INTRODUCTION

I write amid the COVID-19 pandemic. To say that COVID-19 is a communicable disease would seem to traffic in the obvious. On 11 January 2023, the Johns Hopkins University Coronavirus Resource Center reported 665,378,952 confirmed cases and 6,713,334 deaths worldwide. The figures for the United States, where I reside, were 101,409,175 confirmed cases and 1,098,304 deaths. How the virus achieves its communicable capacity has also often overreached the ability of epidemiologists to capture it. After initial projections of the importance of surface contact—leading to an emphasis on hand washing, hand sanitizing, and spraying disinfectant—attention shifted to how human beings share space and at what distance and how long infected individuals offer their unwanted viral companion species to other humans through airborne residues. Projecting COVID-19's communicability through unilinear temporalities and spatialities, the promise that mitigation measures today will lead to "normal" times and spaces tomorrow, proved to be epidemiologically problematic and to induce uncertainty and distrust among public health's "publics," particularly as even more frightful additional "waves" emerged. Tying communicability to a totalizing figure of SARS-CoV-2 gave way to concern with the fractured communicabilities of new variants. Rochelle Walensky, director of the US Centers for Disease Control and Prevention (CDC), declared, “The Delta variant . . . is one of the most infectious respiratory viruses we know of.” Still, the subsequent omicron variant was even more communicable, so transmissible that it crowded out Delta in the viral race to infect human bodies, and then XBB.1.5 outcompeted previous omicron variants.[1]

Full stop. I have just exploited and simultaneously naturalized the second dimension of COVID-19’s communicability. Felicitously, the term *communicability* also points to the circulation of discourse. To be communicable, a semiotic entity must be capable of traveling and invoking a response in others; COVID-19 could not be more communicable in this sense, either. People avidly searched the drumbeat of COVID-19 statistics, even as they were often reminded that figures fell far short of capturing the communicability of the SARS-CoV-2 virus: its circulation far outpaced the ability—and, in many cases, the willingness—of nation-states to provide adequate testing. News about COVID-19 dominated the “mainstream media” starting early in the pandemic. The *New York Times* published some three to five articles daily on H1N1 (or “swine flu”) in 2009 (Briggs and Hallin 2016, 1). For COVID-19, by contrast, I counted thirty-five articles in the 16 March 2020 edition (selected because it was the last day I received a paper copy), with business, international, sports, arts and entertainment, travel, politics, advertising, metropolitan, and editorial sections all infected by the pandemic. Apart from obituaries, which were not yet dominated by COVID-19 deaths, I counted only thirteen articles in which the pandemic was not featured. The massive avalanches of discourse about COVID-19 on social media and the internet significantly shaped people’s experience of the pandemic—and often what actions they took or refused to undertake.

Thus, COVID-19 brings into focus two senses of communicability: the circulation of pathogens and discourse about them. The promise of communicability is that if health authorities create a sufficiently persuasive, clear, and convincing avalanche of “messages” about COVID-19 and mitigation measures and laypeople heed what they say, the circulation of discourse will impede the movement of SARS-CoV-2 viruses. How public health professionals attempt to “control” epidemics posits separate discursive and viral circuits, even as they entangle the two by projecting an intrinsic and inverse relationship between them. Communicability accordingly lives a dual existence. On the one hand, it consists of cultural models that construct their referents, affording particular ways of imagining the circulation of viruses and discourse and mapping their interrelations, even as it impedes other imaginaries. On the other hand, representations of epidemics invite us to assimilate fevers, headaches, and feelings of fatigue as much as masks, spatial gaps, bottles of hand sanitizer, crowds, vaccination needles, and epidemiological statistics through affordances they offer. These terms are far from purely ideological or linguistic artifacts. If we take them in their familiar and narrow senses, this dimension of communicability is also produced by vast arrays of actors (including health officials, journalists, social media "influencers," and clinicians), practices (such as staging press conferences, producing podcasts and social media posts, talking with patients, and discrediting "misinformation" and "conspiracy theories"), and infrastructures (such as schools of medicine, schools of public health and journalism, websites, YouTube channels, pandemic "exercises" or scenarios, and the communications or public relations wings of health-related institutions). Epidemic communicability is also deeply rooted, however, in the more-than-human, the movement of viruses among and inside bodies, as well as immune systems, vaccines, and ventilators.

This book is not primarily a study of COVID-19. Rather, extending efforts to decolonize anthropology by challenging how it has been "complicit if not in fact collusive with the prevailing forces of neocolonial domination" (Harrison, [1991] 1997, 1), I seek to decolonize the fundamental understandings of language and communication and health and medicine that make such projections of communicability possible.[2] The argument traces a three-hundred-year history of efforts to cast science and medicine as both separate from and more fundamental than language and communication. A common conception shared by both professionals and laypeople casts medical and public health knowledge as produced in leading laboratories, clinics, and epidemiologists' offices and then converted into "communication" through translation into lay registers by physicians in speaking with patients, health educators, journalists, and advertisers. Communicative objects are then conveyed to lay audiences. This book offers a countergenealogy. I trace how conceptions of medical knowledge and of communication were coconstructed in the seventeenth century, infusing medical logics into conceptions of language, perceptions of language's precarity as a basis for communication and social relations, and remedial programs for imposing linguistic order. By the same token, communicability similarly shaped what could count as medical knowledge, what would be excluded, and who would be authorized to claim it. I go on to make the more radical claim that how these seemingly opposing and autonomous discursive regimens were connected has placed white supremacy and the colonial production of categories of others at the center of conceptions of language and communication, health and medicine, right through the present.

Communicability is both imaginary and far too real at the same time. It involves what linguistic anthropologists refer to as language ideologies (Kroskrity 2000a; Schieffelin, Woolard, and Kroskrity 1998), cultural models that project particular, partial, and interested ideas about what language and communication are and how they are entwined with individuals, populations, places, and politics. Communicable models cast some words, texts, images, and communicative practices as intrinsically mobile, as imbued with the ability to travel and generate increased knowledge. Discourses excluded from dominant communicable models get cast as intrinsically *im*mobile—or, at least, not worthy of traveling. Formulations classified as conspiracy theories provide a striking example. One way that communicable models exercise power is by naturalizing the perspectives they project, thereby making others seem unnatural, inferior, or even unthinkable. Like forms of knowledge, communicabilities are always multiple and often competing. Some communicabilities gain widespread circulation and aspire to exercise the panoptic power of shaping what counts as knowledge, who gets to make it, how it can legitimately travel, and how it becomes a deus ex machina that should pervasively structure materialities and natural-cultural relations. This effect should come as no surprise. Particular communicabilities become implicit emblems of race, class, sexual, and national hierarchies, invested with power through epistemological and ontological frameworks, infrastructures, and realms of practice. In such arenas as education and medicine, they create hierarchies and imbue them with material consequences by casting individuals and entire racialized populations as failed communicators.

