

Communicability, Racial Discourse, and Disease

Charles L. Briggs

Department of Anthropology, University of California, Berkeley, California
94720-3710; email: clbriggs@calmail.berkeley.edu

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Abstract

This review proposes a model for analyzing the power of ideologies of communication in producing subjectivities, organizing them hierarchically, and recruiting people to occupy them. By way of illustration, it compares this productive capacity, which is herein termed communicability, with schemes of racialization and medicalization. The argument draws on critical discourse analysis, conversational analysis, post-Habermasian research on publics, Bakhtin, Bourdieu, Foucault, and work on language ideologies to synthesize a framework for studying spheres of communicability. The concept is then used in exploring how constructions of race and health intersect in some of the most powerful spheres of communicability—those associated with colonial medicine, HIV/AIDS, severe acute respiratory syndrome (SARS), Alzheimer's, genetics, clinical trials, "race-based medicine," organ transplant, and biostatistics. The review attempts to connect linguistic anthropology and discourse analysis more productively to medical anthropology, the history of medicine and public health, medical sociology, public health, genetics, and science studies.

Contents

INTRODUCTION.....	270
COMMUNICATING	
INFECTIOUS	
INEQUALITIES.....	271
Epidemics and Racial	
Imaginary.....	275
GLOBALIZING MEDICAL	
EPISTEMOLOGIES.....	279
CLINICAL TRIALS AND	
GENETICS.....	280
CONCLUSION.....	282

INTRODUCTION

The research trajectories of numerous disciplines and perspectives are converging on issues of productivity. Many scholars are interested in how knowledge and social relations are produced, how individuals and institutions gain rights over this process, and how social worlds emerge and people are recruited to occupy them. Two crucial loci of attention are racialization and medicalization. Scholars of medicalization (Conrad 1992) are interested in how biomedical knowledge engenders subjectivities and definitions of the body, health, disease, and life itself and imbues them with social and political force. Social constructionists suggest that biomedical facts are produced by configurations of technologies, social/political relations, and institutions (Cambrosio & Keating 1992, Haraway 1991, 1997, Latour 1993). Omi & Winant (1986, p. 64) define racialization as “the extension of racial meaning to a previously racially unclassified relationship, social practice or group.” Others suggest that racial meanings are always already embedded in modernity (Mignolo 2000) and the state (Goldberg 2002); racialization thus implies continual impositions of old and new racial meanings. Racialization is hardly an isolated process; racial categories “intersect” with other forms of subordination (Crenshaw 1989), and discourses of race

are co-constitutive with discourses of gender/sexuality (Gutiérrez 1991, Stoler 1995) and class (Navarro 1989, Williams 1999). The relevance of work on medicalization and racialization—and explorations of their imbrications (Anderson 2003, Briggs 2002, Hunt 1999)—has increased as scholars demonstrate that they are “about” more than medicine and race; rather, they constitute crucial sites for producing notions of modernity, nation, state, and citizenship (Epstein 2004, Martin 1994, Molina 2005, Ong 1995, Shah 2001).

A little-explored dimension is how this knowledge is disseminated in society. Racialization and medicalization include control over the production, circulation, and reception of discourse. Racial and medical knowledge does not simply flow but is dependent on communicative processes structured by inequities of power and resources. Such inequities as differential access to communicative technologies (cell phones, the Internet) and to symbolic capital conferred in schools of medicine and public health have been widely acknowledged. Nevertheless, research on publics and work in linguistic anthropology on language ideologies suggest that disseminating racial and medical knowledge involves not just communicative circuits but their ideological construction as well.

