

A Benign Arithmetic: Taking Up Facts About Indigenous Health

Tess Lea

Of the many stories that are scripted to explain the sickly blood and diseased organs of Indigenous Australians, few explain how the facts of the matter are incorporated into the lives of health professionals, who in turn attempt a reproduction of their understandings into the subjects who are the objects of the epidemiological horrors. Bureaucratic and professional health knowledge is somehow ready-made, and its actors controlled by the organisational logic they play an unwitting part in reproducing. Theirs is a prefabricated instrumentalism. But if we take as a starting point the active and agonised reflexivity of health professionals, the engaging force-field of pre-given ideology quickly morphs into a more animated and refractory set of exchanges.

My argument grows out of anthropological field research (1997–2000) and active participation in Territory Health Services (THS), the Northern Territory Government’s preeminent agency for health and social welfare policy setting, program funding and service delivery. In this essay I explore the anxiety that surrounds the recurring concern that Aboriginal people do not take up health facts sufficiently to change their behaviour—so new facts must be delivered, in more powerful ways, to create the right response. The chief focus of my attention is the native (that is, 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 the health facts that have found them. But I am also concerned with the net effect of bureaucratic struggles with fact absorption and transmission on the administrators and practitioners at the centre of the agonising, and it is here

that I move to a more generalised style of argument as I search for ways of capturing the high momentum stasis that, I will argue, creates the lived imperatives of this domain.

Intervention learning

In my work, focusing on the bureau-professionals¹ of Territory Health Services as they 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. The challenge is how to return the otherwise stable universal category of the healthy person²—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.

A public health physician who has worked long and hard on ways of presenting death information, exploring the persuasion power of pie charts versus bar graphs among various Aboriginal groups, 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.³

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 secrets rendered.

Imagine 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:

Life expectancy at birth
Age adjusted mortality
Rate of death: 25-44 year olds
45-64 year olds
Infant mortality rate
Still birth rate
Infant growth rate

The multi-hued information-dense tabulations embedded within 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.

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,' reassures 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 this is not uncommon among the narrative formulations within health talk: from opening depictions of direness to hope, back to difficulty; out of overwhelming problem to the more that can be done, against the harshest of odds.⁴ The answer, with better data, is around the corner—but it will take time and be a densely problematic process. New electronic information management systems are on their way, which will speed up the rate of localised data collation and dissemination, but accurate capture of elusive Aboriginal people will remain difficult in the face of their multiple identifiers and high levels of (morbidity-induced) mobility.⁵ When decisions are reached about how to count the number of bodies as they move across the landscape, when alternate *noms de plume* can be readily called up by 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 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 re/act in a *more informed manner*.

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, risk consciousness is the defining feature of late modernity, where the production of more hazards has prompted high anxiety on a global stage.⁶ 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’.⁷ Yet under informational capitalism, the structural conditions for reflexivity about causes and effects is unequally

distributed.⁸ 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, information equates with 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 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.’⁹

Travelling facts

Pondering the route of travelling facts, bio-science ethnographer Joseph Dumit asks ‘Who takes up facts? Who does not? How are they produced and distributed?’¹⁰ Now, given our all-over dependence on categories of scientific knowledge for our lived sense of healthfulness, personhood and function,¹¹ it comes as no surprise if I gloss a bureaucratic answer as: it is ‘we’ who take up facts, and it is Aboriginal people who are deemed to not take them up. And it is to epidemiologists and remote area health workers that we turn in Territory Health to produce the transformational knowledge that will fashion appropriately alarmed responses. What we see played out in many 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 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 Walter Benjamin reminds us, is a mode, never a neutral transmitting device.¹²

Re-defleshing

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).¹³

We are familiar with the desensitising power of statistics. But entering the world of public health, 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. It seems unnecessary to the creation of scandal—unlike say, epic depictions of fascism or mass starvation—that we 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?