Moving beyond pandemics, this book focuses primarily on how communicability provides a foundational basis for the immense power of biomedicine and global health and a key locus of the daily work of creating new forms of authority and recruiting patients and populations as crucial collaborators in sustaining its dominance. I trace how particular communicable models are so deeply woven into the fabric of biomedicine that they have become—in ways both minute and largely invisible and as major objects of attention—the manifestation that mostly directly enters into the eyes and ears of laypeople. Daniel Hallin and I have thus used the term *biocommunicability* to refer to forms of communicability that carry the authority of biomedicine (Briggs and Hallin 2016). Juxtaposing what are projected as medical and communicative practices in a single term challenges three centuries of efforts to make science and medicine, language and communication seem like autonomous spheres. Biocommunicability suggests that such “communicative” forms as public health pronouncements, conversations between clinicians and patients, and pharmaceutical advertisements are not only caught up with viruses; health infrastructures; medical technologies; health inequities; and broader social, political, and material inequities but are also partially constitutive of them.[3]

Rather than projecting a self-confident, unified, and pervasive hegemonic force, however, I tell a different story by tracing how communicability has also infused medicine and communication with anxieties and precarities. Ironically, communicability becomes a privileged site for representing and ameliorating failures, contradictions, and challenges that emerge within biomedicine and from refusals to be interpellated by dominant forms of and efforts to assert competing communicabilities. I trace how laypeople, particularly members of racialized populations that get stereotyped as biocommunicable failures, critically engage dominant models in spaces that range from encounters with physicians to efforts by social movements to create alternative perspectives on and forms of providing health care. I am also interested in ways that biocommunicability falls short of dominating the words and actions of physicians and other health professionals, either when its gaps, contradictions, and effects accumulate to such a degree that they cannot be brushed aside or when solidarity with patients and populations denigrated as communicable failures drive them to collaborate in crafting more equitable forms. Indeed, creative and courageous efforts by some physicians and public health professionals to challenge dominant communicabilities and join underserved and stigmatized communities in forging alternatives are also important parts of this story.

The final two chapters of the book provide a striking example of this juxtaposition of power and precarity by focusing on a biocommunicable train wreck: the COVID-19 pandemic in the United States. Even after COVID-19 vaccines were widely available and government agencies at all levels launched massive efforts to urge people to get vaccinated, the unvaccinated accounted for most COVID-19 hospitalizations and deaths in 2021. Early in the pandemic, the CDC and World Health Organization (WHO) linked viral and communicative dimensions of COVID-19 in decrying an “infodemic.” The circulation of so-called misinformation and disinformation was blamed for why the United States, an immensely wealthy country that has hoarded a massive quantity of the world’s COVID-19 vaccines, has one of the lowest COVID-19 vaccination rates among rich countries. And by 2022, even vaccine- and mask-friendly US audiences had grown weary of COVID-19 public health discourse, citing “pandemic fatigue.” Hospital physicians were frustrated with unvaccinated patients who filled emergency rooms (ERs) and intensive care units (ICUs), angry that they seemed to trust "misinformation" more than health professionals' advice.

I argue here that biocommunicability lies behind this massive erosion in trust in the United States in COVID-19 public health discourse and widespread rejection of masking, COVID-19 vaccination, and other prevention and treatment measures. Such statements generally lead to criticisms of the content of "messages" crafted by public health authorities and the role of journalists in disseminating them. I reject this approach for several reasons. One is that the roots of this dilemma in the United States lie in shifting trends in biocommunicability over the past eighty years, particularly in the clash between two competing forms. One projects laypeople as passive recipients of unilinear, hierarchically ordered transmissions of biomedical knowledge from health professionals. The other, more recent variety portrays agentive, self-interested individuals who actively seek knowledge about their health from multiple sources. These two models of communicability are racialized in both implicit and explicit ways due to how they imbricate forms of medical profiling (Briggs and Mantini-Briggs 2003) that stereotype and often stigmatize nonwhite patients and are coproduced with forms of linguistic profiling (Baugh 2003) that project Black, Latinx, and Native American populations as communicatively defective. I demonstrate how these trajectories clashed catastrophically in the pandemic, partly due to the way they got entwined with racial politics during a period in which white supremacy, violence against nonwhite people, and protests against anti-Blackness all intensified.

Racial inequities are crucial here for many reasons. Black, Latinx, and Native Americans in the United States were vastly more likely to be hospitalized and die from COVID-19 than white people, drawing attention to deep, persistent racialized inequities of health. The brutal murder of George Floyd by Minneapolis police officers on 25 May 2020 and the ensuing focus on racism partially de-medicalized these statistics, positioning the differential impact of COVID-19 within broader structural inequities and forms of racialized violence that predate the pandemic.[4] Nevertheless, the implications of my argument are not limited to the United States or to the complex nexus of racializing ideologies and practices that unfortunately still flourish there. A number of examples are drawn from outside the United States, including from nearly four decades of ethnographic work in Venezuela and from research conducted by other scholars around the world. Moreover, the effects of racialization and racism are a global phenomenon, affecting the distribution of resources, rights, and political power worldwide.[5] Crucially, the scientific and communicative imaginaries that feed into dominant communicabilities and help imbue them with power are also racialized: their foundation lies in the elevation of white, elite, European men in the seventeenth century to the status of universal embodiments of rationality, enlightenment, and modernity. I suggest that racialized ideologies of communicability and attendant ways of constructing, classifying, and disciplining individuals and populations shape people's access to rights and resources worldwide.

Responding to demands that scholars reflect on how racial inequities are hardwired into anthropology and other disciplines and into white scholars' own perspectives and practices, I came to see that using dominant communicabilities as a starting point in much of my work on language (Bauman and Briggs 2003) and health (Briggs 2005a) was grounded in white, elite, male, ableist, Euro-American privilege. Although my goal was to dislodge them through documentation and critical analysis, I had not yet adequately appreciated that biocommunicability is fundamentally colonial, deeply connected to whiteness, and constitutes one of the ways that racial violence is inflicted on a daily basis on populations targeted by structural racism. I realized that I needed to unlock my thinking and find a radically new way to begin.

