such and such,' you-know-what-I-mean? That real sense of [exaggerated hand wringing, hunched shoulders, fawning expression] 'is this the right thing to do?' The feedback that you often get from Aboriginal people that you are asking for advice is almost like, 'what are you? what planet are you from?' Because I dunno, somebody's figured that out for the communities as well. Communities didn't say 'well I think the community development approach is the most appropriate.'

Just because it looks good on paper doesn't mean it works well in reality and I think we're so concerned about what looks good on paper, that well, we'll have to keep on doing that because, even if there's something else that looks like it would work better, but if it looks politically incorrect, well we'll never be doing it. I'm not saying I believe this to be true but we are so hung up on what is the right thing to do and all the process and all that, that we'll keep on doing it even if it doesn't work.

*Environmental Health Officer, outside Katherine—still with THS but no longer in the Katherine region (Transcript, 7 September 1998)*
Working it out

The fabulations of community development—alternately manifest as Capacity Building, Partnership, Resilience Strengthening, Health Promotion, Information Sharing and Dialogue, Community Control, Advocacy—make their presence felt in a number of ways. Among the people charged with turning rhetoric into practice, as the saying goes, are many who question the self-evidentiary nature of community development categories, turning instead to other forms of logical interpretation. Perhaps Aboriginal people got used to being ordered into line missionary style. What if being bossed around is more in tune with their real cultural preferences? Could it be that the uncertainty and respectful deference that health professionals exhibit confuses more than it involves? Maybe a dictatorial approach that just gets in and does is what Aborigines require from their helpers? How would anyone know when the unarguable community development logics are so confounding?

Public health field officers are left with many puzzles to solve. Sometimes they pursue the conundrums to the outer-limits of derivation: if self-determination isn't the answer, maybe assimilation is. Maybe that's all we've been up to anyway, disguising our take-over bid in the language of participation and community control. Maybe that's why the Army were so successful in doing the work of environmental health officers, getting community people involved in the building of houses and latrines, the last people you'd expect to have what it takes to build cross cultural rapport with Aborigines. Someone else says blackfellas work well with the Army because they make a lot of sense in terms of Indigenous culture: all male groups with clear rituals and ceremonies, men who muck about in the scrub and affect to live off the land.

An imagined convergence is thus created out of what is imagined about an Aboriginal imagining of the Army, with the Army itself standing as a mix of the assumed and the known. A junction is formed where what is taken to be institutionalised Aboriginal and what is taken to be institutionalised white society are seen as merging in unexpectedly fruitful ways. The Army were organised, they came in with resources, not just words. They delivered results. And they had energy enough to mobilise a listless group of people who otherwise seem to have so little to do.

179 The Australian Defence Forces (ADF) were engaged as project managers in 1997/98 to undertake a number of infrastructure development and upgrade projects in Northern Territory communities. The assignment of ADF personnel to the task was at the behest of the current Australian Prime Minister, John Howard, as an overt media strategy to create the look of decisive new policy action. That is, the announcement that the Federal Government would 'Send In The Army' to do major capital works obscured from public view the fact that the ADF would simply operate as a commissioned group of project managers, like so many before and after them, implementing a wider, already funded and underway program which pre-existed the dramatic announcement. This wider program is managed through the Aboriginal and Torres Strait Islander Commission and is known as the National Aboriginal Health Strategy Environmental Health Program (NAHS-EHP). It was first begun by the Keating administration as a pilot called the Health Infrastructure Priority Projects (HIPP) in 1994. NAHS-EHP is a long term and expensive investment program which contracts engineering and architectural firms (including, by Prime Ministerial decree, the ADF), as project managers to install or sub-contract the installation of infrastructure and capital works in Aboriginal communities. The most visible and costly components of the program concern roads and housing, although power supply, sewage treatment facilities, drinking water and irrigation works are also installed. We first encountered this program in Chapter Three, with the case study of the micro-politics of coordination involving Gwen Marks and the THS NAHS-EHP Infrastructure Support Steering Committee.
I seriously thought the Bulla project [with the Army] was going to be this huge big disaster. I seriously thought that. I could just see all these Army people walking around. But the community people seemed to—they loved the Army, they seriously did. They just thought it was great. All the young boys thought it was great, it was like a big hero thing, people were really interested, this exciting thing. The Army put on morning teas and stuff, the Army came with money and provisions you-know-what—I mean, to entice people to get involved, and they were enthusiastic themselves, and there was enough people to make it an Event. I think that's what's lacking out there. That's why they get so much into those evangelists and stuff when they go out there, it's an Event!

I think that often people don't realise how bored some of the people are. They're just sort of young adults—when there isn't that much traditional connection, like there's connection to the family and stuff that live out there but you know they're just hanging out there, people are bored, really bored. So yeah, things went okay. It went fine. But of course when the Army left it all fell to bits, you know, and that's what we always said [would happen].

To start with when it was thick with Army guys, wow! Energy, energy! People got into it. But I think that's what I find hard, when you go into communities, that is what is often required. It's not your knowledge and it's not your skills, it's your motivation and just that energy and you know, like, that's what people—they know a lot of [public health] things, they've heard a lot of these things before. You ask them, they can tell you. They don't say 'oh I never heard that before!' People can say to you exactly what they should be doing.

But it's to do with motivation and energy. It's like going anywhere, I suppose. It's like going to some poor, bloody economically depressed suburb where everyone's on the dole and no-one's motivated, you know, everyone's got all the time in the world. And it doesn't just come down to money either, it comes down to motivation and that's what is not there. And you know, sometimes you see, where there is one person there who is generating some interest and motivation and what does happen then, because they fire [up] other people—but then as soon as that person goes, things start to disintegrate. Which is a sad thing I suppose. And that's why it's hard going out, because if you go out to a community and you're feeling tired, depressed, or anything—like you could just be feeling down, then in some ways, there's probably not much point in you actually even being there, because you know you're missing out on the essential ingredient. Your energy.

(Transcript, 7 September 1998)
Judging by the look

Sitting at the Formica table in the Visiting Officer’s Quarters (V.O.Q.) at Galwinku (see Figures 17-19), Ivan Church and I are crunching on breakfast muesli, our travel bags ready-packed for a later return by light aircraft to Nhulunbuy.

Galwinku is our last stop on this mid build-up, sticky September tour. We’ve been judging by the look of things the quality of the houses and waste disposal systems, shower recesses and hydraulic pumps in remote communities, remote to us, near and close to our others, installed to make Aboriginal people more healthy. (There is another story waiting to be told about all this, the contradictory processes of creating amenity for Aboriginal people (cf. Ross 1987), the spatial aesthetics involved in assessing things by their look, and the battle with unexpected outcomes installing our best efforts creates, but that’s for another time).¹⁸¹

It is hard, this looking at, draining and disconcerting simultaneously. Draining first. Flying in unpressurised, turbulent aircraft, fighting motion sickness and dehydration, bouncing for long hours in hard four-wheel drives, the tropical heat melting our sun-creamed faces into rivulets of oil. And disconcerting. Witnessing and participating in encounters with Aboriginal people, not so much harsh collisions as gently fumbled, carefully enunciated glidings past, such relief when it’s over.

It is striking that in these years of alternately shadowing public health field officers as they move in and out of communities and immersing myself in more office-based administrative events, we’ve never once set foot inside a lived-in house.¹⁸²

¹⁸⁰ ‘The build-up’ is a local term for the humid but rain-free period before the monsoons start, when hot air and moisture from across the equator replace the cooler southern winds of previous months. See Introduction, n.6.
¹⁸¹ I hope in future work to focus more clearly on the rich and contradictory detail of the kinds of transformations that are being aspired to here. Both housing and nutrition projects (Chapter Six) specifically enact the ‘burden of history’ outlined in Chapter Three. In brief, bureau-professionals operate with a densely theorised sense that Aboriginal people are now having to become sophisticated consumers and householders in ways which sorely conflict with their traditions, but which are vitally necessary for any health and economic improvements. As a legacy of their colonisation, they are now facing unavoidable choices from ‘outside’ (foods, alcohol, drugs, other lifestyle commodities, communication technologies, transport systems, health systems, etc.) which they lack the consumer knowledge and historical experience to know either how to handle or how to enlist to realise their own local goals. To bend our cultural impositions to their own ends they will need our help. But first, and as a matter of human rights and social justice, they must have the same commodities and amenities we have, a demand which many differently situated players, white and black, will variously echo. Needless to say, a lot of conceptual and emotional self-work is demanded of bureau-professionals when they confront the unanticipated configurations and upsets of their equalisation and self-revitalisation projects. At a minimum, institutional actors are challenged to reinterpret these as illogical aberrations or deformations from a truer ideal. In this they are aided, but never completely or adequately, by their projections of models of cultural commensurability, which are visualised in plans for such things as store policies, market gardens, community rental collections, and Indigenous building, repair and maintenance teams. Even when the attempted ventriloquism ‘works’, it can do so unexpectedly, to the point where Aboriginal representatives demand bulk-standard public housing based on unbending models of functionality in order to get maximum mileage out of available monies, creating a problem for helpers who want to consult and design around individual household and special cultural preferences. The real, tangible, intractable problems of putting these tangled improvement efforts into place and making them self-sustainable (if mimicked in narrowly recognisable if fluidly changing terms) provide all the necessary ingredients (conundrums, resistances, improvements, failures) to self-sustain the magic of intervention.
¹⁸² Community based nurses are of course more likely to enter houses to see patients but the nature of this interaction would need further study. See, for early depictions, Brandl (1981) and Riddett (1987). Again, this is a key methodological difference between how anthropologists and bureau-professionals attempt to get to know their others.
Only, and then only occasionally, the shells of houses, too new to be occupied yet, or, much more rarely still, temporarily evacuated for the purpose of an environmental health inspection or a scabies expulsion. Sometimes we might stand outside a lived-in house, and sing out the name of who we want to see, this being the culturally respectful way to attract attention, they say. But we never go inside—commune in silence, trace sorcery intrigues, join in the teasing and the fighting or gamble over a game of cards—despite injunctions to take the time to build relationships. The interaction with community-based people is usually on-the-job, and while it is hard to maintain a work/not work distinction in the increasingly mobile lifestyles of Aboriginal and professionals alike, the general practice that professionals keep themselves clear of non-institutional Aboriginal people at night and off-duty remains more or less the case.

If it is true to say, Merleau-Ponty-style, 'that all human experience emerges from the facticity of being a body-in-the-world' (Casey 1993: 46), then the places we inhabit—our land rovers, the V.O.Q., the council chambers, the health centre, the school, the nurse’s home for dinner should we command sufficient status—these places that bear our presence also mark our absence from the Aboriginal lives we fear might also be refusing us. In the softening, excusing logics of public health, I am told the reason we don’t cross into houses is because Aboriginal people are already so prevailed upon. It would be a gross insult to extend our intrusion into that last bastion of privacy, the domestic abode.

Describing her fieldwork practices, an environmental health officer put it to me this way:

I haven’t ever; I would almost always be separate from the community. Like, I might go out for a walk or something in the afternoon but I wouldn’t go out at night. And yeah, you know, so whoever is in the health flat, have a bit of chat [with them], but I don’t [go out]... Because most people seem to do it that way, most people do think really differently about coming out to a community. Like, there’s no sort of socialising at nighttime or anything. Maybe sometimes some people do but I’ve never really felt comfortable enough to do that. And also the intrusion factor. I sometimes think, like I think public health is a good thing and everything, but sometimes you think, I imagine myself in that situation and someone like health promotion coming in and coming over to your house and [saying] ‘come on, clean up, do this, and feed your kids this. DON’T SMOKE! you-know-what-I-mean? It’s like, imagine if in the evenings you go over and be there all the time! We wouldn’t put up with it [if this happened to us].

*(Environmental Health Officer, Katherine Region, since moved on, Transcript, September 1998)*

Instead, a situation of mutual avoidance has become commonplace. During the day, visiting professionals will follow a polarised route, from our temporary home base at the Vee-Oh-Kew, to the Town Council Office buildings and thence to the Health Centre, with the possibility of a rendezvous with the Aboriginal employee we’ve come to see, if they show, in some previously agreed open space. At night, in the V.O.Q, the few intrusions from Aboriginal people cadging money or smokes or wanting to sell art and craft products are hurriedly dealt with. Instead
the television and other outsiders form company, while writing fieldnotes for future file records restores a sense of interventionist progress and helps keep loneliness at bay.\(^{183}\) Judging by the look of things, our interactions with Aborigines 'out bush' reduce to this: walking lines between the outposts of the THS and wider Northern Territory and Federal Government-funded organisational empire. By the look of things, the trusting guarded relationships that are so insistently dotted as key to effecting change in the Aboriginal domain are experienced by very few, our well-worn tracks an equally insistent delimiting of the borders being maintained in this supposedly more direct encounter and experience zone of 'the field.'

As with ethnographic note-taking itself, such routine acts of separation bring order and facticity, a promise of progress and exit points, in an otherwise entropic and destabilising environment of continuing ill-health and apparent community indifference to the aetiological causes of indigenous malaise. In the way that bureaucratic actions create their own reality through recursive referrals back to themselves, the professional's fieldnotes will later transform into field-informed inputs, the inputs into collective actions taken or needing to be taken, and the actions will refer inwardly and link to other institutional acts (including the need to produce further public health and community development projects to help empower the disadvantaged). Like the high-wire fencing that facilitates the isolation necessary for keeping the other outside while judgements are debated with like-minded helpers inside the V.O.Q, like the interactions which maintain polite distance to preserve our need to work harder on building relationships, all lists of actions and anticipated outcomes will connect with each other to literally re-instate the need for more disimpersonalised contact. This then is what it means to have fully mastered bureaucratised being-in-the-world, to have fully incorporated the corporation: a self-sustaining activism that refers back to itself in an eternal incompleteness.

### On the inside looking out

Interventions, John von Sturmer has observed, are by definition always extraneous. They are always opposed to immersion and co-presence. They always come from the outside and always presuppose a position of otherness (von Sturmer 1989: 137). What stands out here as we personalise the desire for meaningful relationships with Aboriginal people in our very bodily presence in live-time remote area communities, is how tenaciously our intervention-wrought externality is maintained. Pursuing our timorous attempts to enlist Aboriginal people to self- and community-betterment projects, we suffer a self-imposed isolation from the lived actuality of their lives.

\(^{183}\) I should add that field officers will also take up tertiary studies by correspondence whilst doing bush work, often tailoring their subjects around specific work problems, as a means of filling in the time. One man also mentioned joining a pen-pal group, which enabled him to meet people overseas when it came to using some of the frequent flyer points his bush work had allowed him to accrue. Again, while I have not pursued it here, the boredom which is so often attributed as a problem for young Aboriginal people may well be yet another instance of institutionally-generated projection, inverting Clifford Geertz's warning that we should not regard 'ethnographic miniatures' as little everywheres, as 'wall-sized culturescapes of the nation, the epoch, the continent, or the civilization' (Geertz 1973: 21). In THS, my now = their world.
The Vee-Oh-Kews impose their own brand of in-community exile. Available within all East Arnhem communities (excluding homeland centres and outstations), they are defined in advance by their exact duplication of each other. Mirroring our own dispersonalised miming of the organisation, no matter where we go, the V.O.Q. is the same. The same allocation of yard space, high wire fence and locked gates, small verandah out front. The same internal layout, security screened windows, pastel internal wall paint, hard-working furniture, a fridge, a microwave, a stove-top oven, two bedrooms, each with two spring beds, four in all, and access to an ensuite bathroom, meant for separate men's and women's sleeping quarters.

Figure 17: Layout, Visiting Officer Quarters

Figure 18: Outside view of Visiting Officers Quarters
Visiting communities, we import our own food, meet with other visiting personnel and affirm a little world. Crackers, a loaf of bread, sandwich spreads, something to cook for dinner, pasta with pre-made sauce maybe. Inhabiting these spaces after a day of roaming through the community or tripping in our four-wheel-drives, ‘our Toyota Dreaming’ someone cynically remarks, our everyday tasks (preparing an evening meal, taking turns to do the washing up) are little acts reinforcing our own distinctions. The configurations of our domestic structures within communities reinscribe habitual patterns to our movements, the very objects we use linking us back to our homes, our histories, our economy, our systems of mass production and global trade networks.

