If Truth Be Told

The Politics of Public Ethnography

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Ethnography Prosecuted

Facing the Fabulation of Power

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"Absolutely not." I would not meet Dr. X at the Solicitor General's Office. The medical researcher and I were in the midst of a tense disagreement over the interpretation and publication of data we had collected, as collaborators, on right-to-health lawsuits against the southern Brazilian state of Rio Grande do Sul. This was nothing short of intimidation, I told Dr. A, a head researcher who knew Dr. X and was a kind of informal mediator in our unfolding feud. After all, Dr. X was an evidence-based medicine consultant for the state and worked closely with the attorneys reviewing the lawsuits. The Solicitor General's Office was hardly a neutral setting for our meeting.

What a hellish situation. It was mid-August 2010, and I had plans to fly out of Porto Alegre the next day. After multiple failed attempts to contact him, Dr. X had finally approached me, requesting that I remove all criticisms of the health system's malfunctioning from the article I had drafted over the summer, together with three other collaborators in the United States. He also insisted that our ethnographic references to patient plaintiffs were irrelevant and nonrepresentative, and should therefore be removed from the text. Beyond this Dr. X was oscillating between unwarranted claims for first authorship and the need to list the state attorneys as coauthors of the article, neither of which we had previously agreed upon. The results of our research were becoming an affair of the state, I thought, and my anxiety was reaching new heights, as I couldn't imagine a clear way forward.

In this chapter I draw on my own uneasy experience of collaborative research in order to engage polemics surrounding the widespread Brazilian phenomenon of right-to-health litigation, commonly referred to as the *judicialization of*

health.[1] As I reflect on the results of our research alongside the fraught collapse of the collaboration, I critically assess the antilitigation arguments and truth claims jointly articulated by officials, evidence-based public health scholars, and the media. Taken together, our work sought to elucidate the field of the judicialization and ultimately revealed something about *the fabulation of power* and the potential of critical public ethnography to produce counterknowledge.

The project in question was a statistical and multisited ethnographic analysis of right-to-health lawsuits in the state of Rio Grande do Sul, which has the highest number of health-related lawsuits in the country.[2] I worked with research collaborators in the United States and Brazil to develop a quantitative and qualitative portrait of the people who are turning to judicialization and to illuminate their travails. But frictions with Dr. X and state representatives started to surface when our initial statistical analysis of lawsuits found that judicialization was in fact a widespread practice, accessible even to the very poor, and that judicialization had, to a large extent, become an alternate path to health care when administrative mechanisms failed to uphold people's constitutional rights (thus confirming our ethnographic findings). Tensions over the interpretation and dissemination of data ultimately led to an explosive face-off between my university's legal counsel office, on the one hand, and a Brazilian research institute, and state prosecutors, on the other, and to the demise—and, in a sense, failure—of the collaboration.

This failed collaboration might be read as an experiment in public ethnography, whose meanings and stakes, as Didier Fassin has argued, are foregrounded in challenges to local knowledge production and circulation.[3] Such challenges highlight tensions over the reception of counterevidence by the guardians of orthodox knowledge and hint at the interests and political projects imbricated in the making and policing of local truths.

This ethnographic episode itself has a deeply public character: not only are the questions at stake of crucial relevance to public interest—health, rights, truth, policy, and the delivery of care—but the work itself is public, involving direct collaboration with public officials, themselves engaged in judicial, policy, and scholarly projects. Distinct from—although by no means antithetical to—engaged or activist anthropology that speaks truth to power or makes its findings public, this kind of public ethnography simultaneously emerges from and reflects upon work with social actors who themselves work, in theory, for the public good. And while ethnography does indeed have a public afterlife that raises new questions and debates,[4] this public life can further

participate not only in enlarging the ethnographic record but also in providing new openings for conceptual work. Carving out a retrospective *public self-reflexivity* thus brings into view the broader paradigms of statecraft and the specific mechanisms of veridiction and falsification at play in contemporary Brazil, particularly in the field of public health, and opens up new avenues for theorizing power and the political field.

When Ethnography Is a Failed Collaboration

In recent years, there has been an emergent emphasis on the role of collaboration in anthropological work, particularly in relation to the studying-up of scientists and other experts. Noting the "profoundly altered conditions in which relations of fieldwork today must be negotiated," Douglas Holmes and George Marcus, for example, make a case for collaboration as a crucial feature of contemporary fieldwork, envisioning a new form of ethnographic inquiry that brings anthropologists together with other "para-ethnographers" to engage in collective projects as reflexive, active "epistemic partners."[5] If, however, anthropologists engaged in successful collaborative work might learn from the analysis and knowledge practices of their collaborator-subjects, what is revealed when such epistemic partnerships break down?

In a much publicized example, Paul Rabinow's work with Berkeley's Synthetic Biology Engineering Research Center as a kind of anthropological collaborator-consultant fell apart over disagreements about scientific ethics and public risk, highlighting the fraught sharing of terrain by different kinds of experts and the challenges of critique within collaboration.[6] In working on the judicialization project, I found myself, like Rabinow, caught up in the broader interests of my collaborators, who brought their own strategies, political projects, and rhetorical needs to our (then) shared endeavor. Where Holmes and Marcus argue that the point of collaboration is "to integrate fully our subjects' analytical acumen and insights to define the issues at stake in our projects as well as the means by which we explore them," the moments where our insights and analytics clash with those of our collaborators might also become openings to the deeper issues at play.[7] Trained on the points of tension within collaboration, these "second order observations" lend a kind of dual reflexivity to the work, repurposing them as subjects of ethnographic attention.[8]

In the social and natural sciences negative results are seldom published. Yet, as is increasingly acknowledged in scientific research communities, these often unpublishable nonresults might be differently understood as important

contributors to knowledge production. Reconsidering them positively, not as absence but as content, opens up new opportunities for learning from failure, directing attention to the sometimes invisible dynamics of experimental mechanisms and machineries, their assumptions and entanglements, and their contradictions, uncertainties, and political stakes.