Over two pandemic years, these unsettling sources of discomfort began to come together as I reread Hortense Spillers's remarkable essay "Mama's Baby, Papa's Maybe: An American Grammar Book." Spillers (1987, 67) connects the violent "hieroglyphics of the flesh" of slavery to the social-scientific and political violence of the so-called Moynihan Report's efforts to blame the effects of racism on the "matriarchal" pattern supposedly evident in Black families (Moynihan 1965). Tracing the legacy of slavery, colonialism, and conquest through the present, Spillers sees difference not as springing from culture or ethnicity but, rather, as the reduction of subjugated Black flesh to objects whose violent treatment can be justified as necessary. I was struck by her account of Equiano, who was captured in what is now Nigeria, and taken to England, and who wrote an autobiography. Spillers draws attention to the passage in which Equiano describes his European captors on the slave ship: "Their complexions, too, differing so much from ours, their long hair, and the language they spoke (which was different from any I had ever heard)" (Equiano 1969, 27, quoted in Spillers 1987, 69). Spillers comments: "We are justified in regarding the outcome of Equiano's experience in the same light as he himself might have—as a 'fall,' as a veritable descent into the loss of communicative force." I am interested in locating this "loss of communicative force" beyond the issue of a "strange" language. I see it as connected to the total violence of slavery and its legacy in carceral and other dimensions of anti-Black violence and racism in the contemporary United States.

Spillers's essay and other texts that it inspired helped me come to grips with my sense that focusing on communicability was dangerously incomplete. Savannah Shange insightfully brings together Spillers's concern with the "hieroglyphics of the flesh" and attention to racialized perceptions of the materiality of voice in analyzing how gentrification, race, social death, and the afterlives of slavery shaped the politics of race and multiculturalism in a San Francisco high school.[6] Shange (2019, 96) additionally draws on work by Frank Wilderson (2010, 59) in suggesting that "Black (girl) flesh spills forth in excess of the discourses that seek to locate it, to know it, to translate its 'noncommunicability.'" Shange's ethnography opens up other angles that enlarge this concept. One was the refusal of some "ordinary Black girls" to perform the disciplined voices of educational aspirational demanded by the school, even as they created artifacts (homework, tests, etc.) that met its standards. Shange carefully traces how race enters into assessments of the materiality of voices and flesh, into complaints by teachers that particular Black girls spoke too loud and too often. One student engaged in ethnographic refusal, telling Shange (2019, 119): "You can follow me, but I'm not gonna talk to you." Shange extends this "epistemology" by quoting John Jackson's critique of the ethnographic "*will to know everything*" and its connection to the "*will to disclose everything*" (Jackson 2013, 158, quoted in Shange 2019, 121). Shange frustrates what she sees as her readers' wish that she might end the girl's silence through a final act of disclosure.[7]

Reflecting on Shange's refusal thus opened up the possibility of repositioning myriad phenomena construed as pathological failures to perform dominant communicabilities. Here I am drawn back to sites I have often examined in my work that get identified as communicable trouble zones. They include what are deemed to be forms of "resistance," "ignorance," or noncompliance in clinical settings and discrepancies in case definitions and other refusals to fit epidemiological modes of classification. These projected failures are built into the design of health education and communication programs and journalists' interpretations of health inequities as caused by cultural barriers to biomedical knowledge. In school settings, parents are often blamed for educational inequities of race and class. They are depicted as not speaking or reading to their children enough or in the proper ways.[8] Youth are also blamed for embracing communicative practices that purportedly block their ability to learn. When individuals or entire populations get characterized as failing to align themselves with dominant communicabilities, they are held responsible for health, educational, and other inequities, following a rather bizarre cause-and-effect logic that renders invisible shifting relations between language and capital.[9] Adding to Spillers's list of agents who, in Shange's words, "operationalize key nodes in the state apparatus," Shange includes "teachers and principals and police and social workers and anthropologists" (2019, 96).[10]

Building on how Shange disrupted my thinking, I develop here the concept of *incommunicability*, which is productive in three crucial ways. First, it captures how some individuals and populations are banished from communicability, deemed incapable of performing utterances and actions that demonstrate their status as modern, rational, liberal subjects. Even as incommunicability is projected as encompassed by communicability, the subjects it produces are expelled to exterior, distanced, often stigmatized realms. Incommunicability thus becomes a pathological outside that comes after dominant communicabilities are in place—and in charge. Second, Shange's "Black girl ordinary" gestures toward how incommunicability can be inhabited productively, thereby refusing communicability's positioning as the primordial grounds for defining and evaluating subjects, subjectivities, and positionalities. This response both acknowledges how communicability and incommunicability are coproduced and turns its back on the binary. It also plays on "in-community," suggesting how finding ways of occupying spaces of incommunicability can turn forms of totalizing repression into collective ways of being, a point I develop later in the interlude, "Social Movements and Incommunicability-Free Zones."[11] Finally, incommunicability invites us to reject communicability as the taken-for-granted starting point, presenting *incommunicability as an alternative analytic*. The term thus turns the tables by repositioning communicability *within* incommunicability, thereby dislodging communicability from its ideological dominance in defining language, medicine, and other domains and challenging hegemonic practices.[12]

The term also helps extend Audra Simpson's insights into refusal in her powerful book *Mohawk Interruptus*. She details how the Mohawks of Kahnawà:ke often refused the culturalist and subordinating forms of multicultural recognition that denied the sovereignty that rightfully belong to "a precontact Indigenous polity" (2014, 2). Multicultural recognition constitutes a matrix of communicable strategies, purporting to offer subjects projected as incarcerated by culture (Appadurai 1998) the possibility of being granted status as communicable subjects in exchange for disidentifying with stigmatized forms of incommunicability. Turning away from offers of communicable redemption opens up spaces of refusal marked by performing forms of incommunicability associated with what is projected as the inability to claim the rights of Canadian citizenship. Embracing incommunicability "understands the terms of bondage, and chooses to stay within them" (Simpson 2014, 24). This refusal provides critical perspectives on how settler colonialism ties communicability to white supremacy, thereby rendering any alternatives incommunicable. As an ethnographer, Simpson (113) embraces this "theoretically generative" space of refusal, thereby incorporating tactics of refusal into her own work in ways "that can both *refuse* and also take up *refusal* in generative ways." Accordingly, refusal opens up possibilities for embracing incommunicability as an analytical point of departure and for supporting efforts to unseat dominant forms of communicability.

Reflecting on Spillers's, Shange's, and Simpson's provocations made me realize that biocommunicabilities produce constructions of incommunicable voices, flesh, forms of knowledge, and practices and tie them to sites where bodies are deemed problematic. Health professionals attempt to monopolize the agency required to define, classify, surveil, and discipline ways of talking about health; in doing so, they create incommunicabilities, assessing perceived failures of communicability and stigmatizing articulations that lie outside authorized registers, sites, and channels as incommunicable. Like the positioning of "Black girl ordinary" in educational settings, subjects who actively refuse the social, political, educational, and medical promises of communicability expose the claims to transparency, causality, and authority on which communicability rests, including its underpinnings in white supremacy, thereby opening up possibilities for creating or enacting alternatives. Such insights, I argue, challenge us to decolonize fundamental understandings of language and communication, health and medicine and join efforts to craft alternatives.