Chronic disease, known to be eventually debilitating and life terminating, is as it is: a stripped and straightened syndrome, not an embodied state. It is even 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’.¹⁴ The THS Preventable Chronic Disease Strategy, for instance, 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.’¹⁵ Even trained health professionals may not know

it, as when remote area nurses diligently measure and record childhood growth patterns for the epidemiological register and are unable to see the (silent) stunting in the live-wire, energetic, frenetic little black bodies in front of their eyes.¹⁶ Here the visual image which does not have the look of disease, which lacks its encultured, performative dimensions, is not sufficient to activate intervention.¹⁷

Liisa Malkki similarly describes intact Hutu refugees as being 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.¹⁸

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". For the asymptomatic diseased bodies of Aboriginal people, a reverse move takes place: their silent bodies cannot be trusted to tell an 'immediately ascertainable'¹⁹ story, an opacity which must be made transparent through more skilful professional investigation and tutelage. Health professionals, like the nurses who fail to witness properly, need to be told what to look for, assisted with new measuring instruments, practicals 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 they know little.

Authoring, receiving and transmitting

It is day four of a week long remote area nurse in-service session for the East Arnhem Region, held in the Nhulunbuy

Hospital staff conference room, with this afternoon's session 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. As the remote area nurse with the longest tenure in the Arnhem region, it falls to Sherry Riley to lead her counterparts page by page through the latest Growth Assessment Action Reports which collate the annual clinic returns into a report specially designed for community feedback. In a conscientious aesthetic of cross-cultural simplification, minimal text is maximised in large print and vividly coloured drawings, and diagrams replace the dense exegesis of an internal-use epidemiology report. Interacting with Sherry are eight nurses who've already attempted to use the previous year's material in feedback sessions with Aboriginal health workers who are frequently used as the standardised representatives of the (poorly literate) 'grass-roots'. The nurses are cynical, they've seen it all before.

'This is about moving from interpreting the data to doing something about it', rallies Sherry. '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 new layouts of this year's report in the light of their previous efforts at 'feedback'. The interactively negotiated verdict is that fluorescent lime-green and fire-truck red squares gridding under- and over-nutrition rates are the most successful in creating Aboriginal interest.

Page by page analysis of the report continues.

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

Another nurse: 'Do you think your health workers really understand it?'

Sherry responds: '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 what's the problem?'

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 insufficient
- The information is insufficiently known.

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 that 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 bio-social habits from infancy on to explain how concepts of risk and acceptance of health facts are instantiated within a suite of mundane practices—from a dutiful care to combine ascorbic acid when taking iron tablets, to dish washing.

My quest then needs to 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'²⁰ 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 implicitly 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.²¹ For while, like social scientists, health professionals seem to pay little attention to how health facts found them in the first place, at the same time, they know they have been

found.²² 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. A theory of socialisation and personhood is clearly operating in the following narrative by an environmental health officer, here describing her 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.

Barbara plans to fix this imagined osmotic gap by, among 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 eyesight 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.

Barbara 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 temporal and microscopic exposure to help them discern the underlying causes of their own illnesses. And the assumption that Aboriginal people are a psychological facsimile of ourselves,²³ which runs through the quests to change behaviour through (narrowed and simplified, even Aboriginalised) simulations of 'our' education, also draws on a philosophic and sociological tradition which likewise 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'.²⁴

But Barbara is also blending in alternative understandings. Shame figures prominently, both in her recollection of the disgusted maternal figure who installs through admonition a shame-making contempt for bodily products and a lifelong (healthy) respect for the invisible stealth of germs; and in the reminder that Aboriginal people are acutely sensitive to shame, an incantation of a common injunction about Aboriginal cultural distinction that stands here not as a symbol of sharedness but as its inverse: a mysterious and singular attribute which must be carefully guarded against transgression.²⁵