In her work on the offshoring of clinical trials, for example, Adriana Petryna notes that models of drug development and testing frequently underestimate adverse effects, operating within what she calls a "paradigm of expected failure": real risks are known and harms are anticipated, but such failures are normalized under a rubric of experimentality.[9] If, for Petryna, paying attention to failure sheds light on deeper questions about ethical variability, risk, and accountability, how might attending to the failure of the research collaboration in Brazil similarly illuminate core issues of statecraft, evidence-making machines, and political rationality at work?

Returning to the debacle of my collaborative work in Brazil, I am interested in what can be learned from the wreckage. In the first section I trace the origins and context of our project on judicialization in Brazil, arguing that particular government and market dynamics are tied to processes of veridiction *and* falsification that shore up postneoliberal political discourses. In the second section I discuss moments of tension with my collaborators, reading these face-offs as openings to the underlying evidentiary regimes and conflicting interests that shape *state data*. The third section draws on close analysis of one material artifact of our failed collaboration to attend to the ways official narratives are produced and mobilized to particular ends, illuminating what I have called a *de-pooring of people*. Ultimately, I reflect on the kinds of politics and publics at stake, problematizing the criteria for inclusion in contemporary political communities (real or imagined).

Fabulation of Power

In his lectures on biopolitics and neoliberalism Michel Foucault argues that we can adequately analyze biopolitics only when we understand the economic reason within government. In his words, "Inasmuch as it enables production, need, supply, demand, value, and price, etcetera, to be linked together through exchange, the market constitutes . . . a site of veridiction-falsification for governmental practice. Consequently, the market determines that good government is no longer simply government that functions according to justice." In an inversion of older relations between state and economy, the market and its liberal principles are no longer subject to state power but rather determine

the "truth" of government, that is, its jurisdiction and self-limitation. Guided by the principle that it is already in itself too much, government "is now to be exercised over what we could call the phenomenal republic of interests."[10] Excluded from this reality is the possibility that the collective good might be an object of governance or an organizing principle in individual lives.

The late liberal Brazilian political economy complicates Foucault's analytics. Over the past two decades the country has moved through a period of intense neoliberal reform and decentralization of services under the Social Democratic Party to the growth of social programs aimed at reducing inequality during the rule of the Workers' Party, which took power in 2002. Without radically breaking with neoliberal policies, the Workers' Party's poverty-reduction programs and expanded social services led to a redefined self-conception of the government as "beyond the minimal state."[11]

Brazilian state policy and political discourse emphasize the government's active role in guaranteeing the rights of citizenship and in eliminating poverty via cash transfers, for example, while the promotion of a market-friendly environment remains a central priority: "A rich country is a country without poverty," as an early slogan of (recently impeached) President Dilma Rousseff proclaimed. Brazil's political rationality today thus does not neatly align with Foucault's account, instead suggesting a more complex arrangement between state and economy, where the market, while critical, is not the sole dimension shaping governmental reason. The state itself is also entangled with personal interests and the demands of electoral politics, with the recent popular outcry over entrenched corruption highlighting the uses to which government is put even as it operates under the veneer of transparency and social equity.[12]

As I showed in my study of Brazil's model universal AIDS treatment policy, the consolidation of state activism has been coupled with extraordinary market expansion and the vanishing of civil society as a viable transactional reality.[13] In this mounting sphere of "state activism without statism,"[14] public institutions, in their frugality or futility, act in the name of equity while remaining largely unresponsive to the people they serve. While the verification of one thing normally serves as the mechanism for disqualifying another, in Brazil today there is *a decoupling of veridiction and falsification*. The state not only produces and authorizes particular kinds of policy truths but also actively falsifies renderings of its people and their needs. A different kind of unmoored falsification is at work, which coexists with but is also distinct from the joint machine of veridiction-falsification. These dual processes together constitute what I call *the fabulation of power*. They are the mechanisms that make possible

the coexistence of supposed social protection—or "a politics of distribution"—and market expansion, thereby shoring up particular political projects and interests.[15] As Brazil's current crisis shows, state resources are used and depleted to such ends, while the public continues to insist on the importance of social services; as a recent survey showed, an overwhelming 45 percent of Brazilians list health as the country's principal concern.[16]

Thus in the Brazilian judicialization of health we see not a top-down biopolitical model of governance in which population well-being is the object of knowledge and control, but rather a struggle over the utility and purpose of government by multiple private and public stakeholders. Here both market and government are leveraged by people seeking access to services amid crumbling public infrastructures, as well as by regional public officials in the spheres of improvised evidence-based policy and electorally motivated politics, and by a federal government invested in a reclassification of the poor as middle class. By attending not only to how evidence-based policy is fabricated and deployed but also to how claims to need and accountability are falsified, we begin to see a more complex phenomenon of fabulation that coexists with political ideologies and market mechanisms within government. As real people become a part of these strategies, aggregates, and data, public ethnography and the counterknowledge it makes possible open up core questions about paradigms of statecraft and political mobilization.