Bridging the Divide between Medical and Linguistic Anthropology

In pursuing this goal, I find myself up against ways that anthropology is subdisciplined, structured in such a way that medical and linguistic anthropologists generally inhabit separate, sometimes opposing, analytical frameworks, research practices, curricular trajectories, American Anthropological Association sections, and journals. The bibliographies of works in linguistic, medical anthropology, and social/cultural anthropology, even those focusing on the same objects of research, often show little overlap. When graduate programs recruit faculty and graduate students, the processes are often separate and sometimes are guided by a zero-sum logic: if more resources are allocated to that other field, ours will be shortchanged. Even when advanced graduate students and new PhDs coming from different fields are investigating the same phenomena, they often do not know that researchers in other subdisciplines have productively and radically revised our understanding of the objects they are analyzing. Medical anthropologists sometimes do not realize that linguistic anthropologists have critically engaged the commonsense notions of multilingualism, translation, meaning, and embodiment that medical anthropologists often employ. Linguistic anthropologists sometimes embrace commonsense definitions of diseases, forms of care, and medical technologies that medical anthropologists have critically engaged.

At the same time, there is a long research tradition—sometimes reflected in graduate training and even more in ways that graduate students and recently trained scholars explore alternative routes—that offers important synergies between linguistic, medical, and social/cultural anthropology and adjacent fields. A major goal of this book is to question the foundational divides that have often marginalized this research and expand on efforts to offer productive bridges. Let me begin by picking up on the insights offered by Shange and Simpson in pointing to how recent work by linguistic anthropologists can extend their insights. The field has been transformed by Black, Latinx, and Native American scholars and others who argue that understandings of race, racism, and racialization will remain analytically and empirically fragmented and incomplete without "viewing race through the lens of language and language through the lens of race to better understand them as co-constitutive processes" (Alim, Reyes, and Kroskrity 2020, 2). Linguistic anthropologists trace how whiteness and white supremacy are authorized by equating them with communicability, with what is projected as a homogeneous, dominant speech code (the Monoglot standard, in Michael Silverstein's [1987] 1996 terms) that purportedly provides unique access to rational, modern ways of thinking and acting. As communicability gets implicitly—and deeply—connected to whiteness, nonwhite bodies get stereotyped as incapable of performing these purportedly superior forms of language and subjectivity.[13] People racialized as white are thus simply presumed to be communicable subjects unless disqualified by stigmas associated with the working class, sexuality, and disability. However, the default status for individuals and populations classified as nonwhite is incommunicability; middle- or upper-class and professional status provides racialized individuals with only partial, temporary escape from the presumption of incommunicability. Rethinking earlier work (Bauman and Briggs 2003), I analyze the role of John Locke in establishing and naturalizing these relations among race, communicability, and rationality; inscribing them into how medical knowledge is created and communicated;

and both equating communicability with whiteness and obscuring its links to white supremacy.

Linguistic anthropologists have denaturalized these tight entanglements of race and language by demonstrating how they often rest on constructions of stigmatized speech that bear little or no relation to people's actual utterances and actions. A crucial reference is Miyako Inoue's analysis of critical commentary by Japanese male intellectuals at the turn of the twentieth century regarding how women's speech seemingly challenged Japanese values and violated standards of acceptable language. Inoue (2003) brilliantly demonstrated that a highly visible and stigmatized class of incommunicable subjects can be performatively constructed by inventing what are claimed to be ways that its members actually speak, even when the semiotic markers of incommunicability are fictive. She argued that the Meiji male intellectual thereby constructed himself "as a particular historical subject" by becoming the "auditory double" of the schoolgirl. The power of models of incommunicability is thus revealed by how they can create communicable authority and incommunicable stigma in ways that bring categories of subjects into being and attach them to people, even when their correspondence to actually existing bodies, subjectivities, and modes of communication is thin or nonexistent.[14]

Parallel to how medical anthropologists and others have investigated health inequities, linguistic anthropologists have focused much attention on mapping communicative inequities and identifying the structural forces that produce them. Two recent research trajectories have much to contribute. Extending debates about white supremacy, racism, and racialization, an emerging group of scholars has carved out a field of "raciolinguistics" that seeks to "enhance our understanding of the processes of racialization by highlighting language's central role in the construction, maintenance, and transformation of racial and ethnic identities" (Alim, Rickford, and Ball 2016, 7). Jonathan Rosa and Nelson Flores (2020, 90) focus their analysis on how categories of language and race "have been co-naturalized in particular societal contexts." They draw on Inoue's (2013, 93) work in tracing the centrality of a "white listening subject" that constitutes its racial privilege by imagining incommunicable subjects and communicative practices. They examine how "raciolinguistic ideologies" stigmatize the linguistic practices of racialized populations. Much of this work seeks to go beyond documentation and analysis to contribute to efforts to confront white supremacy globally and promote justice.

Influential work by Jane Hill (2008) has sparked a host of studies of linguistic racism. She drew attention not simply to overt acts of discrimination, which many white people would condemn, but also to covert forms that invisibly reproduce denigrating stereotypes of nonwhite people. A key mechanism here lies in dominant language ideologies, whose roots I trace back to the seventeenth century in chapter 1, that are referential, tied to stable relationships between sound and meanings, and personalistic, seen as expressing the beliefs and intentions of individual speakers. This language ideology positions individuals as the prime interpreters of their words, given that they alone can purportedly access their beliefs and intentions, and it directs attention away from the harm that racist speech inflicts on people and populations targeted by stereotypes. Work by Laura Graham (2011), Hill (2002), Paul Kroskrity (2015), Barbra Meek (2006, 2013), and Bernard Perley (2011) has demonstrated how centrally "language ideological processes of racialization" (Kroskrity 2021, 180; 2020) enter into making and naturalizing denigrating constructions of indigenous people; research by white scholars is sometimes complicit in this process.

Work on raciolinguistics and linguistic racism come together in an impressive recent volume, *The Oxford Handbook of Language and Race* (Alim, Reyes, and Kroskrity 2020). I find it interesting that none of the book's twenty-one chapters focuses on health, medicine, or health care.[15] Health—including limited access and poor quality of health care; medical profiling; and higher rates of illness, death, and maternal and child mortality—are principal sites in which racism is constructed and experienced. Clinical settings are crucial spaces in which linguistic profiling is enacted as patients, simply on the basis of their racial classification, are judged to be incommunicable, as speaking the wrong languages or language varieties, being less able to understand their providers, and less capable or willing to assimilate the biomedical knowledge they are provided and less capable of transforming it into "healthy behaviors." Media representations of how health, communication, and race intersect project denigrating forms of linguistic and medical racism to millions of viewers and readers, thereby continually infusing old stereotypes with new political and medical content (Briggs and Hallin 2016). As I detail in chapter 6, the health education components of global health programs transport North American and European racialized projections of health and communication around the world by embedding them in interventions that claim to alleviate health inequities through infusions of communicability, often without addressing their structural roots or providing better access to health care. When incorporated into clinical practices, health education, and media representations, these entanglements of linguistic and medical racism inform unhealthy health policies (Castro and Singer 2004), thereby amplifying the denigrating effects of these embodied inequities. This book argues that research on language, race, racism, and racialization is analytically and empirically limited if subdisciplinary boundaries push health off the map of linguistic anthropologists. It also suggests why linguistic anthropologists have much to offer in studying and confronting medical inequities. Indeed, if constructions of language, speaking practices, and speakers are important means of creating and policing racial hierarchies, even as medicine and health are some of the key ways that racial inequities are embodied—with crucial effects on who lives and who dies—the need for more research that systematically explores their connections seems crucial.