The very practices of inhabitation within regional offices should also be noted in this regard. Is it fanciful to imagine the inwardness of THS at the moment of professing an outward, Aboriginal-directed orientation, to see this inwardness mirrored in the interiority of the narrow public health buildings in regional centres? To see in their rigid forms, their air conditioning, pearl-grey paint and bright fluorescent lights, an architectural defiance of the community development claims to partnership building and client-professional boundary erosion, here where no community people ever visit?

True, for many public health officers, community work is not a world of ease and institutional comfort but something which is grappled with emotionally and physically. It is exhausting, gruelling, stressful, seldom yielding the reward of ‘tangible results’ and, as they say, you need coping strategies if you are to survive long in the job. Yet this very formulation presupposes an ability to detach oneself from the field one is entering and constitute it as an object of reflection (see also Argyrou 1997:162-3). The portrait of hardship presupposes one is entering into—and thus also retreating from—zones of pathology, non-modernity and cultural distinction. I have earlier suggested that it this detachment, this bodily removal, which enables concerned health professionals to imagine disease from their own mind/body somatic tactics (cf. Leder 1990), to imagine illness as fundamentally an issue to be responded to intellectually and educationally. Being able to remove oneself and yet intellectualise the domain one is sojourning through and from is, in Foucauldian terms, the position of ‘the eye of power’ (Foucault 1978). It enables us to re-imagine Aboriginal people as tabula rasa, without individual materiality, only an overlay of cultural difference that belongs to surfaces alone, that we frame by pre-analysis in our own
elsewhere both before and after the event of embodied encounters. Once incorporated, these intellectualised knowledges of cultural difference co-ordinate with highly determined bodily knowledges of difference, and (my addition here) their correlated extensions within patterns of spatial inhabitation and transplantation. It remains for me to show how our various modes of inhabiting an institutional self exhibits our mastery of its fluid forms.

Reinventing by venting

Back with Ivan, our breakfast talk returns to the anxieties of his work, a subject we’ve relentlessly canvassed over our period of travelling together. He is concerned at the history of poor housing design and shoddy workmanship, the failure to incorporate Aboriginal living preferences, the inadmissibility of the heavy claim of kinship on patterns of cohabitation within the public-housing-designed three bedroom layouts. Yolngu don’t live as Balandja, he rails, in three bedroom houses, with fixed nuclear families. He grows angry thinking about the lack of consultation with Aboriginal people and, as bad, the absence of consultation with people on the ground like himself and the other Environmental Health Officers, people who would be able to tell town-based project managers and engineers new to remote areas exactly how long copper wiring and small shower heads can last before they corrode, exactly how badly sited a sewerage drain is in what will turn out to be a wet season swamp, exactly how culturally important it is to have separate ablution facilities for men and women.

He is scathing about the means available to Aboriginal people for living healthily. Take the issue of refrigerators, he insists, as we sit comfortably in the V.O.Q., the government-supplied whitegoods humming in the background. They are designed to cope with open and close rates based on the use patterns of urban families who are absent during the day at school and work, are inactive through the dark of the night, and are not living in tropical climates. Washing machines are the same, he says, recalling the exact story Jimmy Keeler told to his audience of inductees (Chapter Five), when he warned them how important it was that they learnt about what really happened, so they could correct the myths that circulate about Aboriginal people beyond THS. If washing machines out here were used in the same way that the average-sized middle class households get to use them, Ivan now tells me as I know he too has been told, they would break down at about the same rate. But because they are used much more frequently by a greater number of people with far dirtier clothing, the engines collapse much more frequently. Vandalism soon follows. Even more appalling, he laments, Aborigines are then held to blame.

In my notes, it is clear I don’t think to ask exactly who blames like this. In fact, THS bureau-professionals never make it clear whether they’ve witnessed or heard such things themselves, when or who by—but we all know how to relay the offences. We know to be solemn with worry and in our worry we manifest what Basil Sansom might call an ‘honest ethnocentricity’ (1995: 309, n. 13), seeing the intermingling of sweat and dirt amongst too many kinsmen living together as terrible problems indicating injustices to be eradicated, and not as potent signs of the alterity intend such deference towards. I am easily able to assume with Ivan a general racist and
conservative enemy and worry with him (and many others) about how to get better functionality out of whitegoods for Aboriginal people so they can better store our healthy foods and better rid their clothes and bedding of any lingering, disease-causing traces of human use. For I too have mastered and am mastered by the allure of institutional logic; I too am held in the thrall of the magical promise of government-led improvements.

Feuding

The day before our departure from Galiwinku, Ivan Church and I had been taken by Roy, an Army sergeant, to Gawa, Gulmarri, Nanyingburra and Banthula, all part of the group of Marthakal Island outstations to inspect the capital works there being installed by the Army. One outstation had flowed into another, each house, kitchen, shower block and fibreglass septic pod exactly alike, site placements the only variation, a standardisation which, like the Vee Oh Kews, achieves greater economies of scale and thereby additional inputs (greater reproducibility) for the available money.

Figure 20: Galiwinku and the Marthakal Outstations
Roy’s a chippie by trade and a big man. His khaki shirt stretches over a distended belly, forcing his breast pocket to tighten over his cigarette packet like well-stretched cling wrap. He’s here like other members of the Army to oversee the installation of health-conferring houses on nominated outstations and to ensure they are built to the government’s codes. Ivan’s task is to check the installations have in fact been built to code, that the effluent disposal trenches are wide and deep enough to do their work of transpiration and such like.

There is a perceptible strain between the Army Sergeant and the Environmental Health Officer and not just because the Army has already undertaken its own inspections, using its own qualified men. ‘You’re paying a lot of money for shipping air’ Roy had disdainfully pointed out, gesturing his thumb in a curt backward move toward the giant (code-compliant) septic pods awaiting their removal to the outstations and so, with Shakespearian eloquence, giving the thumbs down to the environmental health regulations Ivan and others had fought such hard cross-institutional battles to have mandated. As the two stood each other off with their polite but tight talk. I watched Roy’s skeptically raised eyebrow at Ivan’s hints that his being left out of so much of the Army’s work on this extended infrastructure project demonstrates the Army’s overall cultural insensitivity, and I note his unmoved silence when Ivan talks of the immense privilege, the profound sense of honour and gratitude he felt when approached by a community elder here at Galiwinku to discuss ‘the importance of dogs to ceremony’.

But Roy seems happy enough to drive and show us around, even inviting us to later join his men for lunch at their work camp on one of the outstations.

At each stop Ivan marks where things are sited on a hand-drawn map he has sketched in his notepad and asks construction questions of the site personnel, taciturn Army men with rolled
sleeves, tattoos and sunburnt skin. There is little else he can do, as there are only end results to see. What’s he going to do, tell them to move a concrete slab already laid? As self-appointed advocate, being the last person brought in to look at things is sign for him of the bureaucratic indifference to Aboriginal welfare. He tells me that in Victoria he would have been called out before the men started, called back again to look at the equipment, again when the trenches were dug, and again when the project was ready for sign off. ‘Things are so slack here,’ he says, bitterness burdening his words with grave emphasis, the same firmness I remember weighting his objections when, with his colleagues at a meeting in the Darwin central office, he joined their attack on management calls for a reliable environmental health presence at the outset of projects, claiming overwork, under-resourcing, and professional demarcation boundaries (their job being to promote health, not to inspect buildings). On another occasion, Ivan reinforced the contradictory terms of his community development advocacy: ‘I keep saying ‘I’m not a housing inspector, I’m not a housing inspector—I go where the people want me to go. And I don’t think we should be doing houses for people, it just imposes our ideas on them.’”

At Nanyingburra, after Ivan’s inspections, we follow Roy into the base camp itself, where the soldiers have been living for the last three months. A new house, with khaki green iron cladding—surely a coincidence—has been erected for the traditional owner of the area. It sits on a wind-blown peninsula overlooking a stretch of white sandy beach the soldiers say is stalked by a rogue crocodile.

‘I hate it’ the sergeant says bluntly to our expressions of delight at the beauty of the setting, refusing to be drawn into our sentimentalising of the landscape as if it’s something external from himself and his living preferences (cf. Weiss 1996: 1-2). ‘I dunno how these people can live out here. Give me a spa, access to the T.A.B, a cold beer, a comfortable hotel any day!’

In the middle of Roy’s hot and humid nowhere, the Army have installed a virtual community: one canvas tent with rows of bunks for sleeping, another with a long trestle table and bench seats as the mess hall. I am told to be careful: ‘I’ll go in and tell ‘em to behave, you stay here’ Roy gruffly warns me. ‘They’ve been here for two months straight and there aren’t many women out here.’

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184 As I hope by now I’ve shown, such unacknowledged contradictions are at once fascinating and typical of the mobile systems of public health accounting. They reflect not hypocrisy but best efforts to wade through the inherent paradoxes of externally driven empowerment projects with some sense of professional integrity left intact. Evidence does not need to be consistent to fill this need: people know in depth how to articulate the should and the ought, drawing on anecdotes of the contradictory and the discordant.
Embarrassed by the clichéd allusion to hungry testosterone, I attempt dismissive mockery: ‘How primitive can they be?’

‘If you had ever been to Mitchell Street\textsuperscript{185} in one of their civvy breaks then you wouldn’t ask,’ says Roy, adjusting his girth, my wince confirmation his rebuke had made a mark.

The tent is full of people feeling self-conscious yet assiduously pretending nothing is awry. Ivan and I sat down at one end of the trestle table, uninvited and clearly out of place. Every time I look up from the table I meet a pair of eyes, quickly averted back to metal plates piled with meat stew and deep fried chips, while we delicately prepare sandwiches from a wee tin of low-fat salmon and loaf of wholemeal bread. Ivan is as conspicuous as female me, with his bright blue long sleeved shirt, gold earring stud and little terry toweling hat. And in our out-of-placeness, where the Army has temporarily remade its place, with us surveying the Army’s work to reorganise Aborigines into healthful place, there are no Aboriginal people to speak to at all. Only their rearranged landscape to be surveyed in their absence, binding us to them, them to us, in wordless exchange.

**A fundamental diversity of complementary sense making**

Is this the Army’s Energy, Energy! that Emma imagined catalysing so much Aboriginal interest? No matter. The stories never do quite match, but are instead infinitely adjustable, which only seems to enhance their spellbinding effects in creating situational certainty out of our work and verifying the shared social knowledge, registered in our bodily habits, such sense-making gives rise to. It can sure grate together though, this complementary sense making. Where Marlena had been tentative, Peg was bold (Chapter Six). When Emma suffers systematic doubts about the hegemony inherent in community development, wondering whether decisive forthrightness is the way to go, Ivan thrashes about in the agony of doing too much for rather than with. Yet there’s no torment in organising down-to-earth solutions for straight-shooting Roy. He knows what he’s there to do, then he wants outta there mate!

The little disputations about manner and approach—well, not so little really, they assume momentous import in the cataloguing of who sins most against Aboriginal people—the inflated disputations, mask as they create myriad versions of fundamentally shared, epistemic positions of superiority and competence. They form what Dominic Boyer calls, describing how the binary East/West is constructed and inhabited in contemporary Germany, ‘a fundamental diversity of individual permutations of broader social knowledges (that) gravitate around preferred, dominant typifications of identity and alterity’ (Boyer 2000: 462). Amidst the intense factionalism about approach and political commitment, is a tremendous standardisation in the logic which explains the need for our interventions, for our very positioning as concerned helpers. It is, as we have seen, such a readily (I will not say ‘easily’, for its fraughtness is essential to the constructions of our extraordinariness), it is such a readily generalisable logic, that our shared interventionist discourse can be inserted in any situation, without the need for specific knowledge of these particular people, their place, their contemporary context, specific histories or intimate local concerns.

\textsuperscript{185} Mitchell Street is in the Darwin Central Business District, and has become the entertainment district for the town, with multiple bars, discos and in the late of the night, red light pick up spots lining either side of the street.
Discrepancies R Us

Health professionals are not stupid. Far from it. ‘Off the record’, they admit to a discrepancy between their own subjective struggles and the protocols for interaction and formulaic lessons on culture they have been immersed in. Many would reflect on how little they really know, often within the same conversational breath as declaring relationships have to come first.

It does seem crazy that you have community staff out there but you don’t have public health staff based in communities, and I think that that is, not that I’m volunteering to go and stay in a community, but I think that until there is that real tie, unless you’re a really amazing communicator, you’re not really getting to know anyone and in a couple of years you’re gone and you still didn’t really get to know that many people. How many of the old ladies and the young girls with their babies really trust who you were and stuff? And half the time you didn’t get to see in hardly anyone’s house or you didn’t get to talk to people about it, you-know?

(�nvironmental Health Officer, Transcript September 1998)

They are well able to identify the discordance between the fractious complexity they glimpse of Aboriginal existences and the alternately uplifting or melancholy dot-pointed abstractions that they conscientiously reproduce as explanations for Aboriginal pathology. For instance, Marlena and I had many discussions on what she saw as the need to build on what people know. On another occasion, she observed with some anger that her fellow THS nutritionists preferred finding out about Aboriginal women from the written accounts and anecdotes of other whites rather than from the women themselves. If they took the time to talk to the mothers, she had told me with some vehemence, they would find out that the women already knew about healthy foods and when and how to wean their children. Others, like Emma, have spoken with considerable self-irony about their own initial romanticism, how Aborigines were not the ideal victims their liberal imaginations were originally expecting, leading them to suggest a need to recognise the distinctiveness of individual personalities and histories.

Yet, in the shift from relaxed exegesis to workplace formulations, when public health officers are consulted for their input into some small-scale empirical research projects or perhaps for their expertise in developing action plans and evaluation reports, examples of empirical complexity transform into resources which supplement and verify conventional diagnoses of the need for intervention. They supply practical evidences which re-prove the need for such formulaic remedies as more relationship building/time/collaboration/debriefing. Even within self-critical dialogue, when professionals subject their practices to reflexive scrutiny, the switching from intellectually complicated to simpler prognoses is evident. While Emma challenged the arrogance inherent within the participatory processes community development theory takes as an inconsequential given (complex move), she also posited a commonplace nostalgia that the mission times were better for Aboriginal people compared to the mess of today (simplification).

But how dissimilar are these discursive modalities really? Both forms share a fundamental metaphysical assumption that things have a beginning and therefore also an ending, that fault can be found and therefore corrected, that the teleological lessons of history need only be sounded
to be short-circuited, leaving the original interventionist logic intact. It is a metaphysic which cannot for a moment entertain an order of socio-economic co-existence with Aboriginal people that excludes institutional intervention, a metaphysic which would ask, as preemptory response to even this critique, but what else would you have us do? For doing nothing has now become unimaginable, we have so well mastered the forms.  

What I am saying is, equivocation, conflict and contradiction are the grist for a simplified and flattened out collective verdict, verdicts that are in turn cut and spliced into re-complexified reflection and critique, mixed together in ongoing acts of opinion formation, experience definition, image creating and sense making. Evidence is honed for its need, and is constantly remade to fit pre-allocated conceptual slots. As a rationalistic way of building sense which presupposes that which it purports to be explaining, Emma is also able, without fear of contradiction, to re-tell the social work truisms that unemployment leads to apathy, that Aboriginal people are bored and need to be energised by helping professionals if they are to get involved in health activities. She is able to draw on a common-sensical teleological view of historical transformation which understands post-coloniality as marked by the systematic incorporation by Aboriginal people of a western consciousness, replete with in-built alienations, which poor employment conditions are inevitably bound to disappoint. In the easy manner in which middle class anxieties and their logically derived behavioural consequences are assumed forms of psychic motivation for everyone, people need work, meaningful work, to create self-worth and a sense of purpose. It is of no matter that Aboriginal conceptions of work value and self-esteem seem so poorly known. Like health statistics which capture professional anxieties, but are instead held out as the power-knowledge required for politicized community action, the tendency to amplify cultural differences in terms of iconic peculiarities is simply sustained by its unsaid, the related tendency to project homologues across different modes of existence.