In her recent work on precarity and political assembly, Judith Butler highlights the ways infrastructures are simultaneously the grounds from which and the demand for which bodies enter into collectives. "Everyone," she writes, "is dependent on social relations and enduring infrastructure in order to maintain a livable life." The demand for infrastructure is thus "a demand for a certain kind of inhabitable ground, and its meaning and force derive precisely from that lack."[17] How, then, might the struggle for workable infrastructures in Brazil shed light on state accountability and politics in-the-making in emerging democratic economies?

Critical Numbers

Allow me to contextualize. Just two years before the 2010 confrontation with which I began this chapter, I had embarked on a multidimensional and collaborative study of an intriguing new medico-socio-legal phenomenon in Brazil: individuals I came to understand as "patient-citizen-consumers" suing the government for access to treatment in the name of their constitutionally guaranteed right to health.[18] The rights-based demand for treatment access

championed by AIDS activists throughout the 1990s had quickly migrated not only to other patient advocacy groups but also to the general population. People were not waiting for new medical technologies to trickle down, and they were using all available legal levers to access them. This judicialization of the right to health opened a new chapter in the pioneering history of patient-citizenship and pharmaceutical access in the country.

States were now seeing the number of lawsuits brought in their courts—particularly for access to pharmaceuticals—reaching the tens of thousands. With a population of about eleven million people, the state of Rio Grande do Sul was an epicenter of this phenomenon: right-to-health lawsuits rose from 1,126 new cases in 2002 to 17,025 in 2009; 70 percent of these lawsuits were for access to medicines.[19] Right-to-health litigation had become a subject of contentious debate in political arenas and in the media throughout Brazil. According to government officials and some public health scholars, this practice was dramatically altering administrative practices, encroaching upon state budgets, and ultimately producing new inequalities.[20]

Despite the circulation of numerous opinions, there was no reliable and comprehensive information concerning this avalanche of health-related judicial cases, their medical and anthropological character, and their impact on lives and on health systems. Official data-collecting systems were tenuous at best, and what little scholarly evidence on right-to-health litigation existed was constrained by small samples, limited geographic coverage, and the examination of few variables. I was intrigued by this lacuna and, detective-like, I wanted to identify real-time accessible data in order to get a clearer sense of who was judicializing and what was being judicialized: What sort of citizenship rights were these patient-litigants exerting on what sort of state, and what kind of politics was being enacted here?

I was familiar with Dr. X's health care research, and he was familiar with my work on the pharmaceuticalization of health care, which has tracked how, in both delivery and demand, public health has shifted from prevention and primary care to access to medicines, making Brazil a profitable platform of global medicine.[21] We agreed that a more comprehensive understanding of judicialization was in order and assembled an interdisciplinary "dream team" (as we called it *then*) of Brazilian and North American scholars in anthropology, medicine, epidemiology, and health policy.

Our initial work together was off to a positive start, and Dr. X introduced us to public officers at the Health Secretariat and Solicitor General's Office of Rio Grande do Sul. Dr. X and his colleagues welcomed the resources and

prestige that came with such an international collaboration and, given the dearth of available information, they were interested in participating in the production of new scientific knowledge. The narrative of judicialization as a tool of wealthy patients seeking access to high-cost medicines was already deeply entrenched, and state officials saw the research as a way of showing how the role of market forces shapes physician prescriptions and patient demands. The officers, ever eager to demonstrate state transparency, authorized the state prosecutors to make the right-to-health legal cases they were reviewing available to our team.

With funding from my university and an external foundation, we gathered information from over one thousand active lawsuits, collecting data on demographic and medical characteristics of patient-plaintiffs as well as on their legal claims and judicial outcomes. In addition to this quantitative work I teamed up with local social scientists and started full-scale ethnographic research. I wanted to study this phenomenon from multiple perspectives and to produce a comprehensive view of judicialization on the ground. The broader idea, as I articulated it in an initial proposal, was "to create a critically informed public space in which social actors can move beyond polarized positions and, hopefully, identify a common good."

The findings from our initial analysis of the database were startling, and I was enthralled by the power of numbers to corroborate our ethnographic evidence. In contrast to official state and media accounts, which presented judicialization as a practice of the wealthy, our results revealed that patients who procured medicines through the courts were mostly low-income individuals who were not working (because they were either retired or unemployed) and who depended on the public system for obtaining both health care and legal representation.

The numbers plainly confirmed what we had been chronicling at public defenders' offices, where the poor get free legal assistance and where more than half of the lawsuits requesting medicines from the state originated. Roughly two-thirds of requested medicines were already on governmental drug formularies, suggesting that government pharmaceutical programs were failing to fulfill their role of expanding access. The medicines most frequently requested were for common problems such as hypertension, high cholesterol, asthma, and mental illness. The vast majority of lawsuits indicated that treatment was requested for a continuous duration, reflecting the chronic character of the diseases that afflict these patient-citizens. Moreover judges at the district and higher court levels almost universally granted access to all medicines requested, recognizing that their provision was consistent with Brazil's constitutional right to health.