Yet the cultural difference that seems to be about a distinct form of being is just as quickly displaced by the notion of a universal response to the hyper-real images of the microscopic. We could compare Barbara's widely shared faith in the microscope's power to provoke a particularised form of enlightenment,²⁶ with Emily Martin's discovery of the excess of meanings different viewers bring to the surreal and wondrous

images produced by cells under electron micrographs.²⁷ For Martin's American subjects, the space of inculcating a correct classification of these images of the intra-organic was instead occupied by deepening forms of wonder and perplexity, resulting in anything but closure. The one factor uniting her informants' wildly diverse interpretations of the scientifically derived scale reversal of human cells magnified onto a screen, even with an authority figure suggesting a particular interpretation, was 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'.²⁸ So much for guaranteeing phobic hygiene mentality out of a form of (sur)realist revelation which, it appears, readily translates into deeper forms of concealment, even for the biologically pre-saturated population of English-speaking Americans.²⁹

Barbara's own enchantment with the marvellous activities of little creatures speaks eloquently of the theories of factual transfer and uptake operating among health professionals. These are germs with unique cultural and structural forms, an esoterica which makes sense for Barbara in terms of her understanding of the science informing environmental health, but this subtending ability to objectify the links is stripped of its heritage and reduced to a straight osmosis between the visual and the interior. Here it is the mesmerising effects of minitiarisation which will articulate a connection between germs, domestic cleaning habits, and bodily health; elsewhere it is pie-charts (not bar graphs), green and red (not pastel).³⁰ But the women might not be able to see things clearly because their eyes are diseased. In fact they are all diseased, they are, in 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.³¹ If only they really knew it.

This switching between a sense of radically different sensory alterity and assumptions of cognitive sameness 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'³² in manifesting

refugee-ness, in Territory Health Services 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 lacklustre uptake of health actions by Aboriginal people. Aboriginal people do not know how unwell they are. 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 calls and attempts, which seem to presume a non-absorption of some dimensions. And even this concern switches attention back to forms of anthropologised speculation about Aboriginal absences when it is the astonishing motivational power attributed to the statistical content that must be translated to achieve affective effect which puzzles me here.

Toward retaining this focus then, let's assume that Aboriginal ill-health has been statistically encountered. In fact, let's 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.³³ 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, news 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 scabies infestation. Apologetic and condemnatory facts about poor Aboriginal health may erupt in the form of a scandalised re-recognition of racist inequality, a regularly recurring agast discovery which proves, for instance, that government efforts toward reconciliation are not working hard or fast enough. 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,³⁴ and yet 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’.³⁵ That is, on the subtending cultural and historical depth 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.

And yet, despite the randomness of direction from which facts about Indigenous morbidity, mortality and informational lack can come, it remains both 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. The social life of health facts become denser still, if we add a more than a chrono-historical dimension to the lateral replicating movements, reference to which implies further ‘fact-events’.³⁶ 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 of these would have their own structures of instantiation, which would need to be traced to honour the phenomenological dimension to health information multiplications. 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 it) seem to have shifted very little. Calls for community involvement and greater awareness, more research and better coordination abound and have done so for an astonishingly lengthy period. Among other effects, this contributes to participant feelings that things remain the same, despite the extensive re-analysis, renewed critique and widening sphere of interventions. 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.³⁷

Impacting

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 rules³⁸—and further, if we imagine them as being able to be acted upon, heated up (deployed to create scandal 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 claims to scientific method)³⁹ then I also am 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 there is 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.

The Brownian metaphor is mine, but it draws attention to the analyses health bureaucrats offer of their own inundation. 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, 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—and yet, on the horizon, around the corner, embedded within program success stories and deliverable with perfection of the data sets lies the good news

that improvement is possible, if the more that can always be done could only better handled through a redirection of effort and the design of a new approach. Each time, the problem diagnosis breathes new life into the proliferating need to share information 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.

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 already found them. To put this another way, the health statistics which do not speak for themselves, requiring, as they do, societal steepage and interpretive training to be rendered,⁴⁰ create an alarm for health professionals as a result of their virulent infinity. An indexical infinity created by their inability to encompass all there is to know, or to achieve a perfectly translatable reformulation which creates the alchemy of Aboriginal transformation. 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 Aboriginal transformation through apprehension is, in short, a culturally stylised abstraction of our own governing imperfections and as we are moved to act, so shall they be.