That participants continue to reproduce conventions of understanding and enactment in spite of what they might know, at times refusing their own messy empirical knowledge, reveals something of the power of institutional articulations to make convenient sense of discordant social relations. It reveals something of how thoroughly formal analyses are ingested, how useful the abstractions

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186 As James Ferguson wryly notes, 'the extreme state-centeredness of "development" discourse in a wide range of settings is nearly enough to justify Williams’s blanket claim (1986: 7) that: "Policy makers, experts, and officials cannot think how things might improve except through their own agency." (Ferguson 1990: 260)

187 Again, I would draw attention to the ubiquity of this form of logic, both within the bureaucracy and within anthropology. For example, in an article explaining the ongoingsness of a distinctively local culture for the Western Arrernte of Central Australia, despite their extensive ‘exposure to change’, anthropologist Di Austin-Brooks casually links ‘endemic’ unemployment to diminishing literacy skills amongst women and men, claiming (on the basis of information from a local teacher), that ‘there is too little use for them in Arrernte country today’ (Austin-Brooks 2001: 198). In my experience (Collins and Lea 1989), worried teachers and other concerned whites will often question the very purpose of the school on this basis, asking of what use is literacy and numeracy to a people who face under- and unemployment and no prospect of any major change to their depressed local economies? But in a sense such concerns both presuppose what education is failing to confer and then blames the absence as the reason for educational failure. In other words, somewhere within the hit and miss of the ambivalent education that is being delivered it is assumed that the wage-labour values of the capitalist west are successfully and completely absorbed, complete with its in-built potential for alienation in the absence of jobs on the horizon. A causal role is then attributed to this projected alienation for the overall lack of achievement. Education is indeed having a powerful transformational effect—it creates overwhelming vocational expectations and psychological desires—but as these cannot be realised in situations of poor employment, it feeds the dissolution of further education appeal and effect. Thus continued poor achievement arises because the successfully transferred but thwarted employment ethic condemns the desire for advanced learning, with Indigenous people becoming, in a complex, common and seemingly sympathetic set of interpretive moves, the authors of their own predicament.
are to smoothing the infinite diversity of actual practices into an artificially static taxonomy of characteristics. And it suggests something of how satisfying prescriptive discourses are for providing the allure of conclusive termination points (‘this will all end when we/they...’ or ‘unless and until we/they...’) whilst building on the trade routes of institutional talk to reaffirm alliances and enmities amongst each other. It seems that, once absorbed, well-meaning cause and effect analyses become key citational devices for relaying in showings of knowings to other professionals, part of the easy exchange in deceptively transparent authoritative assessments that marks professional talk. And while there are clear demarcations between different kinds of helping whites (the gruffness of the Army soldier, the softness of the educated professional), indexing social idioms of identity distinction (Bourdieu 1984), the key axis of classification—the very different absent Aborigines—create the shared interpretative frame from which we all commonly orient our discordant talk.

**Effortless and voluntary**

At our breakfast of healthy muesli before our return flight back to Nhulunbuy, after we've done all the inspecting we're expected to do, Ivan tells me about his wife's frustrations, attempting in her part time to get a Women's Centre to function properly in another Aboriginal community. She had been doing it for about a year now, and like Ivan, struggles with the meanings and the fascinating, frustrating processes of 'getting Aboriginal people to take control'. They often talk shop. He says 'I say to my wife all the time—in this business there is not such thing as leaving your work at the office."

He told me from the outset his wife refused to be the one to clean up at the Women's Centre. She knew that if she took that on, it would establish a precedent, when the women need to learn how to run it for themselves if they are to ever have full say about how their lives are organised. So she let the place get unsightly, and resolutely ignored admonitions from other whites about the growing dishevelment. Even when she was told by the CDEP Coordinator to clean it in readiness for a visit from Dennis Burke, the then Health Minister, who was arriving soon to have discussions with the people about how to regulate kava, she steadfastly refused. But when she came to work that next week, concerned Balandas had gone in with their mops, buckets and disinfectant, attacking the filth anyway, with her left furious at the short work made of all her hard work, now spiraled back to protracted beginnings in her attempted instruction of the women in the arts of controlling their environment.

It is an effortless thing to be drawn into the conspiracy of white concerns (cf. Sansom 1995: 277). It must be very difficult, I had commiserated, easily picturing myself gut-wrenched with the same dilemmas of sparking work motivation and navigating the clashing of wills with other interfering whitefellas. It is an effortless thing to be so drawn, and this is critical, given the simultaneity of our mastery and accession to institutionalised logics, given the way such logics, elaborated in so many registers of interaction and action, constitute such a salient, dominant form of being. Our *incorporation* is so complete we even voluntarily and automatically rehearse forms of bureaucratic doing and worrying with only each other (spouses included) as audience and further, will deploy the structure of managerial argumentation in the moment of railing against managerialisms.
Mastery

The spectacular alliance of so much nobility and so much futility

Roland Barthes (1957: 31)

One afternoon I was walking past the office of a Nhulunbuy public health officer to find him buried in a sea of computer printouts, with more charts again on his computer screen. There was Ian Goodman (a colleague I van despises for what he sees as Ian's gung-ho, know-it-all arrogance), furiously marking up copies of a survey form which gave a matrix listing of all the things to look for in community houses so inspectors can objectively assess (and so objectively prioritise) their level of disrepair. Seeing me, he immediately launched into a summary of his activities and his troubles with not being understood by those idiots in head office.

'The Government is not concerned to do things properly but just wants to shovel the money out and pretend that is the addressing Aboriginal issues,' he railed. He was particularly irritated with some recent initiatives emerging out of the Department of Local Government (DLG) in relation to the development of a housing repair and maintenance survey form, which he says has not been developed with any input from people such as him, people at the coal face. He has developed his own version, a more concise survey protocol he claims is both easier to fill in and to later interpret—as opposed to the overly complicated DLG version, which has been through three iterations, multiple institutional negotiations and now includes ninety-five separate questions.

'I thought - Jesus! They must just want to stuff this up! They will end up with a questionnaire that can't be completed and data that’s just not valid.'

I asked if he had raised his concerns with anyone. 'Have I ever!' he exploded. But his inputs were received with antagonism, so now he was just going to use his own forms and they could all just go to hell. Yet here he was, annotating the DLG forms with his forlorn suggestions anyway, making a last ditch effort to renegotiate the technical terms of the matrix and to amalgamate the complicated questions. Why? I asked, and settled in for a long story about villains and victims, suspicions and grievances. Concluding it, he shrugged:

All I can think is that I threatened [the Darwin manager]. This is about his career. Whereas for me it is not about my career but about fixing the houses and improving the health of people, based on educated decisions. In fact, I am ruining my career by pointing these things out. About two months ago they advertised the Director of Aboriginal Housing position and like an idiot I applied.'

Tess: 'Why like an idiot?'

'I was setting myself up. They didn't even bother to interview me.'

(Fieldnotes, February 2000).

Did he really get punished or was his simply a poor application? No matter again. Stories such as these are indispensable to the formation of public health work, where grumbling is as
instrumental as enthusiastic rallyings in giving shape and form to bureaucratic actions, and artfully crafted facts and fictions taken to be real become real because of the needs they serve.

And of course, beyond all this mundane strife and worry about money wasted and forms grown too large, lies no end of real, tangible and tragic things to worry about. As a way of work public health is plagued with communication problems, travel ordeals, cancelled and disrupted meetings, stop-start projects, decisions referred to other sites for (unlikely) resolution, long gaps between the decision to act and action itself, loose commitments, few resources and too many evaluation reports available to describe but not fix the problems. Back in the regional office, professionals may be freed from the claims of heat and dirt through fresh paint, air-conditioning and scheduled meetings, but other antagonisms quickly enter. Head office intrusions are multiple and their policy demands unrealistic. Colleagues can feud over petty entitlement issues and office factions can form over the most incidental disputes. In the envious disputes about good intentions, rivalries reign, judgements are instant, and the possibility of slipping up can stalk every slowed down second of intersubjective performance. Workplace gatherings (like the ones which saw Xavier so resolutely put back in his place, by Ivan no less) can be full of veiled criticisms and camouflaged invectives which sustain interpersonal rivalries and alliances alike and where individuals must constantly work to maintain their reputations as progressives. But through all this, institutional actors can at least feel that by fighting for the right words and emphases with and against each other, they are saying No! to oppressive governance on behalf of and for Aboriginal people, in the same moment that they participate in a collective, if antagonistic, recreating of the organisation.

Nor does exhibiting how mastered and masterful we are always have to be so tense. To the instances I've already given (the transplantings; the ever so easy hand-wringing; the marital pillow talk; the redundant data critique), I want to add another image, of the pleasures that can be had in reproducing the terrible burden of deciphering how best to act.

Far away from Nhulunbuy and the Martharkal outstations, to the east with Ian's and Ivan's counterparts in the rumour-filled Darwin regional office, I joined the environmental health officers Mal Guinness, Jimmy Keeler, Peter Woods and Don Forster in a small informal workshop to discuss the vexed issue of community control and better housing. Don had been in the kitchenette meeting room ahead of us, scribbling across the whiteboard, trying to put the thoughts his recent post-graduate public health studies had given him into a framework of community
control. He started with a stick figure, and the statement that appealing to hearts as well as minds is important for building the understanding and knowledge that are pre-requisites for action.

As we suggested words to fill the optical effect of spaces Don’s arrows and text instantly create, with one of us suggesting an issue and another suggesting better words for little rephrasings, Mal joked about Don’s clothing, at him being the worst dressed of all the men working there. Joining the banter, I told them how I had spotted an extremely good looking woman sashaying past Don’s window earlier that day and had noticed how Don’s office door had then mysteriously closed, lacing the word with deliciously drawn out innuendo. The tables turned. Jimmy taunted that it had been me who’d noticed and drawn the bawdy connections first: ‘This is the anthropologist going native’ he teased, reminding us all of the many locker room jokes inspired by a woman amongst men they’d previously clowned about with. So it went, inane and hilarious, our heavy-hearted participation in the whiteboarding exercise, struggling for words to describe the dimensions of the problem of working alongside (with instead of just for) Aboriginal people, leavened with small office intimacy and coffee room camaraderie.

Jimmy told us that he had received a phone call earlier that day from a doctor alerting the unit that he’d seen a poisons icon marking the inside of a flour tin and asking them to investigate. ‘Puts a new slant on baiting the flour doesn’t it,’ Mal wryly quipped, which segued into jokes about drugs in communities and ‘who’s the dealer?’ wisecracks about Willy at Maningrida who smokes a lot of
dope. 'When I first met him he said 'oh I don't smoke that stuff anymore,,' but that same day we went on a car trip and then he asks if I minded if he had a smoke and he lit a huge reefer!' Jimmy recounted, imitating the blissful smoking of a joint as he spun his yarn. We all laughed, especially at Mal's final quip: 'If he got busted, they could do a movie called *Free Willie*.'

Amidst our goofing, it is important to stress that coming up with responses to Don's whiteboard gaps was as hard going and as grueling, as attuned to public health factionalisms and as subterraneanly, interpersonally, competitive as it is ordinarily for any public health work event. Professional camaraderie, banter and mild-mannered brinkmanship feed off each other. There are, at every moment, many nuances and inter-subjective trades to attend to. But these are integrated, automated—so that we can make jokes, think, worry, compete, and diagnose all in one. The hand-wringing is so second-hand, the formulations about the cultural differences and knowledge gaps to be overcome so comprehensively known, so well mastered, so sedimented into our professional diagnostic repertoire, that we can rearrange the classifications any which way, meandering with jokes and innuendoes as part-parcel of our intellectual labour. Energised by our repartee, the forms on the whiteboard resolutely took shape, our banter activating our will to proceed as effectively as alarming statistics or well-facilitated workshops have in other contexts.

The little jokes and innuendoes spurred us on, just as they made powerful statements about relationships, intimacies and distances all at once. But having little apparent connection to the whiteboard text, they will slip quietly out of focus, from insider and ethnographer depictions of bureaucratic processes alike. And like Ian's wasted efforts to change an already approved questionnaire, our temporary whiteboard artefacts do not produce legitimated policy, nor are they done in response to any management edict. They are as temporary as line drawings in the sand, as ephemeral as Ivan's marks on his makeshift maps, as immaterial as Ian's comments for feedback no one wants—and as impossible to appreciate without the related stories and epistemic links to multiple and recursive like articulations, formally disseminated as accredited research or more humbly as conversational currency within everyday bureaucratic situations. It is a magical, finely laced web of beliefs and justification, critique and the creation of oppositions and things to denounce—in short, a whole cultural organisation being created by people who live and feel in the space between the pen and the paperwork, with its 'spectacular alliance' of institutional embeddedness, creativity, and equally tremendous repetition.
Chapter
Eight

Being t/her

Between the Pen
and the Paperwork
Chapter Eight

Being t/here

In which I focus on my anthropological embodiment of the ‘enabling state’ as I encountered it in my immersion within Territory Health Services.

Methodology of the lived

Now I think of it, I have always known about in-place and out-of-place bodies (cf. Feldman 1997: 35). Growing up in Darwin, before I left in a flurry of self-righteous young adult indignation, I was always fearful of yet intrigued by the flocks of black people walking, always the ones not in cars, theirs a relaxed amble resisting the office workers’ brisk oblique driveness, slowly moving between camps, hostels and doss houses in the dusk or early morning, avoiding the full blaze of sun. Like Soweto I used to fancy, images fed from secondary school texts. Trying to ignore the raucous women screaming fuck you fuckin cunt to their men and hitting scratching kicking wildly as they staggered together in the outdoor mall, wary pedestrians picking out delicate detours, absorbing the familiar spectacle with stern apprehension, bodies anxiously hunched in counterpoint to the groggy flailings of brawls in the street. Well knowing the hostile contempt these spectacles evoked in our fellow citizens, our public secret as sympathetic whites was to speak of this as a problem of itinerancy (‘they need public housing/to go back to their own communities’), its rawness too confronting to be given other names, our very politeness in naming issuing its own decontaminating proclamation, a deft re-securing of our decency in the face of their abjection.

Growing up and leaving the racist, sexist, highest-violent-crime-rate-against-women-in-Australia-redneck-town, never coming back, but coming back anyway, twelve years later. ‘It gets in your blood, this place’ locals will tell you. Yeah, right. Back first as a bureaucrat, armed with a tertiary education in anthropology and the grooming of a federal policy analyst, to work in Darwin and consult with communities, seeking ways of doing things better. Then as an anthropologist, trying to make sense of living one’s flesh and blood in the compromised, bureaucratised swirl of post-colonial encounters, having in turn to flail through the conceits of anthropology, its own assemblage of redemptive explanations (eg Sutton 2001), and even worse institutional politics than the ones I was attempting to objectify in the north.

In Darwin today, it’s still much the same, only more civilised, which means its old rawnness has a new vocabulary. I still get to check the prone black bodies to be found lying in odd places, in the blazing sun of a workplace carpark, on a street corner, or the cool cement portal of an office building. Checking to see—still breathing?—before assiduously moving on. Don’t really want to have that broken conversation, navigating the serial demands of slurred words. Getting tangled instead in moralising debates with professional acquaintances about whether or not to give money to the black beggars in the street: yes they say, but only if it is for food, and you’ll have to buy it for them, never give straight cash—it’ll go straight on booze. So what? I might say, and so spur a new bout of aghast them-ing and they-ing.
Then from air-conditioned offices within the health bureaucracy, there's the beckoning, alluring intensity of the mired determination to see and speak good. 'They come in from the communities to go on benders, they don't drink back in their own country, if the elders could control the young people it would be alright' I am told, have always been told, nurtured in the warmly explaining liberal politics of my mother, of my reading, my professional and academic work. And yet... didn't my father do that too? When he would come back from nine months survey work measuring newly acquisitioned land, subdividing mining towns, laying out roads and fence lines, out with the Aboriginal chainmen frugally equipped with a rifle, Keen's curry powder and Saxa salt, a camp oven and billy can, a theodolite, splintered survey stumps and a beaten four wheel drive, rolled a few times in the scrub, back in town to sit out the monsoon season and throw back a daily slab of beer with red- and black-skinned mates?

Were these benders also then the unruly and abnormal moments of an otherwise ordinary, culturally stable life? A strong memory tugs at me now of killing bullocks with him when he was sober and the macabre treat of being allowed, just the once, to plunge the knife into the warm soft quivering chest of the just-fallen beast, secretly proud that I knew the trick of leaping aside from the fountain plume of warm blood before it splashed across the hard hot ground. As an adult with a new identity as vegetarian anthropologist, visiting women known to me once simply as the mothers of the friends I played with years ago, now grandmothers who relate to me now, woman-to-mature-woman, how fervent was their worry when my own mother had to go to work on the occasions dad was back in town, because he always brought in a truckload of blackfellas with him. How one had checked up to find me playing happily in the bath with a black man on the toilet in the room next door and she cried 'Billy Lea, I am taking this girl now and she is not coming home until this house is safe, you hear me?'