While it is now common in anthropology to think about the power of numbers through Foucauldian analytics or in relation to biopolitical modes of governance,[22] what is particularly striking in this case is how the obscuring or unavailability of certain kinds of numbers mobilizes nonknowledge in the service of state agendas and interests. As Jacques Rancière has pointed out, being uncounted—or unaccounted for—is crucial to how political exclusion takes place, where the "part of no part" is invisibilized within a given social field.[23] Before our study, data on right-to-health litigation was unsystematized and not publicly available, leaving open a space easily filled with assumptions, self-serving narratives, and large claims based on small-scale studies with limited representativeness.

Numbers are indeed powerful tools in the game of veridiction-falsification that is at the heart of policymaking. They can, however, also buttress critique—especially when found within the state machine, like the lawsuits that composed our database. Taken together these 1,080 lawsuits refuted mainstream (government, academic, and popular media) antijudicialization arguments—that is, that judicialization was driven by urban elites and private interests and was used to access high-cost drugs that were not part of government formularies. Coupled with ethnography *our* numbers told a different story, exposing such arguments as part of what I came to think of as a broader *mythology of judicialization* that, in fact, undercut the complexity of the phenomenon and ultimately misinformed public opinion and health policy.

Entranced by the power of the numbers we were uncovering, I wanted to build upon our initial quantitative findings and secured funding for a second, more rigorously representative database, drawing from all medical lawsuits filed against the state of Rio Grande do Sul in 2008, when relevant information was first digitized. Work on this more comprehensive database was close to complete when tensions heightened with Dr. X over the meaning and destiny of our data, and our cooperation reached a breaking point.

State Data

How could I have not seen this coming? The fact is that I needed Dr. X's contacts within the state apparatus to access the much coveted information for our databases. At the time I truly did not think much of the rituals of power in which I partook, performing a kind of courtship ultimately aimed at data access. As is perhaps inevitable in collaborative research, and especially

striking in the contact zones engendered through this kind of public ethnography, all parties came to the project with distinct views on its import, value, and potential, with certain sacrifices and compromises undertaken, especially at first, to appease one another and keep the project afloat.

In retrospect such moments of compromise and participation in uncomfortable rituals of state and academic politics serve as openings to the underlying tensions and maneuvering at work in both the collaborative encounter and public health policy. On one occasion I spoke to a conference of two hundred state attorneys about my work on the pharmaceuticalization of health care,[24] a talk preceded by the singing of anthems and pledging of allegiance to state and country flags, interspersed with interminable populist political discourses and an interview with the region's largest newspaper about my research in partnership with the Health Secretariat. In other fora both Dr. X and state officials had referred to my research as proof of how business interests were corrupting the meaning of the right to health. These sound bites were inevitably linked with pronouncements about "public money" and "equity," explicitly giving voice to the logics of state actors. There has also been growing global interest on the part of public health specialists and policymakers in engaging with anthropologists, and in corridor talks officials also voiced pride in the "scientificity" and "transparency" I supposedly bestowed upon state institutions simply by researching in their precincts.

On another occasion, at a public lecture, an officer from the Health Secretariat adamantly denounced judicialization as "a scandal," driven by well-off patients seeking high-cost and largely ineffective medicines new to the market and by overprescribing doctors in cahoots with profit-driven laboratories. He repeatedly emphasized the role of public disinformation, the draining of public health funds, and the inequity inaugurated by this demand for new medical technologies: "We try to guarantee the availability of medicines. But it is extraordinarily perverse that we have to guarantee the most expensive medicines, which have no effect whatsoever. The laboratories use patients to increase profits."

For this and other state actors such criticisms were, at least in part, a means of insisting upon a certain vision of public health and of the public itself, one that emphasizes population well-being and rejects the injustice of unevenly shared collective funds and services. There are limits, after all, to what the state can actually provide for its citizens, given that there are other pressing infrastructural needs and that medical technologies are developing and circulating ever more quickly.

The same officer proudly proclaimed that the state's Solicitor General's Office had created its own taskforce of medical consultants to verify or disqualify claims for treatment access and efficacy. Indeed Dr. X and this group of evidence-based medicine (EBM) consultants were now crucial assets in the state's efforts to contest judicialization cases and contain costs. Premised on the positive relationship between the use of experimental evidence and improved health outcomes, EBM has become, in the past two decades, a dominant force in health care research, policymaking, and delivery.[25]

If EBM emerged as a "rigorous" scientific means of improving medical decision making, evidence-based policy followed as a rational foundation for standardization, efficiency, and cost-effective rationing in health policy.[26] For example, a paragon of such approaches, the Cochrane Collaboration, was founded in 1993 under the motto "Trusted Evidence, Informed Decisions, Better Health," and now represents an international network of over twenty-eight thousand people in over a hundred countries, including Brazil, preparing and disseminating health care information and research.

The retrofit of EBM to public health has been neither easy nor uncontroversial. Criticism has focused on the narrow conceptions of evidence EBM creates and the incommensurability of population evidence and individual patient needs.[27] Many see EBM's experimental metric as a scientific legitimation of neoliberal political and economic models of health governance. As Vincanne Adams argues, this new landscape of evaluation is displacing the previous goals of interventions, making the purveyance of actual health services secondary to the development of reliable methodologies and the generation of comparable data.[28] In this context statistics are presented as objective, value-free, and abstracted from social and political contexts. Yet in reality, as Susan Erikson notes, "they operate as administrative apparatus that shape health futures by reducing contextualizing 'noise' and enabling business management rationalizations and decision making."[29]

Unlike certain health systems in the Global North that have been practically reorganized around the principles of evidence-based medicine,[30] in southern Brazil the pretense of evidence-based approaches is not borne out in solid institutional structures. While little has changed in the allocation of resources or the organization of health care services, state officials invoke the language of EBM as a stand-in for a certain kind of scientific modernity that works in the service of political interests that are both electorally motivated and publicly marketable. Deployed in the name of equity and the public good, these evidentiary regimes stand in for social concerns while effectively absolving

the state of responsibility for actually attending to people's needs and demands or working to remedy administrative and infrastructural failures.