There are, moreover, countercurrents of research that fruitfully connect issues of language and health. Gregory Bateson (1972) used close studies of interaction in seeking social causes for psychiatric disorders. Aaron Cicourel (1992) made significant contributions to linguistic and medical anthropology based on decades of research in and on medical schools. Drawing on the ethnography of communication and other frameworks in linguistic anthropology, Michael Agar (1973) conducted decades of research on drug use and treatment. Elinor Ochs used interaction analysis and video ethnography to illuminate such conditions as agoraphobia and autism (Capps and Ochs 1995; Ochs 2015). Arthur Kleinman (1988) showed scholars and caregivers alike the value of "illness narratives" in providing insight into patients' experiences of illness and care and the "explanatory models" they use to make sense of them. Cheryl Mattingly and Linda Garro (2000) have emphasized the importance, complexity, and multiple ways that narratives shape illness and healing, and Mattingly (1998) drew our attention to how their plots can be enacted corporeally and verbally. Byron Good (1994) offered a semiotic analysis of medical knowledge and practice that attends to details of the language and aesthetics of patients' articulation of their complaints. In identifying "idioms of distress," Mark Nichter (1981, 2008) documented a broader semiotics that links referential and nonreferential dimensions of speech with somatic, material, and other modes of experiencing and expressing distress and deconstructed how biomedicine deems only particular ways of understanding health and disease and defining practitioners and patients to be legitimate. Charles Goodwin's (2010) sensitive studies of his father traced how aphasia patients collaborate with others in effecting interaction and creating meaning. David Parkin's (2013) work brings together extensive research on both language and healing modalities in eastern Africa. I have used critical linguistic and medical anthropological approaches to explore how communicative- and health-based types of profiling intersect during outbreaks and epidemics (Briggs and Mantini-Briggs 2003, 2016). Joel Kuipers (1989) and James Wilce (2009) crafted review articles that explore points of contact between linguistic and medical anthropology and scholarship that reaches across their boundaries.

Encouragingly, the past decade has witnessed an efflorescence of work that draws deeply on linguistic and medical anthropological perspectives and entwines them in diverse and creative ways. E. Summerson Carr (2011) carefully documents how communicable dimensions of recovery pedagogies imposed on addicts in need of food and shelter reveal connections between linguistic and medical inequities and how clients critically revise them. New analytics and research strategies are needed to grasp the complex and shifting imbrications of media ideologies (Gershon 2010), technologies, and practices, including but not limited to the looming specter of "anti-vaxx" social media networks that algorithms and public health officials cannot tame. Lynette Arnold (2020) documented how migrants use cell-phone conversations to impose biomedical discipline on their relatives back home. Juliana Friend (2022) tracked how sex, modesty, and pleasure circulate digitally in Senegal through both digital health education programs sponsored by nongovernmental organizations and online pornography. Xochitl Marsilli-Vargas's (2022) work in Buenos Aires examined how mediatization helps extend psychoanalysis from dyadic clinical interactions into mass media and everyday encounters among laypeople. Mara Buchbinder (2015, 2021) explored the complex relational communicative practices used by adolescent patients, clinicians, and parents in grappling with pain and analyzed how debates and practices around assisted dying often hinge on linguistic as much as medical ideologies. T. S. Harvey (2013) traced the complexities of discursive, material, and embodied practices that unfold in Mayan healing practices and interface with biomedicine. Sonya Pritzker (2014) traced the diverse discursive practices involved in translating Chinese medicine as it moves between China and the United States. Linguistic anthropologists have provided examples of lay care and health communication initiatives that exceed the logics and channels prescribed by professionals. Anna Corwin (2021) assessed claims that Catholic nuns are less prone to dementia by closely following forms of care in interaction provided by other sisters. Bringing together linguistic and medical anthropology and ethnomusicology, Steven Black (2019) documented how HIV-positive members of a South African choir used songs, stories, and jokes in combining Christianity with HIV/AIDS activism and advocacy, thereby engaging audiences that ranged from global "experts" to relatives, neighbors, and other HIV-positive individuals.

In perhaps the most prominent area of overlap between linguistic and medical perspectives, sociologists, linguistic anthropologists, and other scholars, beginning in the 1970s, opened a broad research agenda focused on doctor-patient interaction (Heritage and Maynard 2006). It particularly sprang from work by sociologists building on conversation analysis and ethnomethodology perspectives who used tape recordings and, later, audiovisual recordings of "actual occurrences" of clinical encounters to produce transcriptions that afforded detailed analysis of, in the words of Emanuel Schegloff (1992, 106), "the details of actual occurrences of conduct in interaction." The physician and sociologist Howard Waitzkin (1991) scrutinized how doctor-patient interaction renders clinical medicine complicit in reproducing broader social inequities in clinical spaces and, simultaneously, in hiding their effects behind narrow biomedical logics. Close analysis of language and interaction have been developed for other arenas of care, such as Mattingly's (1998) careful analysis of narrative and healing in occupational therapy and Carr's (2011, 2021) analysis of language and interaction in social work, addiction treatment, and "motivational interviewing" approaches to behavioral intervention. Scholars trained in linguistic and medical anthropology have examined clinical interactions beyond biomedicine (see, e.g., Briggs 1994, 1996; Harvey 2013; Pritzker 2014). Doctor-patient interaction is a remarkable example in which academic research has transformed professional practices, as taken up by physicians, nurses, and the faculties who train them. Clinical training now includes videos that model how physicians should interact with their patients to maximize biocommunicability. Students gain practice in enacting biocommunicability through staged interactions in which they interview people trained to act as patients and through evaluations of audiovisual recordings of patient encounters.