Was I oblivious then or not?

Can't remember, there's no notes available for re-ordering.

The aching sense of familiarity of walking into Aboriginal spaces as I've shadowed anthropologists, before I shadowed bureaucrats, is an echo of my own lifetime of straddling bush and town, for this is my doubly occupied space too (Stewart 1996). Flies buzzing over food, an axe and a rifle, a billy can for making tea, plastic salt bottles on the kitchen bench and spreading piles of junk, pitted against the neatening of filing cabinets and institutional carpets, professional introspection, managerial agonising and academic refraction.

Charged with examining the parlous state of Indigenous education in the Territory, I interrupted this ethnography for a year in 1999 to work with the Honourable Bob Collins, a former Senator and man with an unusually close and long term connectivity with Aboriginal people in northern Australia. Married to Rosemary Tipiloura, a Tiwi woman, he is the longest-serving Senator and the only Northern Territory politician from any party to hold a cabinet position in Federal Parliament (for Bob it was within two Labor Ministries). Probably the only Cabinet Minister whose constituents could throw up in his office and afterwards demand cash of their cousin/ uncle/ brother. Another memory now, of going to Nguju, Bathurst Island, with Bob in the final weeks of our review, after assembling case studies of over a quarter of all schools in the Territory, tracing a topography of education system failure, illiteracy rates the only indicia showing any signs of
acceleration over a twenty year period (Collins and Lea 1999). Or should that be decline? Anyhow. In the place of holding consultative court my face is caressed by Tiwi women, strangers to me. They hold my chin in their hands and look at me askance.

Others stare, gesture in my direction and talk amongst themselves. It seems like I’ve been waiting for this moment all my life, being told about my father’s children, two black sisters I never knew I had and the contradictions seep back into my refined practices of objectification, the bush life he had, the urban life I’ve tried to have, the buzz of putting on prim court shoes to literally step into bureaucracy, sandals for academia, and black women in the street, too drunk to fight properly, rank and malodorously, swinging wildly, widely and missing their mark. Perhaps one of my sisters, perhaps not. Maybe they don’t even exist, or it’s a case of mistaken identity. Then again, maybe it’s true. It is my own piece of unfinished business.

Writing the life out of things

Annelise Riles has written of her own institutional ethnography:

The discursive critiques of anthropological writing of the last fifteen years have been built upon the assertion that given the process of selection and ordering that this infinity of information demands, all ethnographic writing is a fiction of sorts. Against this interest in anthropology’s truth claims, what I am proposing is not so much a new epistemology as a new aesthetic. One consequence of borrowing one’s method from the ethnographic material at hand, however, is that method becomes far more contingent. In other words, contrary to an ethnographic imagination of methods as universal and data as particular, I understand the ‘method’ to be no more general or particular than the ‘data’ to which it is applied. To state this point another way, the contribution of this work is its challenge to the distance between data and method in the ethnographic imagination of information (Riles 2000: 191, n29).

I would like to be able to claim that I too have borrowed my methods from the ethnographic material at hand, but clearly I have not, or at least not fully. If I assess this ethnography against the criteria of native ethnography, that is, as an attempt to bring anthropological light to bear

189 There is a growing body of literature in anthropology which dwells on categories of insider and outsider, native and exotic anthropology, making something out of the emergence of ethnographers who look and sound other than the products of mid-century Euro-American academia. As Ahmed and Shore sum it up, in a characteristic formulation of anthropology’s intended relationship with western subjects, ‘[t]he natives are likely to be educated, often with a university degree or PhD from a Western University’ (Ahmed and Shore 1995; 19)—and they might even be anthropologists. Like many vogue genres in anthropology, ‘same culture’ research, the anthropology of home and native anthropology constitute a bundle of practices searching for a coherent identity (compare Kuper 1994, cf. Strathern 1987). Adherents have moved from their earlier concern with questions of bias and authenticity (eg. Firth 1981, but see also Ryang 1997) to considerations of the impossibility of ever fully displacing westernised perception as it rules anthropology (eg. Bakalaki 1987, Narayan 1993). Others have stressed that ethnography in one’s own area (however defined) is not necessarily same-culture research (Brown 1994, Gupta and Ferguson 1997, Morton 1999, Passaro 1997, Visvessaran 1994). Whilst theorising on the implications of nativity appear to have passed their peak, I have appropriated the politically invested marker, originally devised to resist the oppressive weight of we’ within anthropological discourse (Appadurai 1988a, Appadurai 1988b, cf. Haraway 1991, Rosaldo 1989), in preference to other possible tags (the ethnography of home, of policy, organisational ethnography, or even, if I stretched the point, medical anthropology), because the project for me has been to interrogate insiderdom. The debate on nativism, whilst at one level an oblique theme to this work, is at another, absolutely central. I have tried to avoid using Aboriginal alterity as the foil to a deeper understanding of bureaucratic culture, as an older anthropology might have done, to instead grope toward the alterity existing within civilised statecraft. This has led me to view much western-institutionally based anthropology as all native ethnography of a sort, a view which shares Strathern’s verdict that the kind of sameness that matters is not ethnic but conceptual (Strathern 1987).
on my everyday, thoroughly bureaucratised and racialised life, then I would say I have failed dismally. While my lifeworld entanglements—entanglements of governance, race and gender, amongst other things—have been progressively alluded to, much has been suppressed and even now, it is hard to put the life that has led me to this point into well-theorised words. To give an account which respects the affective dimension in an arena conventionally thought of in purist disembodied terms has certainly required autobiographical involvement, but in this place, in my place, the frictions of post-coloniality have to be lived through, not just fictionalised. And despite the representational permissions granted by the overhauling of theories of ethnographic representation over the last two decades, including the enabling theories of native ethnography, it remains difficult, if not impossible, to write back in the pulsating life that sustains and subverts the projections of order and rationality that we insistently overlay onto ‘the data’.  

Even in a work such as this, which has attempted to foreground processes of inhabitation, the political and the economic displace the aesthetic and the spiritual, the somatic and the sensory each and every time. Joy, love, sex, pain, hatred, boredom, emotional display and repression, lethargy, drift and delirium, all these marvelous and ordinary modes of inhabiting the world, somehow are always secondary to the greater theoretical point. Instead, we work to create, in Taussig’s words, a ‘duplicitous lucidity’ (Taussig 1987: 463). The magic of life of itself seems to intrinsically resist even the ‘new’ forms of ethnographic representation, while the only privilege being a native ethnographer has possibly given me is a greater feel for the magnificent detail of all that’s still not here (see also Bakalaki 1997, Narayan 1993).

The implications of these omissions define the subject of this, my final, chapter. Rather than lamenting their exclusion, I seek to explore the performative conditions which enabled me to write them out in the first place, arguing a case for seeing such silences as an ultimate anthropological homage to my mastery of bureaucratic logic, and its mastery of me.

The search for what lies beyond

Anthropologists have, in recent times, shown great interest in the silences of everyday life, in the life that takes place without being remarked upon, the sensuous and the imaginary, the intangible contributions of mood and atmosphere, of boredom, inanity and rambling talk that is just talk, not directly interpretive or rule-signalling (see, for example, Lepeselter 1997, Stewart 1996, Stoller 1989, Taussig 1991, and 1999, Turner 1982a). The concern has a long lineage. The critiques of ethnographic writing that emerged in the 1980s condemned the deadening caused by scientised representations that had been anthropology’s trademark. Remember how Mary Louise Pratt, the self-avowed curious layperson, posed the issue? ‘How,’ she asked, ‘could such interesting people doing such interesting things produce such dull books? What did they have to do to themselves?’ (Pratt 1986: 33). The question has since become, what did they have to do to everything else as well?

190 Talking of ethnography in refugee camps, Liisa Malkki notes that despite gestures toward notions of fragmentation and non-fixity, anthropology also remains poorly equipped to deal with the permanence of ephemeral and transitory phenomena (see also Malkki 1995, Malkki 1997b, Passaro 1997).
I am not raising these issues to prelude an overview of the much vaunted identity crisis in anthropology, but to identify the almost too obvious fact that authors who attempt to re-enchant their ethnographic portraits do not turn to bureaucratic fields to make their case. Or rather, if depicted, bureaucracies are the counterpoint for sharpening into greater relief the magic of the non-bureaucratised, non-rationalisable modes of existence that are being ethnographically reclaimed. The bureaucratic modus operandi is a priori, automatically, disenchanted. Even dictionary definitions assume an in-built alienation, with the very term 'bureaucracy' being saturated with negative meaning, opposed in every way to the wonder of life itself:

**bureaucracy** 3 a: a system of administration marked by constant striving for increased functions and power, by lack of initiative and flexibility, by indifference to human needs or public opinion, and by a tendency to defer decisions to superiors or impede action with red tape <inveighed against the evils of the -> 3 b: the body of officials that gives effect to such a system caught in the meshes of a timid and heartless ->

*(Webster's Third New International Dictionary of the English Language Unabridged)*

**bureaucracy** 1. Government by officials against whom there is inadequate public right of redress 2. The body of officials administering bureaus 3. Excessive multiplication of, and concentration of power in, administrative bureaus; a system characterised by power without responsibility 4. Excessive governmental red tape and routine

**bureaucrat** 1. An official of a bureaucracy 2. An official who works by a fixed routine without exercising intelligent judgement

*(The Macquarie Dictionary—Second Edition)*

For bureaucrats, reduced in their own, in wider public and in social scientific analyses to a dull resemblance of their (superficially) unexciting artefacts, all liveliness and excitement, mystery and enchantment are stripped away. The better to deliver a representation of the (imputed) instrumentality of bureaucratic modes of being.

I want to argue that there is something to this writing the life out of things that is essential to bureau-academic being-in-the-world and which, like Cartesian dualism (cf. Leder 1990), may ironically point to the mechanism by which bureaucrat/analysts are able to mask for themselves the incorporated corporeal origins of their own imperatives toward intervening. Or rather, a consideration of the slights of hand and mind that are involved in such writing out may serve to highlight a certain connectivity between modes of bureaucratised perception, metaphysical theorising and bodily-driven experiencing of the world. The way I see it, there is a positive feedback loop between how bureaucrats write themselves out of texts, how academics likewise write the life out of theirs, and how bureaucrats comport themselves in order to actually be bureaucrats. Naming and the signs read into things aren't simple reflections of a more transparent real but are themselves productive of action and affect. We are not given a pre-straightened bureaucratic world but work to create it, through an incessant recategorising of perception and experience. Or to put this another way, there being endless ways to put this, how the bureaucracy achieves its (self)objectifying magic is not answerable outside an analysis of how academia achieves its.

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191 Which are better approached in such standard anthologies as James Clifford and George E. Marcus *Writing Culture: the Poetics and Politics of Ethnography* (1986); and George E. Marcus and Michael M.J. Fischer *Anthropology as Cultural Critique: An Experimental Moment in the Human Sciences* (1986). Critiques of this literature are also plentiful: see, for example Pearce (1990); Marcus (1995); Nenzel and Pels (1991) and from a critical feminist perspective, Ruth Behar and Deborah Gordon *Women Writing Culture* (Behar and Gordon 1995).

192 Taussig's work *The Magic of the State* (1997) is an unusual exception, one which relies on surrealism and fantasy to invoke a world where spirit possession and state functions intermingle. Indeed, Taussig's concern to re-animate the magic of the modern world, especially capitalist relations, has significantly influenced my analysis here (see also Taussig 1980a, Taussig 1993). What I have in mind at this juncture however is a more prosaic point: bureau-professionals have even less space for writing in the chaos of life using the lyricism and poetic politics of a Stewart, a Taussig, or a Jean Genet, partly because they themselves have been so rarely represented in this way and partly because, as I will argue, bureaucratic discourse resolves itself at the level of disembodied conceptions of self.
The magic of bureaucratic creations

What is this 'magic' to which I keep alluding? There are several elements. Firstly there is the magic of intervention. If I were to summarise the key themes of all the previous chapters into a simplified narrative form, it would go like this. Throughout this ethnography I have described the manifold influences that are dynamically brought to bear on bureau-professionals so that they learn to see the world in a certain light; that is, as something to be amended through a series imagined and practical acts which are collectively called 'interventions.' I have also tried to show how this projected world that is to be acted upon comes complete with reciprocal demands. The betterment effort is beset with problems that are intersubjectively and objectively-derived. There are many things to get done, and many obstacles in the way. Apprehension of these obstacles, I have argued, is essential for the sense of task-orientation which bureau-professionals must vivify to sustain (question or subvert and so sustain anew) their sense of collective endeavour—to sustain, that is, their sense of actually acting in and on a pre-problematised world.

When bureau-professionals conceptualise strategies for action, sometimes the obstacles are too confounding for simple goal-directed calculations to easily rectify. But the need for a sense of forward direction is too overwhelming to resist: passivity cannot be entertained. 'They' need our greater commitment. So the effort to change the world is reinvested into the production of 'new' forms of breakthrough analysis. Pathways are repeatedly re-imagined: if this is not the answer, then maybe that is. Such forms of analysis become part of everyday consciousness; they are interiorised.193 The irresistibility and credibility of interventionist thinking depends on our complete and utterly sensual absorption of its myriad forms, to the point where we are fully magnetised within the forcefield of the humanist question: what is to be done?

It becomes an indissoluble part of our apprehension of the world, that seems jagged by, but is in fact corroborated by, an intellectualised and self-critical recognition (partially informed by anthropology) that how we are apprehending the world bears the stamp of our history, power and culture. These corroborating forms of socio-logical self-other awareness bring so heavily a pre-theorised understanding to themselves that deeper conceptual imprints and psychological investments are paradoxically less available to analysis. That is to say, a commonsense understanding of bureau-intellectuals is that things like social roles, cultural constructions, and historical contrivances determine what they take to be real. A surface is held up for joint, endlessly fascinating, acknowledgement that our knowledges are always already partial and culturally-embedded. The contradictions embedded within the tasks bureau-professionals have set themselves and the critiques they make of their own activities are so analytically tantalising, they tend to take on a life of their own to overwhelm any sense of other organising moral

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193 I have also tried to indicate that this absorption process of course precedes immersion within THS, belonging as it does to a wider societal impregnating of liberal-humanist logic within the educated middle-classes. In this sense, THS represents both a slice of something larger and a micro-site with localised forms of sociability and interaction. To put this differently, the 'culture of the bureaucracy' is both an instance of and a product of the dominant cultural formations within the embracing society. The shaping processes within THS may give a particularly racialised and life-and-death urgency to the vocabularies of complete and profound responsibility for doing something, for intervening, but the source of these irresistible longings goes well beyond this particular institutional setting.
concerns and bodily dispositions beyond those explicitly and ever so self-critically presented by participants. But it is this very acknowledgement which allows deeply inhabited forms of institutional knowing to operate at a more primordial level, an operation which I also have periodically sensed only to have the fleeting premonitions eclipsed by more readily available forms of intellectual analysis.194

As I’ve argued it, critique always plays a double role—not only does it register disapproval and even distance from and disavowal of bureaucratic practices, at the same time it endorses the very notion of intervention. Effectiveness, or the effect of action, depends as much on negating what one does as on doing it anyway. In the same way, the frequent unmasking and denouncing of colonial origins and power inequalities simply consecrate present earnest intents. Castigating readings of the past are made over to each original moment of the present in an inexhaustible reaching for termination points. Fighting with each other over words and political meanings performs a key service as well, for the vexatiousness of it all is a powerful propellant for its inexhaustability as a reinventing faith. It is through its hardness to think and implement that interventionary logic exerts its stranglehold over perception and interpretation.

This is one set of ways in which the magic of intervention can be seen operating. Welfare bureaucracies attempt to change the world and do, by orienting the bureaucratic body-subject to conceptualise the world in terms of reform and intervention.195 THS actors engage in their professional activities from embodied subjectivities which combine with and form the institution, which as a humanly created collectivity, at the same time appropriates individuals in return (cf. Merleau-Ponty 1962: 140). As I’ve presented it in this ethnography, the abundant circulation of forms of bureaucratic knowledge dynamically shapes and reshapes health professionals themselves, in such a way that they can creatively claim and sustain the illusory enterprise of community development with all its contradictions, literally living out its irrebutability even when they ‘fail’ to meet their stated goals.