As our research continued I started to see the cracks where social fields and the fabulation of power were coming into view: moments where deception and discomfort were made visible and state agents revealed contradictions, ambivalence, posturing, and manipulation. In one such moment a representative of the state's Solicitor General's Office proudly announced to the media that the office was no longer contesting lawsuits for medicines that were part of government drug formularies, while behind the scenes attorneys told me about devising other ways of disqualifying claims (allegations that the prescribing doctor was not part of the public health system, for example, or—in the name of EBM—that dosages were incorrect or a prescription did not follow protocols). "It is no secret," said a state pharmacist who asked for anonymity, fearing for her job, that pharmaceutical programs were "a mess," with no efforts to upgrade drug formularies or to address problems with distribution and access.

On another occasion, when Ms. Z, an attorney working on health-related lawsuits, had started to feel at ease with us, she let slip her discomfort: "This is tough work we do: to deny treatment. When it is a lawsuit concerning a child, the lawyers generally enclose a photo of the plaintiff. I have a child. This is too much. I hide the picture in order to go through with it." While she was perhaps articulating an attempt to remain objective rather than be swayed by emotion, I could not help but hear in her words inklings of a broader process through which people were invisibilized from the state's handling of judicialization. Despite my unease, I kept quiet. Throughout this research enterprise I had trained myself to read the warning signs popping up from Dr. X and other members of the research team as idiosyncratic markers of stress, narcissism, ambition, academic theater—you name it. Nothing insurmountable, or so I reasoned with myself in order to keep the research going. But no longer.

I agreed to meet my collaborator-turned-adversary in the neutral grounds (or so I supposed) of the research institute managing the project's finances. As planned, the meeting would be an opportunity to address growing points of tension, moderated by the institute's executive director and Dr. A, the head researcher I had reached out to for some clarity on how to navigate the treacherous terrain of this international interdisciplinary research collaboration gone awry. To my total surprise Dr. X came into the conference room escorted by three state prosecutors, including Ms. Z.

Instead of easing frictions the meeting exacerbated them. I was shocked and furious to hear Dr. X tell blatant lies—that "the American team" (I was born and raised in southern Brazil!) had, for example, simply translated what he himself had written and then added an irrelevant anthropological veneer (so much for the work of critique!)—not to mention his unwarranted personal attacks coupled with self-praise of his role as the pioneer scholar of judicialization in Brazil. I was equally incredulous that the prosecutors seemed to condone the alternate reality so shamelessly being woven. I could not help myself and did not hold back in expressing the wrongs inflicted throughout our collaboration. Among other things I exposed Dr. X's earlier attempt to publish some of the database results without consulting me—a move I was made aware of only because he had listed me as coauthor and the journal had contacted me to verify.

In this back and forth of accusation the tone of the meeting had become unbearable. With no resolution on the horizon we all agreed to the head researcher's suggestion: Dr. X and the state attorneys would have two weeks to provide substantial comments on the draft article that three collaborators and I had crafted, which had been the catalyst for this painful confrontation. As I had heard a rumor that Dr. X had prohibited the project's IT assistant from giving us a copy of the second database, which was now complete, I made sure, before fleeing the meeting, to have him agree to share it with us in the next few weeks, although he added the caveat "after it is ready for analysis."

To make a long and tortuous story short: the face-off continued for almost two years, and ironically we almost had to judicialize ourselves. After several months and numerous reminders Dr. X's team finally sent comments on the article. Their request for the removal of all critical assessments from the text amounted to intellectual censorship and spoke volumes to the political and evidentiary stakes of our findings, as well as to our incommensurable takes on truth and the place of the human subject in the production of state knowledge and the political sphere. Moreover Dr. X was now denying us access to the second database.

We had no other recourse but to reach out to my university's legal counsel, who assessed the situation. Ultimately, in accordance with the agreements between the research institutions involved, we made the data from the first database publicly available on our website (with due reference to all researchers and sponsors). Later we finalized the article and published it on our own terms, without Dr. X, including all authors who met criteria for authorship consistent with best practices for scholarly publications.[31]

As for the second database, the counsel reached out to the research institute with which the university had contracted and, in an effort to ensure access, proposed to make the results publicly available on the Internet so that everyone (collaborators and ex-collaborators alike) could access and analyze them and write freely. But as the institute now claimed that the database whose production it had been paid to facilitate was "state data," the counsel began suggesting that legal action might be necessary. Two years after the start of the collaboration it seemed that we would be denied access to the data because our initial results did not support the biased narrative of the state.

How, then, did we finally gain access to the second database?

In a welcome, if unexpected, turn of events a federal judge in Porto Alegre learned of our travails and found our results too crucial for health policy to remain locked up. The Workers' Party had recently come into power in the state, and transparency was a key political buzzword of the moment. The progressive judge made some calls and put me in contact with the human rights attorney of the state's revamped Solicitor General's Office. A few weeks later Ms. Z released the second database, which closely corroborated our initial findings.