I have two goals here. First, I propose a theoretical model and research agenda, arguing that notions of “communication” are no less productive than ideas of “race” or “health.” This productive capacity, which I refer to as communicability, stands alongside racialization, medicalization, and other power-laden processes as integral to schemas of hegemony, coercion, and violence. I draw on discourse analysis, including critical discourse analysis, conversational analysis, post-Habermasian research on publics, Bakhtin, Bourdieu, Foucault, and a range of perspectives in linguistic anthropology to synthesize a framework for studying what I refer to as spheres of communicability. Second, I use the notion of communicability in reviewing literature from medical anthropology,

the history of medicine and public health, medical sociology, public health, genetics, and science studies on intersections between health, race, sexuality, class, and nation. Connecting racialization and medicalization through communicability reveals how their power is derived partly from ideologies of communication with which notions of race and health are imbricated. These links enable me to explore some of the most powerful spheres of communicability—those associated with colonial medicine, HIV/AIDS, severe acute respiratory syndrome (SARS), Alzheimer's, genetics, clinical trials, "race-based medicine," organ transplant, and biostatistics. I also try to weave together linguistic and medical anthropology, and analyses of discourse and health, in a novel way, and I suggest that exploring intersections between communicability, medicalization, and racialization will be of value for scholars who generally eschew interest in fields that are often marginalized as specialized or technical.¹

COMMUNICATING INFECTIOUS INEQUALITIES

I begin with an important wake-up call to U.S. health professionals. A number of authors have argued that greater social inequality leads to poorer health (Kawachi & Kennedy 2002, Navarro 1998, Waitzkin 1983). Then in 2002, a report entitled *Unequal Treatment* concluded, after controlling for socioeconomic status and type of health insurance, that African Americans and Latinos/as receive inferior health care (Smedley et al. 2002). Considerable research and intervention now focus on what are called, rather blandly, health disparities. How might research on discourse help? Here I critically examine a number of

frameworks with respect to their potential contributions.

Unequal Treatment argues that physicians' stereotypes of minority patients affect quality of care. Conversation analysis (CA), the microanalysis of audio and video recordings of social interaction, has explored how inequalities emerge in and structure doctor-patient communication (Ainsworth-Vaughn 1998). Recent work on talk in institutions illuminates the everyday work that underlies how expertise is constructed in health and scientific settings (Goodwin 1994) and the routine categorization that informs procedures touted to be objective and impersonal. Cicourel (1992) and Sarangi & Slembrouck (1996) trace how medical representations are transformed in circulating between classrooms, clinical interactions, texts, and laboratories. Rather than relying on surveys of racial perceptions in studies of health disparities, CA could provide insight into how stereotypes emerge in therapeutic encounters and influence treatment regimes. Nevertheless, strict CA adherents eschew appeals to history, political economy, or broader social relations—to anything that does not appear on the recording. Determining what makes some forms of interaction possible and others unthinkable is accordingly beyond its scope, thereby limiting CA's usefulness for analyzing the production of social inequalities. Moreover, Martín-Barbero (1987) suggests that we do not live in societies with media but in mediated societies, where images of self and society are shaped by the media. As health-related content in news and, in the United States, advertising increases dramatically, media representations shape how professionals and laypersons imagine and enact roles of doctor, nurse, and patient.

Critical discourse analysis (CDA) analyzes how inequalities are embedded in linguistic patterns (Blommaert & Bulcaen 2000, Reisigl & Wodak 2001). Researchers have identified linguistic strategies for reconciling claims to being color blind with racist statements (Bonilla-Silva & Forman 2000, van Dijk 1991). Reisigl & Wodak (2001) argue

SARS: severe acute respiratory syndrome

CA: conversation analysis

¹I give one disclaimer: This review covers a vast range of disciplinary terrain. It was thus necessary to cite only a few works from each field that seemed particularly germane to the argument. My failure to cite other sources should not be construed as a critical judgment regarding their importance.