The divergence between thinking about how the projected world should be acted upon, and living it out, is bridged by the imagining of further requirements for action. As Trinh T. Minh-ha remarks: ‘the invention of needs goes hand in hand with the compulsion to help the needy, a noble and self-gratifying task that also renders the helper’s service indispensable’ (1989: 89). The need to intervene becomes so supremely self-evident it can no longer be explained except through reference back to an original interventionary logic; back that is, to the chicken-and-egg indices of needs requiring interventions. It is this simultaneous movement and fixity which led to my earlier allusion to Brownian motion theory, where I characterised health professionals as held in suspended animation by the sheer force of the factual emissions about service inadequacy and funding insufficiency, gaps in health status, dying and misery, that they are in part responsible for (re)generating.

194 As such, my ethnography has been entirely auto-anthropological, in Marilyn Strathern’s sense of the unavoidable playing out of the anthropologist’s own concepts in the domain at hand (Strathern 1987).
195 The idea that, with a change in perception, the world itself changes (discussed by Sartre in his Sketch for a Theory of the Emotions, 1971) is not such a novel concept. It can be seen everywhere in daily life. Has airline travel truly become less safe in the wake of the September 11 2001 terrorist attack or is it sufficient that we fear it has for it to be so?
Then there’s the magic of participation to be reckoned with as well, the elaborate forms of mastery, of knowing what to know and what not to, that people display everyday in their routine and spectacular enactments of bureaucratic being in the world. For the subjects of this ethnography, all forms of work participation must be interpreted as arduous forms of action, of action directed toward the betterment of others. One has to see one’s own protracted debates about the meaning and balance of serial dot-points, the style of their headings, the significance of this word nudged over that, the layout or the look of a diagram or document; to see one’s presence or input in an event/product development that would continue apace regardless; to view one’s involvement in a tangential professional development activity, a coordination meeting or conference aimed at networking and information sharing; as all signs of action, as tasks which, put together, magically contribute to greater effectiveness on the ground (cf. Riles 2000: 143-170).

The ‘real work’ of ‘turning around’ Aboriginal ill-health is somehow always contingent on activities of workshopping, coordinating, consulting, drafting, creating ownership, finding the funds for more positions and (oh! if only) the time for more community development, program evaluation, researching and relationship building. At the same time, feeding into these enactments of activism and dedication, participants run an ongoing critical dialogue which denounce these same activities for not leading to outcomes, for being repetitions of what’s been done before. That we know to mount this critique, how to name the non-sense with cynical blasts about the waste of time, the misspent monies, the poor data, the reports sitting on shelves, the ignorant policies or the useless paperwork, that we can blend a wry knowingness with suspension of disbelief, calls for breathtaking performative acts. This is art and artisanry, artifice and facticity, coalescing into powerful systems of cultural reproduction.

Just think of what it takes to know that the report one is preparing, a report that is so riven with struggle—domestic struggles about the unreasonable amount of time one may be dedicating to such work, say, or institutional struggles to get it funded and supported, or the overcoming of little acts of semiotic sabotage within workplaces, delayed releases of data, hold-ups on payments and approvals and so forth—just think of what it takes to pursue it nonetheless as if the familiar recommendations one is proposing represent new and radical breakthroughs.¹⁹⁶ Think of the labour of participation, the self-regulation and the theatricality of involvement, and then imagine the equally marvelous capacity to invest one’s arduously produced artefacts with projections of community desire, as if they truly index an Aboriginal testimonial of need and are not an articulation modeled and shaped from the beginning by a priori assumptions that Aboriginal Territorians are fundamentally disadvantaged by what they are deemed to lack. (Let me recall also that I am not talking about the received truths of others but of myself as an adroit producer of such truths).

¹⁹⁶ Left-liberal academics might translate this: Think of what it takes to prepare a paper (or thesis) that argues with conviction how misguided other anthropologists are in relation to understanding contemporary Aboriginal predicaments, knowing it all feeds a greater interventional logic, but putting oneself bodily into the task, as if such (policy) arguments sees the work of anthropology done.
Then there’s the way in which our artefacts (plans, reports, policies, data, charts and diagrams, documents such as ‘Strategy 21’), the abstract forms that bring our desire for breakthrough analysis to terrifyingly logical material life, are themselves attributed magical properties. Not only do they become endpoints for action, they are seen as in themselves also ‘making a difference on the ground’, as provoking system-led improvements in the lives of the people we are worrying about.

Like icons, a high value is placed both on the correct processes for the assembly of such artefacts and on the inherent motivationary power of the resulting stylisations. Ethnographically, it has been vital to move from icon to performative scene and back again to see how information (the name institutional artefacts are better known by) and the actions taken on behalf and for THS clients are seen to be so magically in/effective in relation to the ‘real world’ of persons, things and events. (For what is the verdict of ineffect but another means of buttressing an original intentionality?) So much human artisanry and faith goes into the creation of bureaucratic forms they assume miraculous powers in their own right, to the point where it is impossible to separate the fact of their being artefacts from their binding with the hopes of their artisans. Impossible that is, but for the equally wondrous disappearances which hide the impassioned faith and sensuosity infusing institutional knowledge forms from insider and outsider purview.

Which finally brings us to the ways in which the denial of life’s contingencies and ambiguities, its richesses and mundanities (of all that other magic, the magic of life itself), which, in its very elusiveness to socio-logical analysis, sustains by stealth the credibility of interventionary logic-magic. I want to present this last form of creating modern bureaucratic magic at some length, for it is important to draw out the interweaving between theories of bureau-academic representation and the sustaining of institutional illusions, including the unavoidable creation of ‘deceptive lucidity’ within ethnographic interventions.

**Simplification and the rule of the real**

To begin with, let us look at how the magicality of institutionalised existence is written out of things, out of bureaucratic writing and out of writings about bureaucrats. As a first step, let’s take what it takes to write reports with recommendations which belie the unacknowledged impossibilities of analysis and representation. These are institutionally produced documents where a confident tone and optimistic outlook are necessary to restore the faith that the unruliness of everyday life can be reordered via system interventions and controls. These are documents where the crucial discursive feature is the assertion of certainty, the flattening of empiricism into forms of systematicity to create the rationales for the necessity of intervention (cf. Beilharz 1987). Where the notion that government services are truly instruments in the service of extending governance is obscured by claims about the fostering of community participation and control and the encouragement of capacity building (see, for a sustained example, Botsman and Latham 2001).
As I have shown, such institutional artefacts are familiar and abundant. For the sake of convenience, we will call them all policies, but they could be broken down into their genre categories: mission statements, annual reports, qualitative research, quantitative research, survey results, data summaries, evaluations, program reviews, project status reports, strategic initiatives, budget papers, workshop recommendations, political commentaries, media reports, academic papers and so on. They all, in one way or another, express the shaman-like hope that the projected world that is to be acted upon can be manipulated by means of its representation.

James Scott is one who has given considered attention to this issue of what is left out of bureaucratic representations so that they can achieve ‘the clarity of the high-modernist optic’ (Scott 1998: 347). Taking development projects as his focus, Scott argues that orderly vision (and orderly writing) allow contemporary administration to happen. The standardization of population attributes is a necessary first-premise in development policies, for example, as it makes the otherwise unruly, particularised details of the micro-empirical world amenable to definitive, quantitative answers and therefore to systemic regulation. Order requires synoptic overview, and overview necessitates simplification.

But, he warns, these very understandable abstractions from the more messy real are inherently problematic. It is the alive-and-well yet eruptive details of everyday life, Scott argues, which give governmental efforts their dispersion of effects, ‘their intended consequences, their range of (intended, semi-intended, unintended and indeed perverse) effects, and the dissonance within and between specific strategies, programs, policies and their consequences’ (Dean 1994: 153). At the end of the day, the lived details that are left out of planning efforts in the name of regulatory classification, always return to haunt implementation efforts. In other words, while it is impossible to make plans without simplification, this very failure to capture the greater complexity that stands beyond the plan disrupts the simplified one-to-one correlations between pronouncements and desired effects. The vicissitudes of everyday life amongst the people being improved, a life that developers may barely even know except through their own imputed orderings, inevitably snag the smoothness of interventionary imaginings.

By way of remedy, Scott urges planners and concerned researchers to consider the relevance, detail and integrity of local knowledges and non-modernist practices before leaping to override them with visions of progress and improved amenity, so as to avoid repeat development mistakes (Scott 1998: see esp. Part Four). As an explanation and conclusion, it makes perfect sense. It’s how helping bureaucrats and anthropologists alike might explain the difference between programmatic representations and the ‘real world’. For Scott, the answer lies in paying greater heed to the people’s preferred ways of being in the world, in respecting their alterity and being mindful of the everyday expertise that informs it. And as a bureau-anthropologist, I would have no argument. It is what I might say if I were called on to suggest ways forward for more effective health practice, or what I might also say if I were defending the relevance of anthropological work—and surely this unmistakable congruence is a dead giveaway to the perceptual magic at
work. For in directing our gaze to what policies gaze at, we are once again drawn to consider the in/adequacy of their representative function and with lightening speed are moved on to the idea of resolution (better knowledge). We automatically (and quite voluntarily) lock ourselves into the evaluative question of how to improve the purchase of planning intentions. And, as anthropologists, we are seduced by the beguiling prospect of elucidating fault through detailed ethnographic acts showcasing the suppressed expertise, value and worth of ‘the people,’ believing the micro-empirical work of making conceptual and practical errors visible is a worthwhile intervention in its own right.

Forced to my own correcting point, what Scott’s invocation of simplification’s relationship to rule fundamentally misses out on is the narcissism of bureaucratic practices, how they feed off their own representations and layerings of complexity, including full-bodied wallowing in the practical, erupting complications of the imputed worlds being worried about. Scott’s ‘real’ (the ‘out there’ space where life is inhabited in rich detail) does not flatly precede the diagnostic techniques of institutional actors but neither is it their badly managed product. One is always inside the other. All around the creation of bureaucratic documents is the active social role played by uncertainty and second-guessing, experiences from the field, multiple adversarial inputs, and the need to gain footholds by declaring clear pathways for actions which self-sustain by never being satisfactorily fulfilled.

An image of action is the real

Of course there are deformations of the world of practice in bureaucratic representations, and not just of the sort Scott has in mind. Consider, as my final example, the following diagram produced as an outcome from the Fifth Annual Chronic Disease Network Workshop on the theme ‘Making Work or Making It Work?’, held in Darwin, May 2001.

The workshop gathered into itself representatives from the many organisations concerned with Aboriginal health. THS policy officers and public health field staff were there, doctors and nurses too, NGOs and Aboriginal community controlled health services, researchers and advocates—representatives one and all, of the real world. Concluding the day, the key themes of the workshop were represented diagramatically, a formulation task which stimulated the look and feel of action in the drawn out arduousness of whiteboard constructing in the tired afternoon of the workshop.

197 In her rich ethnography of the aesthetic dimension of expert knowledge practices and associated artefacts, Annelise Riles draws attention to the fact that many institutional documents must conform to a tight, standardized template which also dictates that an outside must be imagined that can be acted upon (research grant application forms in academia would form a parallel). Describing the guidelines for one example, she notes that ‘necessary elements included objectives ‘in measurable terms, where possible’ and lists ‘quantified the expected benefits of the project’, indicators (ways of measuring) to be used to monitor the proposed activity against its objectives’ and ‘a time-line graph labeled ‘activity monitoring chart’ filled in with ‘x and o marks for proposed tasks and tasks actually completed’ (Riles 2000: 154). More than just a simplification, in order to regulate, as Riles notes, these programmatic demands reflect a desire by the donor agency (here AIDAB) for fluidity and access to ‘the real’, with the outside world to AIDAB here being represented by the NGO form-fillers, who in turn have their own external ‘reals’ — such as the grass roots women they are ostensibly advocates for.
I stress the tiredness of the afternoon. Participants were lack-lustre, the day had been filled with disparate accounts of program activities limping along in the field, and the myriad ways in which projects were struggling to achieve ‘runs on the board.’ One survey conducted in the Katherine region had found that Aboriginal men with chronic diseases were not aware that they were meant to be on case management plans, even after the immense amount of work that had gone into providing the technological means to encapsulate health records electronically (overcoming the many difficulties in pin-pointing mobile patients discussed in Chapter Five), and even after establishing an Aboriginal-run health board to oversee proceedings. Another participant, a self-declared member of the ‘stolen generation’, berated attendees for their whiteness, claiming they were deliberately holding on to their positions as doctors, nurses and public health professionals in order to exclude Aboriginal people from holding the same. It was a strained proceeding, a failure of this, a misrepresentation of that, exclusionary processes and power differentials confessed and identified here, there and everywhere.

As the afternoon wore on, the diagram and associated dot-points listing the workshop’s recommendations for Making IT Work juggled participant in-puts into caption points of ‘good practice,’ the magic of intervention being that the very act of listing these attributes made us at once more accountable, striving, in control, compassionate and full of propriety, in the face of all-round (curiously re-affirming) adversity.

![Diagram 1 making it work means](image)

**Figure 25: Making IT Work Means... (White 2001: 3)**

It is a non-sensical construction, ubiquitous and typical. We could contest it on the grounds that for Aboriginal control (individual, community, organisation) to be real, it should be more than a box on one side, and thus obey the silent edict these forms send out to the viewer to participate in the ill-logical constructions as if there really are outside referents being empowered or not through our definitional insistences. This is the agony Scott’s formulations also appeals to, the agony of representation, being the always present tension between the summary point and its inevitably inadequate coverage, or between the plan and ‘the real.’
But my concern here isn't with what does or does not get represented in policies and plans, their rightness or wrongness, comprehensiveness or aridity, but with what such forms deflect in order to draw attention away from themselves as culturally embedded artefacts. This deflection doesn't just depend on the 'magic of style'198 but on the removal of the magic of life itself to achieve an institutional look and feel, which is no mean feat, considering the passionate and in-worldly circumstances in which they are actually made. All around as groups worked through the formulation process of Making IT Work, there were plentiful distractions. There was the angry Aboriginal antagonist, periodically standing up to rail against the racist government and the lack of proper representation for Indigenous People (other institutional players like himself), forcing all subsequent speakers to apologise for their expert qualifications and wrongfully entitled speaking positions and hours later, provoking restless shuffles from an audience grown impatient with a haranguing taken too far.

There were exasperated sighs, giggles, whispered asides and little notes, flirtatious or complaining, passed from one person to another; idle doodlings in the margins of notepads; the background hum of the air-conditioning (a problem on that day, it was too hot or too cold intermittently and delegates needed to keep repeating their complaints); and the disruptive sound of doors opening as intruders barged into the wrong conference room only to loudly and apologetically disappear again. There was the corridor talk between sessions, quick assessments of both the presenters and of the usefulness of the workshop, and dismissals of/support for the ritualistic accusations of racism, combined with endless variations on a theme of all-round lack of support for public health from all-powerful 'thems' (the State, the Government, THS Management and so on).

It was thus a typical public health event, where displays of boredom, attention drift, commitment, critiques and dissimulations were characteristic, constitutive elements of the performative scene. And yet, in the newsletter which later reported the workshop event (White 2001: 3-5), only our flowchart and an account of the systems required to make our identified interventions sustainable survived as the material evidence of our gathering. An entire universe of bureaucratic imagining is thus built on a life-world which it takes completely and utterly for granted. Even participating in the workshop, suspension and attention, fact and fantasy, real and unreal, nourished and blended into each other. Being there, the objective conditions of our participation—the institutional surrounds, the actors, the air-conditioning—blurred into our tacit, becoming, as Dufrenne puts it, 'no longer truly real for me' (Dufrenne 1987: 5), while the 'unreal'—the collective conjuring of an abstract representation of the problems to be fixed—was 'not truly unreal, because I can participate in the play and allow myself to be lost in it without being duped' (ibid.). It was not truly unreal, because what we create is meant to logically reflect 'the real world' and its true deficiencies, because what we create becomes the most real product, the tangible thing we are

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198 Michael Taussig describes what many contemporary scholars, led by feminist work from at least the 1980s, are now very familiar with—the trick of objectivist fiction, 'namely, the contrived manner by which objectivity is created, and its profound dependence on the magic of style to make this trick of truth work' (Taussig 1987: 37, emphasis added).
remembered by, one more institutionally crafted thing amongst many designed to change the qualities of the real world. Through being so seriously moral and purposeful as we produce our incantations ('involve young people', 'funding'), transformational qualities are thus magically conferred into our artefacts (cf. Sartre 1971: 66-7). This is bureaucratic magic, sweet and pure.