Epistemic Machine

The saga of our collapsed research collaboration adds more texture to the critique that emerged from the data itself. Particularly telling were the state prosecutors' comments on our original article draft, read in light of a broader sense of prevalent (and ultimately misconstrued) accounts of judicialization and who it is for.

Backing up to when we finally received the comments from the state prosecutors, before anything had been published, the comments on our draft came with the warning that "any publication based on the database must be submitted to the review of the Solicitor General's Office and the Health Secretariat." While there were no comments on or requests for changes to the actual numbers drawn from the database, there were plenty of highlighted notes throughout the text signaling "things with which we disagree" and orders such as "This must be removed," together with a few minor editorial suggestions. The objective (so to speak) labor of the social scientists was acceptable; the problem was with contextualizing, making connections across scales, and moments of interpretation and critique.

The officer of special affairs who signed off on the document did so in the name of the Solicitor General's Office and the Health Secretariat, lending

the views expressed an official, public character. Considered as a document, the draft made visible certain assumptions and positions, laying bare the core tensions underlying our faltering collaboration. As Anneliese Riles has shown, documents are "paradigmatic artifacts of modern knowledge practices": they instantiate and render legible ways of knowing, doing, and studying. She calls for attention to documents as artifacts that enable us to "take other people's knowledge practices as an ethnographic subject" seriously, shedding light on the commitments of their and our own knowledge.[32] In this sense the document in question—our article draft with commentary—becomes a window into conflicting epistemic practices as they play out over time.

This particular document gains analytic currency not only as an embodiment of our failed collaborative project but also as a critical artifact of political rationality.[33] In this capacity it embodies how evidence is constructed and deployed in the service of political schemes and an improvised statecraft ultimately removed from the people it supposedly represents and governs. As I have shown elsewhere, judicialization has become a "para-infrastructure" that allows the state to disqualify claims and delay action;[34] in the logic of state actors, if the poverty of claimants can be denied, so too can the pressing need to change policy and improve the delivery of services.

Our draft of the article began with a case study: that of Mrs. Y, a patient-litigant I knew from my ethnographic research who was suing the state for medication to treat her pulmonary hypertension. Forty-eight years old and HIV-positive, married to a taxi driver, and living in a shantytown of Porto Alegre, Mrs. Y lost her job as a custodian when shortness of breath made it impossible for her to perform her duties. Unlike her HIV treatment, which is provided free of charge, Sildenafil, the drug her doctor prescribed, is not offered through the public health care system and costs US$1,300 a month. With free legal representation from the Public Defender's Office, Mrs. Y sued the state for the medication, losing her initial lawsuit but winning on appeal. As we noted later in our article draft, Mrs. Y was in many respects (middle age, female gender, low income, ill health) a "typical" patient-litigant, although in other ways (HIV status, losing her initial lawsuit) somewhat anomalous.

The state prosecutors' response to this story in the introduction and throughout the article was unequivocal: *It must be excised from the text.* There was no place for particular stories, and ethnographic knowledge was refused as unscientific. Taking issue not only with the chosen vignette—which, they claimed, was not representative of the larger sample and was therefore misleading to readers—but with the broader possibility of acknowledging or

learning from life stories, they dismissed such personal narratives as working against objectivity. They wrote, "There is no one specific case that could represent the issue of judicialization." From this perspective no singular life story has value against the supposedly generalizable aggregate of data. An appeal to accuracy becomes a means of erasing human stories, and the fetishization of data performs a kind of scientific legitimacy. Staying with the numbers lends the guise of objectivity while leaving space for tinkering with interpretations, unbound by the precarious realities of bodies and voices. Visible in this interpretive machinery are efforts to erase the singularity of circumstances and to reduce dissensus. These efforts enact political work as they circumscribe state accountability.

The commentators also objected to much of the interpretive and analytic work of the article. They denounced contextual information on the health system and public bureaucracy as irrelevant and decried commentary on the failings of current drug formularies and systems of provision as "speculative" and "opinion," even though it was backed up by interviews with local patient-plaintiffs, families, pharmacists, caregivers, and public defenders, all of whom alluded to local and regional administrative failures. They cast aside arguments about the limitations of the public health system in adequately meeting the needs of the public as "not based on the data." Data come to stand in for infrastructure here, and, in a strategic inversion, where there are no data there can be no problems with existing services. This reasoning buys time, as it were, postponing the need to address gaps and lacks in the system and slowing the immediacy of judicialization's temporality. The political thus becomes a means of controlling time.

As a demonstration of an incipient, grassroots form of counterpower, judicialization is subject to a war over interpretations. As Rancière reminds us in *Moments Politiques*, "All transformation interprets, and all interpretation transforms."[35] Dismissing our analysis as "differing opinions" and "value judgments" and relying on a narrow view of evidence, the state officials suggested edits and commentary managed to reduce our findings—which in fact *countered* dominant accounts of judicialization—to the self-same stories we sought to challenge, all in the name of science. Rehashing arguments that place blame on individual patient-litigants claiming unnecessary and unjust use of the system while denouncing our analysis as irrational and value-laden, their policing of relevance becomes a means of controlling the judicialization narrative. These explanations both erase critique and its power to enlarge public conversation, and foreclose broader political questions. In this way an

epistemic machine comes into being through which evidentiary claims are mobilized and perpetuated, performing a work that folds all data (even counterknowledge) into its own logics.