One of the most fruitful areas in which synergy between the two fields can emerge lies in attention to issues of inequity and profiling. Researchers have demonstrated that Black and Latinx patients receive lower-quality health care than white patients, even after controlling for socioeconomic status and health insurance (Smedley, Stith, and Nelson 2003). Strong evidence of medical profiling emerged from work by Michelle Van Ryn and Jane Burke (2000), who found that US physicians assumed that Black patients abused drugs and alcohol more frequently and were less educated and intelligent, less attentive to medical guidance, and less likely to follow treatment guidelines. Systemic health inequities are often individualized as questions of communicative incompetence, bad behavior, lifestyle, ignorance, or noncompliance. Medical anthropologists have studied health inequities ethnographically. To name just a few examples, Dána-Ain Davis (2019) sensitively documented how medical racism positions Black female professionals—despite their apparent class privileges—as more likely to face premature and low-birthweight infants. Work on HIV/AIDS (Farmer 1992; Sangaramoorthy 2014) and diabetes (Doucet-Battle 2021; Moran-Thomas 2019) has analyzed how systemic health inequities are often individualized and misrepresented as questions of bad behavior, lifestyle, ignorance, or culture. Carolyn Rouse (2009) showed how doctors normalized requests by sickle cell patients for pain medications through a stereotype of Black patients as manipulating practitioners to satisfy drug addictions. Social justice perspectives have helped change conversations about health, locating scholars as part of broader efforts initiated by members of medically underserved populations and social movement organizations to confront inequities (see Krieger 2011).

To extend research that challenges linguistic-medical scholarly boundaries and suggest the importance of these efforts in addressing justice issues, I have used the concept of *health/communicative inequities*. The term uses a lexical juxtaposition to suggest how these seemingly discrete axes are deeply connected. A primary focus of this book is on the ideological labor that both coproduces communicative and health inequities and obscures their entanglements, including from scholars and practitioners.[16] Dominant strategies often project communication and medicine as separate, autonomous domains, even as they enmesh them in ways that naturalize health and communicative inequities. A central part of this ideological labor is crafting dominant communicabilities: understandings of how knowledge is made and who makes it, how it travels, who is required to receive it, and how this knowledge should be embodied. With reference to biomedicine, one way that dominant biocommunicabilities become powerful is by framing them as direct reflections of how communication and medicine work. Any gaps between these idealized, abstract, hierarchizing models and facts on the ground are deemed problematic, requiring a search for what seems to have gone wrong and who is responsible.

Here is where incommunicability comes in. Although gaps between ideological models and the pragmatics of how communication and medicine unfold are unavoidable, they usually get blamed on people with the least power and access to linguistic and medical resources. Judging an individual or population to be incommunicable reifies health and communicative inequities and blames patients for their health problems. The result is not only the stigmatizing of populations but a thwarting of the stated goals of improving health, empowering patients, and fostering cooperation between health professionals and patients. The impact of being judged incommunicable goes far beyond clinical and public health spaces. It not only renders entire populations expendable by obscuring the need to focus on and transform the structural factors that produce grossly inequitable distributions of health, disease, and death, but it defines a baseline of rationality and moral responsibility—stigmatizing members of racialized populations as incapable of saving, or unwilling to save, not only their own lives but those of their family members.[17] By critically engaging how established perspectives and practices systematically produce incommunicability through processes—such as doctor-patient communication and health communication and their institutional and global extensions—I hope to help remove one of the major roadblocks to fundamental changes and make a significant contribution to achieving justice. Far from condemning by fiat all health professionals as conspiring to advance this project, I try to highlight here how some clinicians and public health practitioners work with social movements to craft alternatives.

A Reader's Guide to the Book

This book moves through a wide range of issues, fields, and analytics and is in dialogue with multiple interlocutors. At the same time that I incorporate examples available in the published literature, as well as from a broad range of media sources, the argument draws on nearly four decades of research that brings together linguistic, medical, and media anthropology, mostly conducted in Venezuela and the United States. I have worked in many areas of Venezuela, but mainly in the Delta Amacuro rainforest on the country's eastern edge. People I met there in 1985 thought that studying the indigenous language, called Warao, might be of value to efforts to establish bilingual education programs and help improve health services. Racialized health inequities, including unconscionable levels of infant and child mortality, tuberculosis, and malaria, meant that issues of health, disease, healing, and death pervaded everyday life and conversation and emerged in a host of verbal and musical genres. These range from mythic narratives and gossip to healing songs and chants, funerary laments, and performances of political speech that advanced demands for an end to centuries of crushing colonial policies and practices. I witnessed outbreaks of cholera in 1992 and rabies in 2008, events that first led me to assist with public health and clinical efforts and then conduct research designed to figure out why so many people died from diseases that can be prevented, respectively, by clean water and vaccinations. In both of these cases, I collaborated with a remarkable Venezuelan public health physician, Dr. Clara Mantini-Briggs. A central focus throughout was linking perspectives and practices of nurses and physicians with those offered by healers. I also draw on research in other areas of Venezuela that documents how underserved communities and progressive professionals and political leaders crafted bold alternatives to unhealthy health policies (Castro and Singer 2004), as inspired by the Bolivarian socialist revolution led by President Hugo Chávez Frías.

Working in cholera and rabies outbreaks was, in a word, devastating. I promised myself that I would never investigate another epidemic. Then along came COVID-19 in 2020. Teaching and administrative duties were so overwhelming during the first year and a half that I had little time to think about research. My affiliation with the Latinx Research Center at the University of California, Berkeley, led me to collaborate with eight undergraduates, two graduate students, and Mantini-Briggs in launching the Latinx COVID-19 Auto-ethnography Collective, starting in January 2021. Dr. Mantini-Briggs and I wanted to support UC Berkeley undergraduates' efforts to reflect on and confront through activist interventions the effects of the pandemic in augmenting the impact of racialized inequities of education, health, housing, employment. Weekly, laterally organized meetings over Zoom enabled us to share our experiences of the pandemic. Their accounts of being displaced from their UC Berkeley dorms and apartments, losing jobs, caring for relatives, and trying to forge new futures after the pandemic led me to begin to think about the effects of COVID-19 and mitigation measures.

In July 2021, a sabbatical leave gave me time to look more broadly at how the pandemic affected people's lives, work, fundamental assumptions about the world, and visions for the future. I thus began interviewing physicians, psychiatrists, physician assistants, nurses, dentists, public health officials, journalists, community-based organizations, elected officials, judges, educators, religious professionals, firefighters/paramedics, police officers, and laypeople. I have conducted over eighty interviews, some by Zoom; others, in person. When possible, I have stayed in touch with interviewees, learning how their lives and reflections have changed since our conversations. I complemented interviews and observations in California with work in New Mexico and Montana. A month in Montana helped illuminate the complex worlds that people who embrace biocommunicability often reduce to stereotypes about people who are depicted as "anti-vaxxers," "anti-maskers," "conspiracy theorists," and circulators of "misinformation." Conversations with them suggested how they came to view scientists, health professionals, journalists, and public health officials as forming a category of arrogant, prevaricating Others. Complementing interviews with extensive observation enabled me to see how in/communicabilities circulate and how they have been woven into the details of ranching, building, worshipping, shopping, and relaxing—and what happens when people experience COVID-19 symptoms.