I take this case example to illustrate, in a tight and exemplary little nutshell, everything that I have strained to articulate about the health bureaucracy and institutional life. The inanity, the ubiquity, the imitative turn-taking with its in-built soliciting of learnt analytical forms, the sideline talk-work, the politeness and abjection, the repressed sensuousness, the foundational dependency on an imputed world full of absences that careful and caring intervention can remedy, and perhaps most especially, a boxed representation of the actions to be taken to improve that projected world, an abstraction which simultaneously depicts the institutional desire to extend its reach and a product which also, because of the tired effort of producing it, became an arduous end in itself. As an action put forward in its own image, it winds up being the lasting image of our actions. One that at first glance glides over the eyeballs, because of the grandest and most magical of all its achievements, its quintessential banality.

Blurring in and out of view

When I first began thinking of the taken-for-granted backgrounds to bureaucratic texts, backgrounded into the tacit realm of undiagnosed kinesthetics, backgrounded despite their necessity to the reproduction of the whole enterprise, an analogy with film production initially suggested itself to me. Like films, policy words remove the imprint of their own chaotic and mundane conditions of production, which cannot be captured after the fact, except perhaps fleetingly as pared away snippets of remembrance. It is the nature of bureaucratic texts, just like films, to be uprooted from their production processes to assume a life of their own as contained products with their own effects and force beyond the full intentional control of the makers, exerting a gravitational pull on attention which analyst-critics are unable to resist. And like the filmmaker who simultaneously apprehends an image of the person before the camera as both subject and object, as both the physical being and the anticipated absent body that will survive the rushes, the collator poised at the whiteboard (keyboard, document template or report that awaits annotation with comments) has learnt to intuit what to filter out: most obviously, the phrases which don't conform to the style of the emerging artefact, and beyond that, the surrounding presence of human bodies, who likewise disappear into the wording (cf. Adams 1979, Devereaux and Hillman 1995, MacDougall 1998).

The analogy doesn't hold. As filmmaker and theorist Bill Nichols notes, answering his own question of why, despite their gravity and attempted verismilitude, film documentaries remain try-hard aspirants to the company of other serious discourses, at the end of the day, documentaries remain films for all that. They cannot shed their untrustworthy alliance with the 'imagistic company' of cinema (1991: 3), and the subterfuge of 'trompe l'oeil effects' to assume the same authority 'as the
dominant instrumental discourses in our society,’ namely ‘science, economics, politics, foreign policy, education, religion, welfare’ (ibid.) Such ‘discourses of sobriety’, he argues,

... are sobering because they regard their relation to the real as direct, immediate, transparent. Through them, power exerts itself. Through them, things are made to happen. They are the vehicles for domination and conscience, power and knowledge, desire and will. Documentary, despite its kinship, has never been accepted as a full equal. (ibid.: 4).

The analogy proved imperfect, because we do indeed believe that policies ‘can and should alter the world itself’ (3), and for that foundational belief to be explained we must break away from theories of representation and the fictions involved in creating facts that film analysis ultimately directs us toward.

Even so, Nichol’s allusion to the inventiveness of documentaries as being their falling down as enduring statements of fact, is suggestive of the importance of the denied poetic element in policies, as that which sustains their seriousness. Now, this suppressed poetics can certainly be regarded as a side-effect of the characteristic effacement of the speaking, experiencing subject which claims to scientised authority usually exhibit, or equally, it can be attributed to the unavoidable heavy-handedness of analytical writing. But I also want to argue that it is an accurate reflection of the incorporation of corporatised being-in-the-world. The way in which bureaucrats are instrumentally depicted and sensuously evacuated resonates with how professionals foreground a projected Aboriginal (or general public) neediness in order to background their own fears and desires. Propriety in both the field of Aboriginal encounters and within the walls of the formal workplace similarly require bodily suppressions and controlled passionate outbursts to reassert the right kind of demeanour, attitude, and formulations of action. Remember how hard-working such formulations are, how well they stabilise contrary lifeworld empiricisms into generic dot points? Wording yourself out of the picture, ‘dis impersonating’ some things yet being conventionally earnest about others, takes considerable, practiced personal (physical, emotional, visceral, cultural) investiture.

It is the compulsiveness of being involved, the magic of participation, which paradoxically whisks lifeworlds out of sight, as the impersonality of caption point diagnoses of problems and solutions triumphantly displace the din of everyday affect. The bureaucrat, forgotten in the insistent foregrounding of characteristic frustrations, shortcomings and the kinds of program and project-led improvements everyone has learnt how to yearn for, nonetheless has embodied and intersubjective experiences, in every single moment of every single day, which present an indefinite multiplicity of elements needing to be reframed within the interpretive grid of interest-free, depersonalised, improvement-oriented service delivery. The (learned) interpretive apparatus that enables such reframing to become instituted at the level of the self, as everyday happenings are retranslated into expertly-worded interventions, returns selected aspects of the everyday as amenable to action. By reframing the complexity of our surrounds in order to simulate the look and feel of interventionary action, a transformation of our surrounds indeed takes place, as much brought on by the changes that have in fact occurred within ourselves as in the reciprocations we perceive from the arena of
our developments. Borrowing from Sartre, we might see the work of interpreting the world anew in terms of points of intervention as a way of forgetting, of symbolically blocking out what we don't want to see or know in order to continue unviolated (Sartre, 1971: 65-67).

So, not only is it the case that bureaucrats leach out the specific characteristics of specific persons in order that they may become manageable population groups (cf. Scott, 1988). Bureaucrats exclude themselves from their own writings, for these are the screenings and obscurings we've been taught to make, that we have mastered and internalised, in order to perceive the world as one that constantly invites our interventionary response. This bodily-derived containment of the self, the occluded corporeality of institutional activity 199, is a key experiential source for the widespread perception of the professional world as the counterpoint to 'real life', nonsensical as such a segregation turns out to be. And so we fix on the artefacts of bureaucratic production as power-filled and other-animating yet disembodied, and not on the role played by the participation of institutional actors with all their distractions and passions.

In this ethnography I have tried to shift focus to this backgrounded participation of institutional actors. And I have urged that we think of the work that goes into sustaining bureaucratic practices in such a place as THS with a sense of admiration and wonder in the place of a more usual (falsey-distancing) disdain. But, in trying to make of bureaucratic practices something of a testimony to forms of human cultural capacity, I have also tried not to lose sight of the hegemonic quality of a logic which cannot imagine betterment without some form of government intervention. I have not wanted to gloss over the fundamental first premise of the logical deductions in bureau-academic analyses, being the assumption that Aborigines (or 'clients' in general) are lacking, and how the artfulness of institutional actors is directed at working backwards from there to create an unarguable rationale for further interventions. I have also never wanted to deny that lives are being lost, that pain is real, that much ill-health is avoidable, that (in)justice exists, that professionals bring an honest commitment to their work or that improvements are and can be achieved. I've simply tried to follow an anthropological pursuit of appreciating the ingenuity and multi-dimensional processes which feed into expectations of rightness and order, which give magnificent ritual form to institutional activities, and which explain their compelling attraction as systems of thought and action, for both myself and others likewise caught in interventionary logics of our own compulsive devising. 200

199 It is interesting to consider the question of sexuality in this light. As Hearn and Parkin observe, 'Enter most organisations and you enter a world of sexuality...This can include a mass of sexual displays, feelings, fantasies, and innuendoes, as part of everyday organisational life, right through to sexual relationships, open or secret, occasional sexual acts, and sexual violations, including rape' (Hearn and Parkin 1987: 3). But if the vast amount of material on matters organisational is to be believed, organisations are 'inhabited by a breed of strange, asexual eunuch creatures' (ibid: 4, see also Cohn 1987). The way people allow themselves to be kept by the secret of sexuality at work is one aspect of a larger phenomenon I am attempting to trace here.

200 As one of the few Australian anthropologists who has railed against 'the great circularity' of what I call interventionary magic and what he calls 'remedialism,' John von Sturmer's reflections on where it all leads is telling: 'What remedialism means in practice, according to my experience, is more of the same. ...We get caught in a great circularity; and behind it we suspect the continuing workings of a covert social Darwinism, notions of European Cultural Supremacy and a Social Evolutionism that take it for granted that change is inevitable, not along new lines (which might represent a legitimate use of social evolutionary thought, adaptations in terms of potentials and responses to actual historically-produced environments) but according to the West's historical consciousness of its own history of change: in other words, the future becomes for the other (though not subjectively) merely a replay of what the West conceives itself as having endured. There is in it, too, a continuing sense of the White Man's Burden. ... It is this drive itself which has to be understood.' (von Sturmer 1995: 113).
I've met the state...

It is as an anthropological pursuit, I am now arguing, that the surrounding life of bureaucrats, and the surrounding life that has supported and sustained my ethnographic capacity, are both paradoxically made irrelevant to the work. Writing ethnographies, we gear ourselves for the norms, play within the parameters available, create a pretended order for things and experiment at the margins of being an eye-I-witness, without being able to undo the meaning-finding, order-imposing whole. As for writing oneself in—well, it's all a bit like 'fessing up to negative experiences in the workshop encounter: there are rules for making ethnographic experiences tellable in the first instance; there's an ordinariiness to when and how to claim the extraordinariness of our accounts. Inserts about the life of the ethnographer strategically reveal how one's subjective experience pressed into the fieldwork and its writing up, told in ways which are themselves authorising, authenticating, and destined to create unarguability.

There are two issues I am intent on merging here: what one has to do to be a bureaucrat amongst bureaucrats, and what one has to do to be an anthropologist amongst anthropologists. Bureaucratic language undeniably demands that we speak of the world in terms of 'authoritarian reason' (Taussig 1987: 133), which seems to require that we sacrifice the life that goes on beyond the objectivity assigned to it so as to create the image of a manipulable reality (see also Dufrenne 1987: 64-6). But, I am arguing, this is also the practice of anthropology, and for not dissimilar reasons. To inhabit one's ethnographic self requires the same bureaucratic ability to deflect the fullness of living human beings and the sentence of lived environments out of the account, replacing it with something other, a knowable (predominantly language-based) object. A performance requirement of anthropology is that we further transcend what people do and say and seek the larger (wider, deeper, occluded) answers lying beyond and behind the (culturally construed) everyday concepts held by ourselves and our subjects.

Let me here return to my opening critique of ethnographies of policy (Chapter One), where I noted that anthropologists seem to revert into administrators when thinking through what the beliefs, theories and actions of western professionals may mean. This is not an accidental conventionalism.

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201 This is where I depart from Dan Miller. After a consideration of the criticisms leveled at anthropology's 'overly abstract, analytical and objectivising tendencies' (Miller 1995: 17), he makes a case for the necessity of anthropological abstraction and objectification, not on epistemological grounds, as I am attempting here, but on the grounds of marking the superiority of anthropology's authority claims over those of positivistic science and bureaucratic knowledge. Says Miller: '...our kind of doubt-ridden knowledge is amongst that most clearly distinct from the naturalistic positivism evoked by the terms 'science'; and ... our plural and quarrelsome rationalities are equally distinct from what might be called the bureaucratic lack of imagination' (Ibid: 19). I wholeheartedly agree with Miller's sentiment that anthropology's unique challenge lies in its ongoing attempt to breakthrough its own eurocentric scholarly preoccupations by questioning universalisms as best it can (see also Dharmeshwar 1990: esp. 234-5). But I cannot agree with the depiction of 'plural and quarrelsome rationalities' as being unique to anthropology (for, as I've argued, plurality and quarrelsome are constitutive forms of rationality for bureau-professionals). Nor can I concur with the ultimate act of anthropological objectification which refuses to see the tremendous work of imagination invested in anthropological and bureaucratic rationalities alike, including the creative doublethink required to see such lively sites of human interactivity, image making and meaning creation as somehow dull and lifeless or at best, helpfully (or blightingly) instrumental.

202 See Rabinow's critique of Bourdieu as representing an extreme valorisation of objectification as a model for critical thinking (Rabinow 1996: Chapter 1, Rabinow 1997).
There is something essential being brought out by this replaying of bureaucratised perception within admonishing accounts of bureaucratised perception. For all that it may be an unintended mimesis, it is nonetheless an accurate one.\(^{203}\) As if to affirm this, there is only a limited vocabulary available to ethnographers to describe of the seduction of the tragic occupation, to evoke the sensory dimension of being animated by the urgency of the (institution-spreading) question: *what is to be done?* The unarguable forms of liberal rationalism enacted by the benevolent ‘we’ that feels compelled to act, the very subjects of this ethnography, are much easier to define in terms of complicity, conformity, governmentality, because ‘we’ anthropologists are likewise ensnared by the same (institution-spreading) desires for order-from-disorder and further, by the same belief in the power of representation to bring the misconceptions of others to correcting light, and the related need to disavow involvement in order to continue apace. In which case we are simply swapping shared concepts back and forth and pouncing on superficial indications of difference to avoid confronting our own submersion in it all.

...and she’s an anthropologist

For me it has been hard labour, trying to make sense of people whose job it is to produce sense until I realised that this very effort was itself evidence of the problem at hand. The inundations of bureaucratic knowledge forms send out an enticing challenge to decipher the truth, or the proper approach, out of the confusion of programs, projects, theories, research, professional and intuitive opinion. It is hard not to want to clarify and evaluate, hard not to demand, in response to the circularity and repetitions I’ve described, well, surely there are real programs which can be shown to work? Surely there are tangible improvements that can be claimed? Occasions where we’ve undeniably ‘made a difference’? Policy shifts which lead to seismic historical change? People become passionate, which makes taking part and contributing unavoidable. Reasoning gets confounded, which sets up its own mind-bending intrigues. The very act of trying to pin causes to solutions, problems to interventions, real outcomes from claims of intent draws one into the process, which is why it fascinates, frustrates and pleases, which is how its magical power is exerted. It is the compelling nature of this appeal that I have tried to understand.

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\(^{203}\) Michael Herzfeld’s work, *The Social Production of Indifference: Exploring the Symbolic Roots of Western Bureaucracy* (1992) illustrates this reflecting perfectly. In it, Herzfeld repeatedly argues that anthropology’s task is to go beyond representations of state organisations which caricature bureaucrats as soulless system-servers opposed to a repressed citizenry, admonishing readers to remember that ‘the official world is itself peoples’ (1992: 59). Yet nowhere in his book are the subjectivities of bureaucrats delivered with their full complexity intact. Rather, the text is littered with anecdotes casually drawn from Nazi Germany and modern day Greece illustrating indifference, corruption and incompetence at work, with Herzfeld’s chief task being to explain the public’s forebearance (their ‘fatalism’) about such a state of affairs. Whilst rich in hovering theoretical overview, this is no ethnography of bureaucrats. Or rather, it is a perfect ethnography; if ethnography is understood as a mirror of the internal logics of the cultural order being represented. That is, it is a perfect simulation in its reproduction of the problems being criticised, in the way Herzfeld’s expectation of instrumentalism encloses people like himself (other bureaucrats) into a classificatory ordering which expects institutions to be logical and fair, and logically enough, he finds deficiencies. By blaming bureaucrats for their bad habits of classification and rigidity (the inclusions and exclusions necessarily introduced by entitlement criteria which, as Scott shows, must needs overrule empirical complexity, as a for instance), Herzfeld reifies through objectifying critique the homogenising habits he wants overturned. Is this not a classic reproduction of a classic administrative dilemma? And thus also, in its own right, a truly reflective ethnography?
I hope by now the ordering of this ethnography has become clear, why it was important to start with an attempt to describe the attractions of bureaucratic work and its compelling intensity of demands. Why I began with a chapter that attempted to assert the pleasure and performance of word-work up close and personal before the more synoptic chapters which followed, to return again to the micro-detail of interactions and the recursive loops linking expert representations to modes of subjective inhabitation and enactments of participation. And why the core of the chapters are riddled with a concern to describe and account for the ways in which health professionals describe and account for their worlds in deep and inextricable entanglement with their multi-layered and strangely distanced projections about how Aboriginal people account for theirs.