De-Pooring People

The story is still being written. The judicialization of the right to health remains a contentious subject in Brazil, extending its reach into the national sphere of media and political discourse, where the narratives I encountered in the field continue to circulate and gain strength.[36] "Judicialization Increases Health Inequity" was a recent headline in *Folha de São Paulo*, one of Brazil's most influential newspapers. The article framed judicialization as a scandal of the "haves" triumphing over the "have-nots," a view echoed by government officials. Brazil's health minister has said that lawsuits seeking medicines "take resources away from the poorest to benefit those who have more." "It's a kind of Robin Hood in reverse," added the health secretary of the State of São Paulo, "to take from the poor to give to those who can afford to pay for a good lawyer." The director of Brazil's Cochrane Center for evidence-based medicine has speculated that the pharmaceutical industry is behind the phenomenon of judicialization: "Why does no one file a lawsuit for the government to give calcium to pregnant women and prevent hypertension? Because calcium does not cost anything, there is no lobby behind it."[37]

I searched online and found the study most likely mentioned in the *Folha* article: "The Right to Health in the Courts of Brazil: Worsening Health Inequities?" by the legal scholar Octavio Luiz Motta Ferraz.[38] As in his other publications the author unsurprisingly responded yes to the leading question in his title, resting his judgment on studies that "confirm that a majority of right-to-health litigants come from social groups that are already considerably advantaged in terms of all socioeconomic indicators, including health conditions."[39] Repeated and self-reinforcing, these portrayals congeal into a dominant myth that casts patients as malingerers and the state as a just defender of equity, depoliticizing the actions of patient-plaintiffs while buttressing state actors' political projects.

What comes into view in the prosecutors' comments on our article draft is precisely the production and perpetuation of such state stories. "In all legends," writes Foucault, "there is a certain ambiguity between the fictional and the real—but it occurs for opposite reasons. Whatever its kernel of reality, the legendary is nothing else, finally, but the sum of what is said about it. It is indifferent to the existence or nonexistence of the persons whose glory it

transforms."[40] For Foucault legends walk the line between the fictional and the real, between what is known and how it is talked about, thereby gaining a kind of story-life of their own and crystallizing into truth. The stakes of such circulating stories are both real and unfettered by human concerns, "indifferent" to the "persons whose glory it transforms." These stories thus come to serve as a kind of machine of fabulation, managing how evidence is absorbed, reconfigured, or put to work.

A recent review article on lawsuits for access to medicines, published in a Brazilian public health journal, sought to aggregate available research (our own study included) in order to offer a more general, comprehensive account of the phenomenon of judicialization. Read critically the article speaks to the extent to which the mythology of judicialization operates largely unchecked; the authors misread and inaccurately report on our research, restating conclusions that, while unsubstantiated by available evidence, have already made their way into the dominant narrative.[41] For example, on drug costs, the authors state, "In most cases, the prescribed drugs can be classified as medium to high cost"—an assertion that is at odds with the strong evidence in our results. Moreover only one study under their review actually contained specific drug costs.[42] Self-reinforcing and recounted as fact, such arguments insidiously stand in for the truth of judicialization, where the fictional is recast as the real. Attending to falsehood thus opens up space for asking what stories are told and how they gain currency, offering entry points into both the conditions of their making and their force in the world.

An ethnographic approach to our numerical data produced an entirely different empirical portrait than the one relied on by officials and public health scholars.[43] This highlights the potential of publicly engaged ethnography to produce counterknowledges that might render pressing infrastructural challenges visible and support the mobilization of counterpublics. Indeed as cost-cutting public officers kidnap the discourse on equity, one wonders how the inequalities produced by government policies (or lack thereof) can be alternatively politicized.

While a reduction in inequality under the federal rule of the Workers' Party and the associated rise of the so-called new middle class, which supposedly now occupies 50.5 percent of the population,[44] have been heralded as the end of endemic poverty, mainstream narratives about judicialization frame the phenomenon as a practice of the wealthy. In a sense these stories dovetail with the knowledge and policy systems through which this new middle class is being fashioned, as new forms of statecraft and ideas of citizenship and legitimate politics accompany a massive social recasting of Brazil's poor in terms of market inclusion and the potential to consume. While in the United States poverty has been stigmatized and rewritten as illness,[45] in the populist, "postneoliberal" state of Brazil the erasure of poverty takes a different form, whereby those who were once poor now find themselves categorized as middle class.

Ultimately, critical ethnography allows us to call into question the *fabulation of power* that not only makes poor patient-citizens publicly invisible, but also *proves* (through stylish modeling and bizarre quantitative maneuvers) that the subjects of judicialization are not poor at all—an epistemic mechanism I think of as *de-pooring people*. This supposed proof is generally offered in the name of the country's neediest, who, the argument goes, suffer from the impact of judicialization on health care budgets and policies. The mythology of judicialization which de-poors actual people seeking access, care, and justice in a faltering public health system thus sits in awkward tension with a state caught up in projects of championing and speaking for "the new middle class." These shifting categorizations and ways of imagining citizenship, justice, and politics actually render the poor less visible—all in the name of the public good. As ethnographers we must attend to these forms of statecraft and to the kinds of evidence and political subjectivities built into the para-infrastructure of rights and interests that the judicialization of health has occasioned.