Nevertheless, this book is not an ethnography of language and health in a Venezuelan rainforest; nor does it focus entirely on the COVID-19 pandemic. One goal for this book is to upset ways of thinking about these topics that have been in place for some three hundred years. Equally important, I want to provide a resource for scholars and students who are more open to radically different perspectives on what it even means to say "language and health" or "communication and medicine." The book also seeks to assist clinicians, public health professionals, journalists, and community activists in developing new approaches and practices. I hope to contribute to efforts by academics, practitioners, and activists to counter monopolies over biocommunicability—over claims that there is only one legitimate way to produce health knowledge, promote its circulation, and receive and embody it. This process of decolonization must, I think, be designed and deployed in such a way as to effectively counter the projection of particular individuals and populations as unfit for communicability—as incapable or unwilling to assimilate biomedical content and transform it into healthy states, let alone to join in contributing knowledge of health and disease. Here's the crux: I want this book to help eliminate one of the primary excuses for blaming disadvantaged populations for the effects of racialized health, housing, employment, educational, economic, and other inequities and inspire collective efforts to achieve health/communicative justice.

This book is written in modular fashion. I invite you to approach its three working parts in whatever way makes the most sense to you. Part I attempts to provide a new philosophical and analytic base by creating dialogues with four interlocutors. You may know the work of three of them—John Locke, Frantz Fanon, and Georges Canguilhem—but you may not have met them in the guise in which I introduce them: as philosopher-physicians. Few of Locke's vast legions of readers know that he was trained and practiced as a physician. The reason, I suspect, is that he hid it. His *Essay Concerning Human Understanding* was a foundational attempt to cast science and medicine, on the one hand, and language and communication, on the other, as "separate provinces of knowledge." As a result, important connections between these two crucial arenas for the development of semiotics have warranted little attention.[18] Establishing himself as the patron saint of communicability, Locke decreed that only individuals who magically separate body and mind and speak in purely rational, disembodied, transparent, and disinterested fashion could save the world from confusion, discord, and disorder. I want to introduce you to a different Locke, one whose work was shaped by disability and who decreed that disorders of language and disease must be cured by similar reductionist, instrumentalist practices of diagnosis and intervention. By reading Locke against the grain by foregrounding his pervasive anxiety about incommunicability, we can begin to see how, in spite of himself, he can teach us how incommunicability can become a productive force rather than a stigmatizing plague to be stamped out.

Fanon's many readers know that he was both a doctor and a philosopher. His diagnosis of the colonial and racist roots of ill health and his careful presentation of political diagnosis uses the classic clinical method of closely examining details of particular cases, even as he jumped scale to analyze the structural underpinnings of mental illness engendered by colonialism. I connect Fanon as physician and as philosopher of language in exploring his insights into ways that colonialism and racism infect languages and language varieties and how they racialize patients as ipso facto communicable or incommunicable. Locating Fanon as the prophet-in-waiting of the field of doctor-patient interaction studies that would emerge decades later, I suggest that his trenchant, angry, and ironic critique of how colonial physicians speak to their patients holds the key to analyzing pedagogies that currently promise to teach providers how to be better communicators. Even as his focus is on highly racialized and denigrating examples, he opens up the possibility of taking a broader approach in analyzing how caregivers more generally can render patients incommunicable. Fanon also pinpointed how denigrating images of Blackness in media texts prefigure the violence sparked by anti-Black racism.

The transition from Locke to Fanon is bridged by a dialogue with W. E. B. Du Bois, especially his *The Souls of Black Folk*. He provides a powerful voice for countering Locke's claims for the universal primordiality of communicability and disrupting its implicit connections to whiteness. Writing decades before Fanon, Du Bois ([1903] 1990, 8) analyzed how racialized media forms and everyday racist acts, along with pervasive structural inequities, require Black people to practice double-consciousness, "this sense of always looking at one's self through the eyes of others," that induces a painful splitting of the subject. In discussing his concept of "the Veil," I follow his keen analysis of how racism produces white incommunicability vis-à-vis Black social worlds, thwarting the ability of white people to perceive them or to gain awareness of their own myopia. Du Bois layers his texts with stylistic and generic shifts in such a way as to move between analyzing and performing the entanglement of communicability with incommunicability. I sit uncomfortably with the powerful chapter that recounts the death of his eighteen-month-old child. The chapter leaves me with a troubling question. The figure of the doctor enters the story not through an analysis of racialized inequities but through a visit by a “gray physician,” who arrives as the child is dying. I reflect on the racial health inequities that might have helped lead to the death, wondering that Du Bois did not work this element into the impressive mosaic he provides of the effects of anti-Black racism in *The Souls of Black Folk*.

My third philosopher-physician is Foucault’s teacher, Georges Canguilhem. Alas, he does not join Du Bois and Fanon in shattering the illusion that bodies, minds, and patients are individual, deracialized, and universal. Canguilhem does, however, make a powerful contribution to the primary focus of the book: how health professionals’ efforts to promote biocommunicability often systematically produce incommunicability. Canguilhem carefully reflects on how patients’ experience with a chronic or prolonged illness forces them to reexperience their bodies and how they are situated vis-à-vis space, others, and the world. He shows that these new spaces are not interpretable through the lenses patients had used in negotiating their prior, “normal” lives. The pathological state instead becomes the only world that is experientially accessible. Physicians, in a nutshell, make things worse. In clinical encounters, doctors ask these patients to calibrate their world, point by point, in terms that spring from anatomy and physiology, from understandings of how organs are supposed to function. Physicians thus ask patients to use a lost language to describe corporeal worlds that seem alien and confusing. In the process, physicians not only impede what would later come to be known as doctor-patient communication but undermine patients’ struggles to know and articulate the pathological worlds that are becoming “normal” for them. Canguilhem will later help us at various points, including sorting out why attempts to impose biocommunicability as the only legitimate foundation for confronting a complex, sneaky virus named SARS-CoV-2 ended up turning boundaries between communicability and incommunicability into social and political chasms.

Part I has a different structure than you might expect. The last thing I want to do is to turn these interlocutors into tools for constructing a single, overarching, tightly woven framework that purportedly flows from my own ideological labor. Mountains of writing focus on Locke, Fanon, and Du Bois, but I invoke them only sparingly. My reasons are twofold. First, I don’t want to drown out their voices and or dilute how they can help us make a fresh start in rethinking in/communicability. Second, I try to avoid oversimplifying their interventions as bodies of content, as propositions that can be easily shuffled into the decks of existing scholarly literatures. This move permits an engagement with figural and formal (or poetic or rhetorical) features of their texts and dimensions of their lives. I have chosen these four figures because they highlight how communicability became a fundamental part of the infrastructure of white supremacy and racial hierarchy and, through the work of Du Bois, Fanon, and Canguilhem, how we can craft a philosophical and analytic base for dismantling it and crafting alternatives. I find reflection on the complex interplay between their lives and their written work provides a productive way to explore these issues.