It would not have been enough for me to describe the constructedness of bureaucratic forms, for my subject has not been the artifice of bureaucratic constructions but their social life, and how they are brought to life by social actors. There is a mutability to the communicative moments in which such representations are deployed, a context-dependent dynamism to how they are expressed, which is as much a testament to professional creativity as it is an indication of complete immersion in and accession to institutional logics. In its denunciability, the scandal of Aboriginal health, and all the self-recriminations about the lack of time and resources available to deal with it, obliges participants to obscure the ways in which the remedies they struggle to implement speak of their own longings. Just think about what it takes to sustain such an obscuring in the face of endless professional introspection and up-close and critical self-analysis. There is a real mastery at play here, forms of artisanry and adroitness which go fundamentally unrecognised, and certainly uncelebrated within anthropology, which only sees a non-fantastic state rationality at work. Indeed, it is just as fascinating to think about what kinds of self-denial anthropologists must-needs make to be left with so little wonder at forms of bureaucratised incorporation, but that’s a whole other story.

Finally, knowing that the magic of intervention (synonyms: statecraft, remedial circularity or bureaucratic socio-logic) lies in the malleable ways it can shift itself to adjust to and if necessary recuperate any configurations that might challenge it, why would one knowingly be a bureau-professional? I ask this question because it is frequently asked of me. Of all the many possible explanations this ethnography has already suggested—Brenneis’ ‘conventional self-interest’ (1994: 33-4), the compulsiveness of doing good, the witty sociality of like-minded company, and the allure of rubbing up against the societally-acknowledged decision-making money-allocating power of the sovereign state—I want to isolate the same answer that is available to anthropologists to explain their own participation. However slim the margins and narrow the cracks for influencing or altering the course of institutional events away from their colonising intent, however befuddled such an undertaking is from the outset, there is still the hope that participating from the inside at least offers opportunities for such deflections to be identified and fanned.
In the same way, if a bureaucratised lifeworld is the ground for our thinking about, amongst other things, bureaucracies, how can one get 'outside', 'above', 'beyond' (pace Nader 1972)? One of the few options available to anthropologists who sense how overwhelmingly enculturated they are within the 'great circularity' of (interventionist) liberal reason (cf. von Sturmer 1995), is to use anthropology against its own grain to help sense what the master forms of sense-making habitually expel. Anthropology is at its best, or more accurately, is at its least bureaucratically (socio)logical, when it tries to understand its own will to explain the (un)familiar via insistent returns to culturally familiar conventions of explanation. I have been at pains to argue that a complete epistemological break is not possible, for being native means never being able to fully leave. To live with the prospect that as intellectuals, bureaucratised-being-in-the-world is a naturalised inhabitation, not an imposed one, may be for many politically-driven thinkers a frightening, repulsive apprehension. But it can also be liberating to gain some measure of the lived-in, externally-driven and consensual limits on our own agency. Or at least, that is my hope, and the hope that has driven this work to this point, a point which I now see as the ultimate honouring of bureaucratic magic in the faith it sustains in the power of description to amend conceptualisations of how the world 'really is' and with that improved perception, somehow yield a better outcome—for who and about what no longer seems to be the point.
Bibliography

Between the Pen
and the Paperwork
Bibliography

Aboriginal Development Unit, 'Strong Women, Strong Babies, Strong Culture: Part Four—An Overview of the Program', Darwin: Aboriginal Development Unit, NT Department of Education.


Department of Local Government. 'Visiting an Aboriginal Community for the First Time?,' , pp. 1-4. Darwin: Department of Local Government.


Langton, M. 1993. 'Well, I heard it on the Radio and I saw it on the Television...': An essay for the Australian Film Commission on the politics and aesthetics of filmmaking by and about Aboriginal people and things. Sydney: Australian Film Commission.


Appendix

Between the Pen
and the Paperwork
Appendix One

Research Agreement

STATEMENT OF UNDERSTANDING CONCERNING THE RIGHTS AND RESPONSIBILITIES GOVERNING
TESS LEA'S ETHNOGRAPHIC RESEARCH WITH TERRITORY HEALTH SERVICES

Tess Lea, Anthropology PhD student, the University of Sydney

This statement has been developed to clarify the obligations and responsibilities of Tess Lea as
researcher and of Territory Health Services as the institution which is granting research access.
The following document presents details of the research arrangements and issues followed by
a summary of guiding rules of conduct. Together these constitute the research understanding
concerning Tess Lea's doctoral fieldwork within the Department.

Consultation
In determining where Ms Lea is and is not able to do fieldwork (and what issues this Agreement
should cover) she has consulted with:
the Operations North Regional Executive
relevant public health managers and staff in Operations North
members of the Remote Area Training Unit, Staff Development Services;
the Division Heads and staff in the Family and Public Health Services Division and Aboriginal
Health Strategy Unit.

Summary of Research

As host institution, Territory Health Services agrees to allow Tess Lea to undertake ethnographic
fieldwork within the Department. An ethnography is an intensive cultural study of a particular
grouping or groupings using participant observation (literally, doing or observing what others are
doing and recording/analysing along the way) as the main fieldwork method. In this case, Ms Lea
will be working alongside field staff in the nutrition, environmental health, and health promotion
programs and policy staff in related strategic areas, to understand via first-hand observation what
public health staff actually do when they work on Aboriginal health issues, what problems and
issues they routinely confront, and what they think about their work. She will also be spending
time with remote area training staff as they form an important link between public health policy
and practice, being likewise engaged in the attempt to shift THS' internal practices to better
serve Aboriginal people.

Data collection

Ms Lea will spend time with the operational staff during the first six months of her fieldwork year
(June to November 1998), followed by six months with policy staff (January to June 1999). Work
with trainers will be interspersed throughout the year, in accordance with the Staff Development
Services course development schedule. With all three groups, she will be 'tagging' people as they
go about their daily work, taking part in activities where possible, and recording field notes of
conversations and events in journals. Ms Lea will mimic being a public health staff member as far as is reasonably possible by undergoing remote area orientation training and doing (mostly administrative) tasks within the work units she is in.

Ms Lea's principal concern is to observe and listen to people in naturalistic work settings, including in meetings, when something is being organised, corridor conversations, doorway exchanges, chats around work stations and photocopy machines, workshops, training sessions, meetings, problem-solving discussions and so forth. Notes about such occasions will be made in field journals at the time and usually in the presence of participants - although there will also be times when participating in the moment overtakes making jottings and write-up occurs later. Data analysis and write-up will commence in July 1999 and will continue through to mid 2000, when the doctoral dissertation will be presented for examination.

As host institution, THS agrees that Ms Lea will have access to all relevant documents, data and files, including confidential documents, within the Department whilst abiding by the conditions of confidentiality specified within The Public Sector Employment and Management Act. Should THS subsequently decide to disallow access to key documents and/or other data, it agrees to provide sufficient notice that Ms Lea's research program will not be jeopardised.

Consent

At all stages, THS staff have the right to refuse:
Ms Lea's presence in the first instance;
Ms Lea's involvement in particular work incidences or settings;
to divulge or discuss particular issues with Ms Lea.
Participants will also be able to specify when and where Ms Lea can accompany them and what they would prefer she did or did not note. To this end Ms Lea will seek people's written or verbal consent as appropriate, and will negotiate access on an ongoing and occasion-specific basis.

Confidentiality

The primary data Ms Lea gathers is confidential and her research will not use people's names unless she has their explicit and written permission to do so. However, in an organisation such as Territory Health Services, where personalities are known to each other, it may not be possible to prevent individuals from being identified (eg from a characteristic expression) despite efforts to maintain anonymity. This being the case, Territory Health Services agrees that participants will not suffer any form of career damage or penalty for what they might reveal in the course of Ms Lea's research, or conversely, for refusing to be involved in Ms Lea's research.

Another issue in peer-research is blending confidentiality requirements with professional codes of conduct expected of NTPS officers. Under The Public Sector Employment and Management Act, an employee must prevent bringing the organisation into disrepute, which in ordinary circumstances might involve disclosing evidence of unprofessional practice to a superior officer. However, Ms Lea's first priority as a researcher will be to protect the confidentiality of her informants. This imperative will apply unless, in the course of her research she happens upon (overhears, accidentally witnesses or has disclosed to her) an extraordinary issue which because
of its illegality or potential implications for the safety of others should be disclosed to a superior officer. In such a situation Ms Lea will receive the advice of Dr David Ashbridge or Ms Rose Rhodes within Operations North; and Mr Peter Plummer within Central Office. In all other circumstances it is THS’ understanding that Ms Lea is not undertaking an evaluation of program areas or individual performances and is not scrutinising people’s work practices with the idea of reporting on them. Ms Lea’s field note records will remain with Ms Lea in a secure location and will not be accessible to others unless for legal reasons. Intellectual property rights remain vested with the researcher.

Feedback and information handling

In accord with the wishes of THS managers, Ms Lea will provide feedback during the course of her research through staff workshops and meetings and in more formal presentations and seminars. She may also be approached at any time for a verbal summary. At the end of her research she will produce a summary of key findings for internal THS use. THS agrees that the research material and intellectual property gathered by Ms Lea in the course of her ethnography shall be vested with Ms Lea and will form the basis of her doctoral dissertation. Ms Lea will also publish work deriving from her ethnographic research. Following examination, copies of Ms Lea’s thesis will be lodged with the University of Sydney library services, the Northern Territory University library, and the THS Library Service for public use.

Expenses and Logistical Support

Ms Lea’s research will not involve additional financial costs to work areas. Ms Lea agrees to meet her own travel expenses and to be as minimally disruptive to people’s everyday work routines as possible. The Department agrees to continue to provide Ms Lea with access to a computer and electronic mail system capable of communicating externally. Work Units which agree to work with Ms Lea will provide appropriate office accommodation (some space from which to work) for Ms Lea during the period of her time with them.

Ethics Clearance

Ms Lea is to submit her work for clearance with the Joint Institutional Ethics Committee of the Royal Darwin Hospital and the Menzies School of Health Research.
Appendix Two

Ethics Agreement

THE JOINT INSTITUTIONAL ETHICS COMMITTEE OF THE ROYAL DARWIN HOSPITAL AND THE MENZIES SCHOOL OF HEALTH RESEARCH

Application for Ethics Clearance for Research
Procedures Involving Human Beings

Applicants should read the NHMRC Statement on Human Experimentation and the guidelines for the Protection of Privacy in the Conduct of Medical Research before completing this application. Also the recommendations of the Aboriginal Deaths in Custody Royal Commission and the NHMRC Guidelines on Ethical Matters in Aboriginal and Torres Strait Islander Health Research should be read if proposals involve Aboriginal people. Please contact the Menzies School of Health Research Academic Administrator for assistance if required.

Applications MUST be filled out in a way that is meaningful to the informed layperson. If they are not, they will be rejected. Be concise and address the ethical issues that are implicit in each question.

Eighteen copies of this application and two copies of the full scientific protocol are to be submitted by the applicant to the Academic Administrator, Menzies School of Health Research, PO Box 41096, Casuarina, NT 0811. Copies may be double sided.
THE JOINT INSTITUTIONAL COMMITTEE OF THE ROYAL DARWIN HOSPITAL AND THE MENZIES SCHOOL OF HEALTH RESEARCH

Application for Ethics Clearance for Research Procedures Involving Human Beings

TITLE OF PROJECT:
An ethnography of public health work in Aboriginal health within Territory Health Services

CHIEF INVESTIGATOR:
This person should be of sufficient standing so as she can bear full responsibility for the project. It is unlikely that an undergraduate student would bear such responsibility.

Name:
Teresa Lea

Position:
Doctoral Student, Anthropology Department, University of Sydney

Professional Qualifications: BA (Hons1), Australian National University

Name, full address and postcode of Department/Institution for all correspondence:
Tess Lea
c/- Menzies School of Health Research
PO Box 41096
CASUARINA NT 0811

Phone (Business hours): 89228196 Alternate number: 89813317

ACADEMIC SUPERVISORS:
Name: Dr Gillian Cowlishaw Department/Institution: Senior Research Fellow
Sydney Institute of Technology
PO Box 123
Broadway
NSW 2007

Name: Dr Franca Tamisari Department/Institution: Senior Lecturer
Anthropology Department
The University of Sydney
Main Quadrangle A14
NSW 2006

APPLICATION TYPE:
Please circle intended response to the following questions

Is this a continuation of an existing project already given Ethics Committee approval? Yes/No
Has this protocol been submitted to another Institutional Ethics Committee? Yes/No
If Yes, which one(s)

Is this application for Clinical Trials Notification (CTN) or Clinical Trials Exemption (CTX) purposes? Yes/No

DURATION OF PROJECT:
From June 1998 to Dec 2000

FUNDING:
is this protocol the subject of a grant application? Yes/No
If Yes, what is the Agency?

Has it been funded? Yes/No/Pending

The University of Sydney
Carlyle Greenwell Research Fund (Anthropology)

Is the same chief investigator named on the grant application and this ethics application? Yes/No

Applications MUST be filled out in a way that is meaningful to the informed layperson. If they are not, they will be rejected. Be concise and address the ethical issues that are implicit in each question.
1. **SUMMARY OF THE PROJECT**

*Specific aims and hypothesis should be stated clearly in non-technical terms. A formal literature review should be included with the full scientific protocol submitted with this application.*

The British anthropologist Susan Wright has noted that policy "is a major institution of Western and international governance, on a par with other ideological and politicised concepts like 'family' and 'society', yet one which has received scant attention from anthropologists" (1995: 81). The objective of my anthropological research is to document the cultural logics which inform and define public health activity on Aboriginal health within Territory Health Services (THS). THS employs over 3000 staff and is charged with the responsibility of delivering 'health and well-being' for all citizens of the Northern Territory, including a significant Aboriginal population base.

I wish to study, through first-hand observation and participation, the process by which health professionals go about learning the ropes of Aboriginal public health work at the policy and operational levels. This will include observing and spending time with the following over a one year period:

1. 'central office' public health administrators who develop policies and strategic directions;
2. public health trainers who prepare policy and field staff for working with Aboriginal people; and
3. the public health operational or field staff who visit Aboriginal communities and attempt to make central office and their own regional policies and directions 'stick'.

There are some important distinctions to be made at this point. I will be working amongst public health staff in such programs as nutrition, environmental health, women's health and health promotion, who do not reside in communities but work as policy and/or visiting program professionals out of the central office and regional centres of THS. I am studying the processes through which Aboriginal health is governed rather than Aboriginal perceptions of health and/or the bureaucracy (for an example of the latter, see Collmann 1988). This is an ethnography of those whom anthropology usually ignores: the mainstream actors who work on the bureaucratic side of the counter, who are often operating with commitment and intelligence in complex and testing situations. I am particularly interested in learning what happens to public health staff after they join the organisation, the preparation they receive, and in discovering the areas public health staff find particularly troublesome and problematic in their attempts to work on Aboriginal health. Amongst other things, I will be exploring what public health staff and others in the bureaucracy feel is the appropriate balance between public health and clinical service delivery, across a range of health problems. Mostly I will be seeing from the inside what is meaningful and important to particular public health professionals and how they carry out their daily rounds of activities, as they attempt to work within 'the system' to emphasise disease prevention and health promotion.

To achieve the level of empathy and rapport which I believe is necessary to uncover these issues from the point of view of the officers involved means being committed to the ethnographic principles of long term participant observation. The key ethical issues are to do with disclosing my reasons for being there and the impact of the information that I gather. These issues are further discussed in section 3 below.
Summary of the literature

There is a large body of work exploring aspects of institutional thinking, including Weber's analysis of the values which imbue the rise of capitalism (Weber 1930) and Foucault's tracking of the ways in which "the administration of bodies and the calculated management of life" (1984: 140) has come into being. Unfortunately, little work has been done in the area of organisational anthropology in Australia. Of the work that has been done overseas, to my knowledge none have addressed the issue of cross-cultural public health policy and program development, nor have they taken the culture of the bureaucrats involved as the starting point.

Within Australia, the work of medical anthropologists has played an important part in assisting health staff to understand the implications of their work from their patients' point-of-view (Reid 1978, Reid and Dhamarrandji 1978), or to refine their cross-cultural practice with the know-how derived from anthropological work (Brandl and Tilley 1981, Devitt, 1995 #775, 1996). Anthropologists have also involved themselves in the analysis of government policy and its (often damaging) effects on Aboriginal people (Morris 1985, Rowe 1992, 1996). Tarun Weeramanthri's preliminary work on medical practitioners and their understandings of Aboriginal approaches to death and dying (1997) indicates the potential scope of research that explores the cultural identities of the health professionals. But in the main, little has been done on the culture of public health professionals. Why? Possibly western anthropologists have been guilty of assuming the familiar is already known. Or it could be simply that anthropologists in Australia have repeated the common assumption that culture is something the organisation has, and Aboriginal people have, but the salaried middle class do not (cf. Rosaldo 1988: 202).