Entering Justice

This experiment in public ethnography asks what happens when the ethnographer approaches the black box of power and grapples with what might be learned from it. In this attempted entry, failure itself opens space for considering how and to what ends truths about both citizens' needs and rights and state accountability are mobilized. Opening the failed collaboration to self-reflexive scrutiny I assembled elements for a critique of contemporary political rationality, showing how public ethnography might simultaneously contribute to an enlargement of the ethnographic record of statecraft and evidence-making machines and to theorizing on power and politics more broadly. It is only through second-order ethnographic reflexivity that it becomes possible to consider the explicit logics of what state actors say and do but also, through careful exegesis, to move beyond face value to the more entrenched political rationalities at play.

Arguments about the reality and impact of the rampant judicialization of the right to health in Brazil are often crafted around economic analyses and

appeals to evidence-based medicine and policy. Critics fail to recognize that judicialization can itself help to create alternative sources of practice-based evidence, showing where existing administrative mechanisms fail people and offering clues on how to improve the system. A rhetorical machinery is at play that not only denies poverty but also erases people. Just as evidence-based medicine is mobilized to rationally allocate resources, fictions and falsehoods are marshaled in the name of equity and the public good, even though there are no existing mechanisms to actually assess or act on public needs. A fetishization of evidence lends an aura of authority to the aggregates of quantitative data while refusing the value or evidentiary force of the singular lives out of which all data are ultimately produced.

The individual patient-citizen here is at once blamed for abusing the system for personal gain and dismissed as a potential embodiment or representative of the collective. Such subjects do not meet the threshold of acceptance for political inclusion, even as the state supposedly guarantees universal health coverage for all. In the fallout of our collaborative research we glimpse the calculus of this exclusion, where fabulation and the machineries of veridiction and falsification are thrown, ever so briefly, into stark relief. Truth production is tied to forms of political rationality that depend on slippages of scale between individual and collective, the person and the public, where claims for the broader collective are defended at the expense of the individuals who actually compose it, obscuring unexpected grassroots politics around workable infrastructures while shoring up state politics-as-usual.

Countries have legitimate concerns about regulating new and high-cost medicines, and resource constraints mean that trade-offs will inevitably occur.[46] Brazil's experience highlights the importance of ensuring explicit and functional mechanisms for participation, transparency, and accountability in health systems. It also illustrates the significant role of counterpublics and the judiciary in monitoring the quality of health care and assessing the need for new medical technologies amid competing and contested considerations of value, cost-effectiveness, and efficiency.

Referring to their lawsuits, people often use the expression *entrar na justiça*, "to enter the judiciary" or, literally, "to enter justice." This suggests a more capacious reading of individual acts of suing the state in light of the broader forms of "entry" at stake—into politics, an emergent collective, and a different conception of truth, justice, and the public sphere. It is only through ethnographic work, and an undoing of the mythology surrounding judicialization, that such moments and mechanisms come into view, allowing a politics of entry to complicate prior understandings about the judicialization of health and its subjects.

Going against the grain of appearances and affirming dissensus, public ethnography thus illuminates the improvised quality of late liberal democratic institutions of government and challenges the remodeled logics of today's inequality. It also breaks open a distinct sense of politics in the making, in which people find means to hold the state locally accountable, creating an alternative political space from dire infrastructural conditions. Only by working against the fabulation of power and insisting on a space where precarity is actually a mobilizing force might we restore the place of the poor in political community.

Notes

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1 Biehl et al. 2012; Messeder et al. 2005.
2 Bassette 2011.
3 Fassin 2013.
4 Fassin 2015.
5 Holmes and Marcus 2008: 81.
6 Gollan 2011; Rabinow and Bennett 2012.
7 Holmes and Marcus 2008: 86; Marcus 2009.
8 Luhmann 1993.
9 Petryna 2009, 2010: 60.
10 Foucault 2008: 32, 46.
11 Maillet 2012.
12 Nobre 2013; Romero 2015.
13 Biehl 2007b.
14 Arbix and Martin 2010: 6.

15 Ferguson 2015.
16 Leite 2014.
17 Butler 2015: 21, 127.
18 Biehl 2013.
19 Biehl et al. 2012.
20 Azevedo 2007; Ferraz 2009; Vieira and Zucchi 2007.
21 Biehl 2007b.
22 Foucault 2008, 2009; Hacking 1982.
23 Rancière 2006: 12; Rancière 2001.
24 Biehl 2007a.
25 Daly 2005; Evidence-Based Medicine Working Group 1992; Lemieux-Charles and Champagne 2004.
26 Klein et al. 1996; Timmermans and Mauck 2005.
27 Behague 2007; Lambert 2006.
28 Adams 2013a, 2013b.
29 Erikson 2012: 369.
30 Such as the United Kingdom's National Health Service. See Harries et al. 1999.
31 Biehl et al. 2012. See International Committee of Medical Journal Editors 2016.
32 Riles 2006: 2, 17.
33 Hull 2012.
34 Biehl 2013.
35 Rancière 2014: xii.
36 Chieffi and Barata 2009; Da Silva and Terrazas 2008; *Economist* 2011.
37 Collucci 2014.
38 Ferraz 2009.
39 Ferraz 2009: 33; see also Ferraz 2011a, 2011b.
40 Foucault 2000: 162.
41 Biehl et al. 2016.
42 Gomes and Amador 2015: 9, 6.
43 Biehl 2013.
44 Neri 2011; Kopper 2016; Souza 2010.
45 Hansen et al. 2014.
46 Dittrich et al. 2016; Yamin 2014.

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