Reflection

This essay works through a puzzle: what do we know about the people undertaking forms of (paid) worry on behalf of Indigenous people; about *their* states of being; how they acquire and absorb information; and why they are so convinced that data sharing will be life transforming for others? At the most straightforward level, the mantra ‘knowledge is empowerment’ underpins the knowledge-sharing imperative that drives much of the outreach work in Indigenous public health. Lots of data is collated which describes just how unwell Aboriginal people in regional and remote Australia are, how early this starts, how complicated its causes are and so on. If this knowledge could only be made accessible, then everyone will be operating from a shared starting point. But what other convictions are health professionals expressing in their fervent belief that facts act? This essay looks more closely at the effect of statistical bombardment on health professionals themselves, arguing that the imperfection of the quest helps explain the ready-to-think quality of data translation strategies. For hope to stay alive, an elusive sense of what lies beyond is needed, if only we work harder to get there. Data and its translation feed a (hope-creating) battle with futility. Like the Borges map, the task of statistical completion is without end, with many impediments and distractions in the way. The flurry creates urgency and stress; a somatic impact that easily becomes a cultural homologue. If I am so animated by these portraits of suffering, surely the ‘subject-objects’ will be too—only more so, because this important information that I have privileged (stressful, partial, never-completed) access to, is denied to them, because of unequal states of power-knowledge.

The idea that futility might be psychically and organisationally productive took me to a greater puzzle about Indigenous social policy: how does a domain as automatically self-reflexive and smart as Indigenous health continue to serve up the same kinds of answers, over and over again? How are bureaucratic logics made so resilient given they are subject to relentless critique? An extended ethnographic account of how fiercely independent and intelligent people learn to do deeply bureaucratic and repetitive things can be found in my book *Bureaucrats and Bleeding Hearts: Indigenous Health in Northern Australia* (UNSW Press, 2008). This book looks at the circular and narcissistic quality of bureaucratic rationalities, and how there seems to be no way that interveners can imagine

improvements that omit their involvement ... except as a desired future redundancy when working beyond the limits of wit and energy to solve the intractable issues of neo-colonial health inequality will stop being so necessary. In a similar way to how the search for data becomes an end in itself, a sense of the sheer impossibility of this endpoint fuels what I term 'remedial circularity'. In Indigenous health, futility and optimism operate as a hologram, ultimately being one and the same thing. Viewed from one angle, the hologram shows crises—impossible and endless work—and then, with a twist of representation and a dash of institutionally ordained optimism peppered with compulsory good news stories, the same issues magically transform into challenges (not problems) and opportunities that can be acted upon with the right attitude and means. It is all a form of suspended animation, or what I call here 'dynamic inertia', a description that could well hold true of many forms of work and life in this alienated, information-saturated, time-fractured age.

Notes

- 1 The term 'bureau-professionals' was introduced by Henry Mintzberg to capture the simultaneity of professionals trained in personal social services with their location in contemporary welfare programs and government-funded bureaucratic structures. Mintzberg, *Structure in Fives: Designing Effective Organizations*, Prentice Hall, Englewood Cliffs, 1993.
- 2 Joseph Dumit, 'A Digital Image of the Category of the Person', in Gary Lee Downey and Joseph Dumit (eds), *Cyborgs & Citadels: Anthropological Interventions in Emerging Sciences and Technologies*, School of American Research Press, Santa Fe, 1997, pp. 83-102; Andrew Metcalfe, 'Living in a Clinic: The Power of Public Health Promotions', *The Australian Journal of Anthropology*, vol. 4, 1993, p. 31.
- 3 Tarun Weeramanthi, 'Knowledge, Language and Mortality: Communicating Health Information in Aboriginal Communities in the Northern Territory', Territory Health Services, Darwin, undated, p. 7.
- 4 See Joseph Dumit's account of the different modalities of resting answers in the research that is yet to be done in Dumit, How to Do 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, p. 26.
- 5 The reference is to explanations which cite as causes of high mobility the need to attend funerals, to care for sick relatives or to seek tertiary treatments. See, for example, John Taylor, 'Measuring Short-term Population Mobility among Indigenous Australians: Options and Implications', *Australian Geographer*, vol. 29, 1998, pp. 125-37 and Nicolas Peterson, 'An Expanding Aboriginal Domain: Mobility and the Initiation Journey', *Oceania*, vol. 70, 2000, pp. 205-18.
- 6 Ulrich Beck, *Risk Society: Toward a New Modernity*, Sage, London, 1992.