The anthropological neglect of the culture of mainstream institutional settings has nonetheless allowed business schools, political and management science formulations of the bureaucracy to flourish, while the varieties of tacit, common-sense (ie cultural) knowledges which underpin the operations of the bureaucracy remain poorly understood (see, for examples of the former, Barnett 1988, Barret and Fudge 1981, Ham and Hill 1987, Lindblom 1980). The tendency in scholarly work on government activity is to depict organisations as static, orderly domains, with the main debates centring around what forms of management will extract the best performance from employees (Alvesson 1993, Jones, Moore, and Snyder 1988, Kilmann, Saxton, and Serpa 1985, Martin 1992, Sackmann 1991, Smircich 1983, 1984, Trice and Beyer 1993). While many claim to be about organisational culture, with few exceptions the use of anthropology is piecemeal. In the process, who bureaucrats and professionals are, what motivates them, what they make of their work, and the strategising that informs their actions, is lost from view.

Within recent times, critiques have emerged of the public health approach which draw attention to its social engineering aspects (Bunton 1992, Lupton and Peterson 1996, Peterson 1994) but again, the subjectivities of the officials involved are not the central focus of the work. Given this research void, my proposed ethnography would make a critical contribution to debates within the health system about the nature of health's business; to formal studies of bureaucracies through the introduction of different analytical techniques and disciplinary knowledges, and to Australian anthropology, through opening up a much neglected area that is crying out for critical appraisal through an ethnographic lens.
2. **SUBJECTS**

*Please circle intended response to the following questions*

Is this research to be carried out on:

- Patients: Yes/No
- Students: Yes/No
- Human Foeti: Yes/No
- Children: Yes/No

- Dependents: Yes/No
- Patients Records: Yes/No
- Animals: Yes/No
- Human Tissue or Sera: Yes/No

How and from where are the subjects to be selected?

Participants in my study will be public health professionals who work on Aboriginal health policy, program and training issues who agree to my sustained presence in their workplace as a participant observer.

Will healthy normal volunteers/controls also be asked to participate in this study? Yes/No

If Yes, how will these volunteers be recruited and then selected?

3. **SUMMARY OF THE ETHICAL CONSIDERATIONS**

*Outline the likely benefits to the subjects and/or wider community. Indicate the possible risks and inconveniences to which subjects might be exposed.*

The key benefits of my research for subjects fall within the social, rather than individual, realm. By spending extended time with public health staff and trainers, listening to stories, learning the ropes, understanding the frustrations and rewards, I hope to learn about the constraints and possibilities of Aboriginal public health action from the bureaucratic side of the equation. My work will also inform discussions around the issues of work satisfaction (NT recruitment costs are very high) and training and orientation efforts which in turn will help to define the questions and perspectives of a range of evaluative efforts in the future.

The participants of my study are not patients but health professionals occupying salaried positions within Territory Health Services. In the main they are educated, English-speaking, literate and numerate, and, as most have tertiary qualifications (including at the post-graduate level), they are familiar with research processes and are more than aware of their consent rights. In other words, the normal imbalance of power in the researcher-researched relationship doesn’t apply - which does not mean the research is risk-free. In ‘same-culture’ research, the key ethical issues pivot around disclosure and the potential impact of the research on both the researcher and participants. I deal with these in turn.

- **Deception:** Participant observation takes a number of guises, from clandestine studies in which the researcher keeps her identity and purpose from others in order to ‘pass’ as a complete insider, to more overtly observational roles. In my case, I will be attempting to be participant-as-observer: that is, to participate in activities where this is permitted and
welcome but with my role as researcher declared and permission to be there pre-established. This allows me to achieve the spatial and social proximity to public health professionals I feel is required to see how they deal with attempts to work on Aboriginal health and prevention issues whilst not being deceptive about my role.

- **Anonymity:** A concern for all qualitative researchers is that of maintaining the anonymity of subjects and their settings. A common technique is to rename people and places. However, with an organisation as small as Territory Health Services, it is impossible to guarantee that individual personalities will not be identifiable, even with re-naming. My strategy here is straightforward: people who agree to let me observe them do so with the full knowledge that I cannot fully guarantee anonymity. I have attempted to minimise the risk associated with identifiability by securing an agreement from the Department that no employee will be censured or otherwise suffer career damage through being involved with my research or sharing information about their work with me - or conversely through refusing to be involved (see Statement of Rights and Responsibilities, Attachment C). This is not a fool-proof approach but one which aims to minimise the chance of my research findings being misused.

- **Peer research:** The NHMRC information paper Ethical Aspects of Qualitative Methods in Health Research makes the critical point that little attention has been given to the ethical issues involved in doing research within institutional settings where the researcher not only forms relationships with those observed and interviewed but is part of an existing social network and may in fact be in a less powerful institutional position vis-a-vis 'the subject' (1995: 25). This directly applies to my research situation and my comments on the implications of this are necessarily speculative. I have worked for Territory Health Services in a policy capacity, and intend to work there again at the completion of my research. I will not be able to withdraw from the research arena at the end of my research and return only when and if it feels comfortable for me to do so. This may unintentionally or subconsciously constrain what I feel able to say, despite my firm adherence to the principles of critical research and theoretical reflexivity.

A further ethical issue arises in that, as a member of THS, I am expected to abide by certain standards of conduct. In normal circumstances this would include reporting instances of unprofessional behaviour to management. I have discussed this issue with senior managers in THS and specified in the Statement of Rights and Responsibilities that, as a researcher, my first concern is to protect the confidentiality of my informants. Possible exceptions to this rule - for example, if I learn of illegal activity that poses a clear danger to others - I am to discuss with Dr David Ashbridge, who is auspicing my project on behalf of Operations North, or Mr Peter Plummer, Secretary, THS. .

- **Publication:** The need for critical analysis has to be balanced against my related desire to contest the muckraking tradition in social scientific work which simply blames bureaucrats and conveniently ignores the empirical complexity of Aboriginal public health work. My concern with the complex and contradictory reality of bureaucratic work is the key strength of my approach and will help mitigate the "unanticipatable consequence" of negative research findings being published and psychological harm being experienced by participants (cf NHMRC paper 1995: 25-26).
4. LIST THE TECHNIQUES AND/OR PROCEDURES WHICH WILL BE USED IN THE STUDY WHICH WOULD NOT FORM PART OF ROUTINE PATIENT MANAGEMENT.

Justify your choice of techniques in light of any available alternative techniques and/or procedures.

Ethnography is an anthropological study of cultural practices using participant observation (where the researcher attempts to understand a group from the inside to the greatest extent possible) as the principal method. It involves the study of groups and individuals as they go about their everyday lives and involves two distinct kinds of activity: firstly, entering a social setting and participating as far as possible in the daily routines of that setting; and secondly, recording detailed field notes about what has been observed in a regular and systematic way.

In an older but still pertinent definition, Conklin defines this methodology as involving: “a long period of intimate study and residence in a small, well-defined community, knowledge of the spoken language, and the employment of a range of observational techniques including prolonged face-to-face contacts with members of the local group, direct participation in some of that group’s activities, and a greater emphasis on intensive work with informants than on the use of survey data.” (1968: 172). To this definition I would add the use of in-depth open-ended interviews, the use of audio-recordings, archival research; policy and document analysis, speech and communication analysis.

With all three groups - public health operational staff, trainers, and policy staff - I will be ‘shadowing’ people as they go about their daily work, taking part in activities where possible, and recording field notes of conversations and events in journals. There are many work activities I hope to observe, including meetings; training sessions; problem-solving discussions and a raft of more informal and mundane moments. With the permission of participants, and when it would note disturb the flow of events to do so, field notes will also be augmented by the use of tape recordings and photography.

5. STUDY DESIGN

Please justify sample size and any other aspects of study design such as randomisation procedures.

As noted, ethnographic studies focus on gathering intensive, descriptive data on actors within a given location. Instead of studying large samples of people or attempting to select a sample group which contains a representative mix of variables, an ethnographer engages in the lives and concerns of smaller groups by entering as fully as possible into their daily arenas, using participant observation as the principal methodology. The three groups with whom I will be spending extended time with are public health operational staff in Nhulunbuy, Katherine and Darwin rural; public health trainers; and policy staff in the Aboriginal Health Strategy Unit and Public Health Division. I will be working with the Operational staff during the first six months of my fieldwork year, followed by six months with policy staff. Work with trainers will be interspersed throughout the year, in accordance with the Staff Development Services course development schedule. I hope to mimic being a public health staff as far as possible by undergoing remote area orientation training and doing (mostly administrative) tasks within the work units I am in.
Anthropological fieldwork is an inductive approach whereby analysis of data and the formulation of theoretical explanations are derived out of the research, or from 'the ground up' (cf. Glaser and Strauss 1967). I will be watching for the sorts of things which are most meaningful for the people I am spending time with in an attempt to see from the inside how people carry out their daily rounds of activities and what they feel about what they are doing. At all times I would be assuming that I do not know in advance what is meaningful and important for public health professionals but letting themes and research questions develop out of the fieldwork. What people say about their work will be cross-checked and augmented with detailed records of observed events and transactions, and the gathering of multiple perspectives on a given issue. My principal concern is to observe and listen to people in naturalistic work settings, including in meetings, when something is being organised, corridor conversations, doorway exchanges, chats around work stations and photocopy machines, workshops, training sessions and so forth. Notes about such occasions will be made in field journals at the time and usually in the presence of participants, although there will also be times when participating in the moment overtakes making jottings and write-up occurs later. Extended speech events (such as a recorded meeting or group discussion) will be transcribed according to the notation system developed by speech analysts and most clearly refined by Jefferson (1978, 1990). Data analysis and write-up will commence in July 1999 and continue through to mid 2000, when the thesis will be presented for examination.

6. **CONSENT STATEMENT**

*Please circle intended response to the following question*

Who will obtain informed consent for the study? **The Chief Investigator**

- Will written consent be obtained? Yes/No
- If Yes, please attach Consent Form Attached (Attachment A)
- If verbal or no consent, please give reasons

Whilst I will be obtaining written consent from participants, I also want to make a case for an ethically and empirically more complex situation. As the NHMRC information paper *Ethical Aspects of Qualitative Methods in Health Research* notes, it is not always possible in observational research to gain written consent from all the people a researcher may observe (NHMRC 1995: 15). Further to this, I regard consent as an ongoing process which has to be negotiated on an occasion-specific basis. That is, I consider research within an institutional setting requires the researcher to negotiate recursively throughout the organisation, with the complete expectation that agreement reached at one level or for one occasion is not a guarantee of continued permission at all levels and for all occasions (for a discussion of this point, see Van Maanen 1978a). Where research is dependent on the pursuit of unfolding events, research bargains take a number of forms. Therefore, in addition to initial written consent, I expect to be negotiating implicit and explicit, verbal and written agreements, throughout the terms of the research in a process of continuous exchange with participants.

To gain initial access to workplaces, I observe the following procedures:
- write to the relevant staff unit head/manager to request a meeting to discuss my research
- meet with staff in person to explain my research in detail
- provide a written summary of my research (attachment B)
If staff agree to me spending prolonged time observing them at their work, I will:

- seek their individual, signed consent (as per form, attachment A)
- provide a copy of the Statement of Rights and Responsibilities drawn up between myself and THS (attachment C) which specifies the principles governing my research, and which affirms that employees will not suffer any form of penalty for what they disclose or for choosing not to be involved in my research.
- In meeting situations, where people other than those I am working with directly may be present, I will ask the Chair leave to explain my presence and have the group's assent/rejection noted in the minutes.

As there will be times when I would like to record discussions on cassette tape and/or photograph people in action, I will ask people’s permission to do so at the time. At no time will I record information without participant’s full awareness and consent.

In the case of subjects for whom English is a second language, what arrangements will be made to ensure comprehension of the details of the study and the Consent Form?

Not applicable.

Have you provided participants with a means of contacting you urgently in case of an emergency?

Yes, participants will have both my contact details and that of nominated departmental auspices, including Dr David Ashbridge, Deputy Regional Director, Operations North.

7. SUBJECT INFORMATION STATEMENT

*Please circle intended response to the following questions*

Will written information about the study be provided to the subject

- Yes  No

If No, please give reasons

Will subjects be offered any money for their participation in the study?

- Yes  No

If Yes, on what basis?

8. PROGRESS

*How will progress of the research be measured?*

The University of Sydney requires annual status reports to be lodged with the Anthropology Department following the preparation and fieldwork components of the degree, against which progress is monitored by two supervisors, the post-graduate coordinator and the Departmental Postgraduate Committee. In addition, the Scholarships Office of the Faculty of Arts has a separate reporting schedule to ensure the student's continuing eligibility for the scholarship award. This includes a supervisory report and must be endorsed by the Head of Department, Anthropology.
How will any possible harm to subjects be monitored?

Should it become apparent that participants are uncomfortable as a result of disclosing information, I will stop or modify my line of questioning and/or renegotiate conditions of access, and/or ultimately withdraw if the issue cannot be resolved.

When and on what criteria will the study end?

See note above. I anticipate that the formal component of my fieldwork will end June 1999 on the basis that this depletes the 12 months available for field research within the doctoral program. Analysis and write up should be completed by June 2000.

How will the subjects and/or community be informed of the process and outcome of the research?

Feedback on my work will take place using a variety of methods:
- publication of articles in anthropological and public health journals;
- production of a summary report for internal THS use;
- staff workshops and meetings;
- presentations and seminars.
Participants will also be able to approach me at any time for a summary.

Finally, the statutes and regulations of the University of Sydney require that the examined thesis be publicly available for research use and lodged in the University Library for such purpose.

9. **PROPOSED STORAGE AND ACCESS OF FILES AND DISPOSAL/STORAGE AT END OF STUDY**

*Please include what steps are being taken to ensure confidentiality of patient information.*

My field-note journals, files and assorted data (eg departmental brochures and other corporate documents) will be stored in a locked filing cabinet in my private study. Following transcription, cassette tapes will be re-used, thus erasing pervious recordings. I will not be using patient records.

10. **COMMUNITY CONSULTATION**

<table>
<thead>
<tr>
<th>Has the proposed research been discussed with leaders of any communities (Aboriginal, ethnic or other) which might be particularity involved?</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Yes, please detail the process of consultation and the comments received. (Written support should be attached if possible)</td>
<td></td>
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</tbody>
</table>

I have negotiated entry to Territory Health Services through a multi-tiered process. During the preparation stage of my proposed research I conducted a number of discussions with members of THS which helped refine my ideas about what I might be able to do. I have established overall permission to undertake an ethnography within THS from the Secretary of the Department, Mr Peter Plummer, and from the Division Heads of Public Health Services, the Aboriginal Health
Strategy Unit, and Operations North. I developed the Statement of Rights and Responsibilities (endorsed by the THS Senior Executive) by first meeting with senior managers and unit staff from the Operations North, Aboriginal Health Strategy and Public Health Divisions, in groups and/or on a one-to-one basis according to preference, to establish what staff saw as important issues for the Agreement to cover. To establish where I can and cannot do fieldwork, I have negotiated directly with a mixture of staff in the Health Promotion, Environmental Health, Nutrition and Family, Youth and Children's Services Programs in Darwin Rural, Katherine and Nhulunbuy, and with members of the Rural Health Training Unit, Staff Development Services.

DECLARATION:

All proposals must be reviewed and approved by the Head of the relevant Department/Institution prior to submission to the Committee

I certify that the information given is correct to the best of my knowledge. I acknowledge that I must notify the Committee if there is any ethically relevant variation. I have read and agree to abide by the relevant parts of NHMRC Statement on Human Experimentation.

Name ____________ Teresa Lea
(Chef Investigator)
Signed ________________ Dated ______________
(Chef Investigator)

Name ____________ Dr Franca Tamisari
(Supervisor)
Signed ________________ Dated ______________
(Supervisor)

Name ____________ Dr Gillian Cowlishaw
(Supervisor)
Signed ________________ Dated ______________
(Supervisor)

SIGNATURE OF DIRECTOR/MEDICAL SUPERINTENDENT HEAD OF ANTHROPOLOGY DEPARTMENT, THE UNIVERSITY OF SYDNEY:

Name ____________ Dr Daryl Fiel
Signed ________________ Dated ______________

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References cited


