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Book review

Briggs, Charles L. 2024. Incommunicable. Toward communicative justice in health and medicine. Durham, London: Duke University Press. 336 pp. Pb.: $28.95. ISBN: 9781478026006.

Book review by

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In *Incommunicable: Toward Communicative Justice in Health and Medicine*, Charles L. Briggs examines the intersection of medical knowledge, communication, and power. He reveals how these domains are deeply intertwined with colonial histories and structural inequities, shaping whose voices are heard in health discourse and whose knowledge is valued in medicine. Drawing on linguistic and medical anthropology, as well as decolonial theory, the book examines how dominant models of communication privilege certain narratives while marginalizing others, often reinforcing racial, ethnic, and class-based inequities. This dynamic becomes particularly visible in Briggs' discussion of responses to disease outbreaks—from cholera to COVID-19—where health authorities have frequently framed illnesses strictly in terms of scientific and biomedical knowledge, overlooking the complex social, cultural, and political dynamics experienced by various communities.

A particular aspect of the book is its self-reflexive turn. Briggs critically reassesses his previous work on language and health, acknowledging how it was shaped by the dominant communicability framework "grounded in white, elite, male, ableist, Euro-American privilege" (p. 7). In response, he argues "to decolonize fundamental understandings of language and communication, health, and medicine" (p. 10). He introduces *incommunicability as an alternative analytic* and "reject[s] communicability as the taken-for-granted starting point" (p. 9). He understands incommunicability as a condition actively produced by dominant structures, which cast some individuals and populations as incapable of participating in recognized forms of rational, liberal, and modern discourse. Recognizing the harmful effects of labeling people as incommunicable, Briggs also ex-

plores how incommunicability can be reclaimed and inhabited in ways that challenge hegemonic norms, emphasizing its potential for creating new collective forms of being.

The book is divided into three parts and has eight chapters. In *Part I*, drawing on the works of John Locke, Frantz Fanon, Georges Canguilhem—whom the author describes as philosopher-physicians (p. 20)—and W.E.B. Du Bois, Briggs explores the conceptual efforts aimed at separating language and communication from medicine and the body. At the same time he seeks to develop a new philosophical and analytical framework while re-evaluating in/communicability, and aiming, as he puts it, "to bury the Lockean legacy" (p. 25). He outlines how the concept of communicability is not neutral but deeply embedded in the structures of white supremacy, racial hierarchy, classism, and colonial violence on the one hand, and the specific historical, geographical, political, and economic conditions that shape societies and their health systems on the other. These interwoven structures form exclusions and power dynamics within medical discourse.

In *Part II*, the author delves into two research areas: doctor–patient interaction (*Chapter Five*) and health communication (*Chapter Six*). Based on the social science literature, he discusses how racialized inequities and biocommunicability operate in clinical spaces. Building on his ethnographic work in Venezuela and research conducted by other scholars around the world, he expands the analysis beyond the United States. Briggs examines how global health programs export biocommunicability frameworks from the United States, Europe, and international agencies (such as the World Health Organization) to so-called low- and middle-income countries, often reinforcing racialized hierarchies and structural inequities under the guise of improving health communication, while dismissing and marginalizing other forms of knowledge, practices and modes of health communication. At the same time, Briggs highlights how various social groups and movements resist these dominant biomedical narratives. He examines their ability to transform stigmatized, "incommunicable" statuses into unique roles within biocommunicability, actively reclaiming spaces where alternative forms of knowledge and communication can thrive, and building solidarity-based collaborative communication networks. These movements create what he terms *incommunicability-free zones* (p. 156), where individuals who have been excluded from mainstream health discourse redefine their experiences and carve out new ways of sharing knowledge that challenge dominant hierarchies and open possibilities for more inclusive health communication.

In the final, third part of the book, Briggs offers a compelling ethnographic account of the COVID-19 pandemic, introducing the concepts of *pandemic ecologies of knowledge* (*Chapter Seven*) and *pandemic ecologies of care* (*Chapter Eight*). He offers a critical perspec-

tive on what he calls the *pandemic-industrial-complex* (p. 161) and "opens up different analytical strategies for thinking about why COVID-19 has had particularly catastrophic effects in the United States" (p. 163). He explores how the United States' response to the COVID-19 pandemic was shaped by tensions between three communicable models: the top-down biomedical-authority model, which centers expert control and seeks monopoly over knowledge production; the patient-consumer model, "which projects laypeople as agentive, self-interested individual consumers of health knowledge and care"; and lay-activist communicability, emerging from the margins, in which patients take an active role in interpreting and producing biomedical knowledge (ibid.). Briggs argues that "laypeople who have been classified as good sanitary citizens; contentious long covid activists; 'anti-vaxx' and 'anti-mask'" were all part of broader ecologies of pandemic knowledge (p. 195). These competing frameworks reveal deeper conflicts over authority, trust, and knowledge in the pandemic context.

The book offers a rich interdisciplinary insight into issues of health, communication, and justice, placing particular emphasis on access to knowledge, its production, and the provision of care. Its significance lies especially in dismantling dominant beliefs that portray laypeople (patients) as passive knowledge receivers. Instead, it attributes to them a particular form of epistemic agency, recognizing them as experts of lived experience. As Briggs reminds us, "One thing that is needed is openness, a willingness to make space for exploring new approaches to knowledge and care" (p. 271).