- 7 Robin Bunton and Roger Burrows, 'Consumption and Health in the 'Epidemiological' Clinic of Late Modern Medicine', in Robin Bunton, Sarah Nettleton and Roger Burrows (eds), *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*, Routledge, London, 1995, pp. 206–22.
- 8 Scott Lash, 'Reflexivity and its Doubles: Structure, Aesthetics, Community', in Ulrich Beck, Anthony Giddens and Scott Lash (eds), *Reflexive Modernisation: Politics, Tradition and Aesthetics in the Modern Social Order*, Stanford University Press, Stanford, 1994, pp. 110–73.
- 9 Robert W. Connell, Class, Health and Justice, Address to the first Conference of the Public Health Association of Australia and New Zealand, Sydney, 1987, p. 1; as cited in Metcalfe, p. 35.
- 10 Dumit, 'A Digital Image', p. 83.
- 11 Donna Haraway, *Simians, Cyborgs and Women: The Reinvention of Nature*, Free Association Books, London, 1991; Emily Martin, *Flexible Bodies: Tracking Immunity in American Culture—From the Days of Polio to the Age of AIDS*, Beacon Press, Boston, 1994.
- 12 Walter Benjamin, *Illuminations*, Fontana/Collins, New York 1955, repr. 1977.
- 13 Paul Rabinow, 'Artificiality and Enlightenment: From Sociobiology to Biosociality' in Jonathan Crary and Sanford Kwinter (eds), *Incorporations: Zone 6*, Urzone, New York, p. 243.
- 14 Joe Wright, *Community X: Final Report. Evaluation of Existing Health Care Service Delivery and a Measured Health Needs Analysis of a Remote Aboriginal Community in the Top End of the Northern Territory*, Commonwealth Department of Health and Family Services, Darwin, 1996, pp. 5–6.
- 15 Ministerial Statement, August 1999, 'Preventable Chronic Disease Strategy' (Eighth Assembly First Session 10/08/99, *Parliamentary Record No.18*), available at <http://www.nt.gov.au/nths/publichcdc/preventable/minister.html>; emphases added.
- 16 Alan R. Ruben and Alan C. Walker, 'Malnutrition among rural Aboriginal children in the Top End of the Northern Territory', *Medical Journal of Australia*, 162, 1995, pp. 400–403.
- 17 This is well established as a syndrome in the sociology of medicine literature. Although the subject of extensive revision and critique, Talcott Parson's classic original concept of the 'sick role' firmly established the idea that the sick person has to perform unwellness and actively comply with the injunction to noticeably desire improvement to attain legitimacy. Talcott Parsons, *The Social System*, The Free Press, Glencoe, 1951. In contemporary literature, post-Foucault, this notion has been expanded to cover a more continuous set of rights and duties: a shift captured in the term 'health roles'. See Robin Bunton and Roger Burrows, 'Consumption and Health in the 'Epidemiological' Clinic of Late Modern Medicine', in Robin Bunton, Sarah Nettleton and Roger Burrows (eds), *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*, Routledge, London, 1995, pp. 206–22.
- 18 Liisa Malkki, 'Speechless Emissaries: Refugees, Humanitarianism and Dehistoricization', in Karen Fog Olwig and Kirsten Hastrup (eds), *Siting Culture: the Shifting Anthropological Object*, Routledge, London, 1997 p. 232; original emphasis.
- 19 On the cult of the immediately ascertainable fact, see: Alan Feldman, 'Violence and Vision: The Prosthetics and Aesthetics of Terror', *Public Culture*, vol. 10, no. 1, 1997, pp. 24–60.
- 20 Ibid., p. 31.
- 21 See Bruno Latour and Steve Woolgar, *Laboratory Life*, Princeton University Press, Princeton, 1986.