Part II, however, requires a dialogue of a very different sort. There my dialogic partners are quite different, given that I jump some three hundred years ahead from Locke's foundational move to concentrate on two ways that clinical and public health professionals attempt to cross the divide between medicine and communication. Chapter 5 follows a body of social-science literature that has made a significant difference in how doctors and other health professionals are trained and the fine-grained, moment-to-moment dynamics of how they interact with patients. The ambition is lofty: helping caregivers listen more sensitively to their patients and increasing patients' engagement with their providers. Fanon's early warning sits on my shoulder, however, as I look closely at how this emphasis can enact biocommunicability in ways that can stigmatize patients as incommunicable failures, thereby affecting health outcomes and patients' confidence in providers and forms of care. Chapter 6 shifts to the field of health communication. Building on fieldwork in Venezuela, the chapter complements US-based examples, including some that focus on COVID-19. It traces how biocommunicability jumps scale as health communication programs are exported from the United States, Europe, and international agencies such as the World Health Organization to produce what are sometimes denigrating diagnoses of incommunicability in low- and middle-income countries. An interlude that follows the chapter discusses examples in which populations that face racialized health inequities grabbed hold of biocommunicabilities and used them to forge innovative health communication and healthcare programs.

Part III pivots toward ethnography. Engaging just a fraction of the remarkable conversations I was honored to undertake during the pandemic, I try to figure out what went so terribly wrong in the United States with COVID-19 health communication. Chapter 7 traces a remarkable situation in which research on severe acute respiratory syndrome (SARS) infections—fairly limited despite the major role of SARS viruses in such manifestations as the "common cold" and past epidemics—suddenly become the global priority. Rather than entering into the contested fray of efforts to trace SARS-CoV-2's global footprints, I focus on how health professionals declared a monopoly on the production of knowledge about a remarkably tricky microbe. Even as scientists, physicians, and public health professionals struggled to understand the virus and its effects, they clung to a long-standing communicable model that grants health professionals a monopoly over producing biomedical knowledge. Because laypeople were cast as passive recipients of emerging medical and public health knowledge and guidance, their potential contributions to addressing the pandemic's unanswered questions were dismissed in advance. Nevertheless, many laypeople used their own experience of the pandemic, the archives of health commonsense they had acquired over decades, and the tsunamis of material appearing in mainstream and social media to fill in remaining gaps. I use two ethnographic dialogues to provide depth here: an artist trying to figure out how post-acute sequelae of SARS-CoV-2 infection (PASC), or long COVID, was taking hold of his body and a retired package delivery driver and contractor in Montana whose negative view of COVID-19 communicability led him to reject masking, vaccination, and just about everything health professionals were saying about the disease. I place them in dialogue by exploring how—despite the incredible dissimilarity in their lives and political views—they both felt they were thrown by health professionals and journalists into a space of incommunicability.

Chapter 8 involves dialogues with a more extensive set of interlocutors in reflecting on a conundrum: even as health professionals claimed a monopoly on pandemic knowledge production, they largely passed along the burden of care to laypeople, except when severe symptoms required hospitalization. Undertaking this task, even in the absence of COVID-19 symptoms, required remarkable forms of creativity and collaboration that expanded notions of care far beyond narrow biomedical definitions of prevention and treatment. We listen to the challenges faced by grandparents, students, farmworkers, and people stereotyped as "anti-vaxxers" as they attempt to innovative forms of care and daily living. The very concept of "the pandemic" explodes as viruses, mitigation measures, and their seemingly constantly expanding effects get woven into the fine details of lives, mainly through ongoing relations of care. We also listen to caregivers—firefighters/paramedics, an ICU nurse, an ER doctor, an epidemiologist, and an infectious disease physician—to see what happens when patients do require acute care. Here dominant stereotypes—that of the heroes celebrated by pot-banging neighbors and of arrogant, distanced professionals—collapse as health professionals found themselves sinking into incommunicability even as they attempted to impose biocommunicable authority on patients and lay populations. We learn that many professionals got trapped by the same contradictions between insufficient knowledge and overwhelming burdens of care as laypeople. In the pandemic, biocommunicability was called on to perform the same task in the pandemic that Locke decreed for communicability more than three hundred years ago: locating what are deemed pragmatic failures of communicability, diagnosing their source, and intervening in such a way as to eradicate them. Chapters 7 and 8 demonstrate the continuing failure of the promise of communicability—how claiming monopolies on legitimate knowledge and stigmatizing anyone who challenges them—thwarts efforts to improve health and end health inequities.

I analyze in this book how communicability and incommunicability are relational, such that making seemingly new biocommunicabilities (perpetually required of medical schools and global health programs) and imbuing them with power requires producing new incommunicabilities. I fear that the process still requires making incommunicabilities seem so pathological that they undermine communicability, communication, rationality, and, according to Locke, social order. In short, we could paraphrase a comment that is attributed to Malcolm X about racism: communicability is like a Cadillac; they come out with a new model every year.

My goal in this book has been to help break this cycle. I suggest that it is time to bury the Lockean legacy, which decrees that communication requires diagnoses of miscommunication and interventions whose ethical value is ensured in advance by the claim that they are designed to fix things. One of the major things that went wrong in the United States with COVID-19 is that some 99 percent of the population was continually told that it had nothing worthwhile to contribute to making sense of a new, puzzling disease. On the contrary, I suggest that starting from the assumption that all parties have something significant to offer and then placing their perspectives in dialogue is far more likely to result not just in "buy-in" but in perspectives and actions that generate structural change. My concern in the pages that follow is not just to analyze the negative effects of imposing communicability and stigmatizing all those who are deemed to reject its authority or fail to embrace it. I also point out, particularly in the interlude, ways that groups classified as incommunicable have creatively crafted alternatives, not by denying the value of biomedicine, but by challenging its monopolistic claims. Given the stigmatizing and denigrating effects of classifying people as incommunicable, I end with a proposal that we should collaborate in creating *incommunicability-free zones* and in turning each encounter enacted in medical, educational, public health, and other institutional spaces into efforts to confront health/

communicative inequities and further health/communicative justice. If anthropology can play a leading role in breaking the cycle of the production of incommunicability and helping to end the pervasive role of dominant communicabilities in producing hierarchies, inequities, and stigma, this may be one of its most important contributions to countering a matrix of intellectual quagmires and to promoting health, justice, and dialogue.