- 22 Much attention has been paid to the role of science, with its sense of the molecular, combined with the societal 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. See, for example, Deborah Lupton, *The Imperative of Health: Public Health and the Regulated Body*, Sage Publications, London, 1995. With brilliant exceptions, such as Martin and Downey and Dumit, these analyses tend to imagine a world of ideas as discrete from, but locked in a tight embrace with, broader 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 and with the facts before and within them.
- 23 Barry Morris, 'Making Histories/Living History', *Social Analysis*, vol. 27, 1990, p. 85.
- 24 Elizabeth Grosz, *Volatile Bodies: Towards a Corporeal Feminism*, Allen & Unwin, Sydney, 1994, p. 117.
- 25 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', *Australian Feminist Studies*, vol. 12, 1997, pp. 227–39.
- 26 My fieldnotes overflow with informant references to the use of microscopes as a strategy of information sharing to compensate for what is diagnosed as the Aboriginal lack of germ theory. 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 Richard Trudgen, *Why Warriors Lie Down and Die: Towards an Understanding of Why the Aboriginal People of Arnhem Land Face the Greatest Crisis in Health and Education since European Impact*, Aboriginal Resource and Development Services Inc., Darwin, 2000, p. 246).
- 27 Martin, pp. 167–82.
- 28 Ibid., p. 179.
- 29 Michael Taussig, *Defacement: Public Secrecy and the Labor of the Negative*, Stanford University Press, Stanford, 1999.
- 30 Consider also Alan Feldman's critique of realist strategies of depiction in which he points out 'the ethic of the correctness of the gaze, the concept of homoiosis—the resembling gaze that matches perception to what should be sighted—is the ground of realist aesthetics and should be placed under question in any inquiry into... politicized vision'. Feldman, p. 41.
- 31 MSHR, Menzies School of Health Research, Northern Territory, Australia. 1994–1995 Annual Report, MSHR, Darwin, p. 12.
- 32 Malkki, p. 233.
- 33 See also Kim Fortun's arresting description of information deluge in her study of the Bhopal environmental disaster, 'Locating Corporate Environmentalism: Synthetics, Implosions, and the Bhopal Disaster', in George E. Marcus (ed.), *Critical Anthropology Now*, School of American Research Press, Santa Fe, 1999, pp. 214–15.
- 34 In Dumit's terms, 'a material history of modification ... which in each situation effects one or more intercorporeal transformations'. Dumit, 'How to Do Things with Science', p. 6.
- 35 Theodore M. Porter, *Trust In Numbers: The Pursuit of Objectivity in Science and Public Life*, Princeton University Press, Princeton, 1995.
- 36 Dumit, 'How to Do Things with Science', p. 6.
- 37 Australian Reference Service, *The Australian Aboriginals*, Commonwealth of Australia, Canberra, 1976.
- 38 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 and also

specified by Bruno Latour in *Science in Action: How to Follow Scientists and Engineers Through Society*, Open University Press, Milton Keynes, 1987.

- 39 I am familiar with the rhetorical deployments of statistics having myself called upon front line researchers to deliver dramatic statistics to heat up a political speech or policy document.
- 40 As Rayna Rapp puts it: '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.' Rayna Rapp, 'Real Time Fetus: The Role of the Sonogram in the Age of Monitored Reproduction', in Downey and Dumit, pp. 31-48.