that seemingly universal discourses—even liberal or left varieties—can contain historical residues of racism (Blommaert & Verschueren 1998, Wodak & Reisigl 1999). Accounts of epidemics, which are analyzed at greater length below, suggest CDA's value for understanding racialization and medicalization. Theories of medical causation constitute ways of thinking about the world and acting on it (Lindenbaum 2001, Rosenberg 1992). Accordingly, narratives about epidemics make racial and sexual inequalities seem natural—as if bacteria and viruses gravitate toward populations and respect social boundaries. CDA would stress how linguistic features grant agency to microbes as they purportedly threaten and invade persons, institutions, and nation-states. Latour (1987, pp. 172–73), Sontag (1990), and others draw attention to overlaps between military and medical lexicons; Arnold (1993) reads the militarization of health more as institutional strategy than as metaphor. The title of a *New York Times* article on SARS suggests that “From China's Provinces, a Crafty Germ Breaks Out” (Rosenthal 2003, p. 1); stereotypes of Asians as sneaky and/or cunning are seemingly transferred onto the SARS virus. Officials assert their own agency—investigating, taking precautions, and providing information. Racialized and/or sexualized populations are deprived of agency, becoming passive victims lacking knowledge, resources, and initiative (Briggs & Mantini-Briggs 2003, Epstein 1996). Immigrant groups are often characterized metaphorically as a racialized flood or invasion, even though individual immigrants are denied agency (Chávez 2001, Santa Ana 2002); this convergence in metaphorical displacements of agency suggests why efforts to blame immigrants for outbreaks find ready audiences and mesh so neatly with political-economic inequalities (see Lowe 1996).

Insofar as traditional linguistic analysis imagines linguistic patterns as divorced from politics and history (Bauman & Briggs 2003), juxtapositions of linguistic and political analysis will prove problematic. Rather than analy-

ses of how seemingly neutral, objective features are bent to racist uses, we need to examine how political ideologies shape communicative practices (Bourdieu 1991, Hanks 1996). Similarly, if racialized representations circulate on a daily basis, why do they gain such force when embedded in accounts of epidemics? Why do some narratives become authoritative? Why are statements that challenge them erased from public discourse? Questions of reception are crucial—meanings do not spring directly from textual features but are appropriated through practices of appropriation and reception.

Foucault's *Birth of the Clinic* (1973) illuminates how medicine generates new types of subjects and bodies, and his *History of Sexuality* (1978, 1990) reveals how medicalization produces ideas of pleasure, desire, and self. Scholars now pursue Foucault's notion of governmentality (1991), the rational, calculated ways that the conduct of individuals and populations is regulated—through their active self-regulation—in becoming self-actualizing subjects (Dean 1999, Rose 1996). Foucault (1990) argues that health becomes an ethical imperative, requiring individuals to regulate their behavior and reshape their selves in keeping with new medical knowledge. Those who seem to succeed acquire the status of sanitary citizens (Briggs & Mantini-Briggs 2003), individuals deemed to possess modern medical understandings of the body, health, and illness, practice hygiene, and depend on doctors and nurses when they are sick (Ong 1995, Reid 1997, Shah 2001). People who are judged to be incapable of adopting this modern medical relationship to the body, hygiene, illness, and healing—or who refuse to do so—become unsanitary subjects (Briggs & Mantini-Briggs 2003). These terms incorporate what have been referred to as biomedical citizens (Ong 1995, Shah 2001) and, at the same time, draw attention to the broader moral, social, political, and cultural meanings that shape how citizenship is defined in terms of health. They also evoke the deep historical residue of how a broad range of conceptions

of health have shaped notions of state and citizenship since the nineteenth century (Anderson 2003, Hammonds 1999, Leavitt 1996, Molina 2005, Rosenberg 1962). Governmentality constructs epidemics in such a way that getting cholera or living in an infected neighborhood constitutes natural proof of a moral failure to conduct oneself in a rational, informed manner. Governmentality scholars have emphasized notions of risk, which locate individuals in relation to epidemics and contagion. Here, medicalization emerges in specialized cartographies that map demographics, “environmental” conditions, and “lifestyle choices” onto projections of health and disease outcomes (Lupton 1995, 1999; Reid 1997). Discourses of risk invite individuals to interpellate themselves in relation to scientifically based imperatives (“don’t smoke,” etc.), thereby performatively constructing themselves in multiple and shifting ways. As the stigmatization of “homosexuals” vis-à-vis HIV/AIDS suggests, individuals can become objects of discrimination simply through inclusion in “risk groups” (Epstein 1996). Analyzing risk in terms of governmentality can help us understand how representations of epidemics are transformed into self-knowledge and self-regulation.

Foucault (1973, 1978) points to the power of medical epistemologies in monopolizing nineteenth-century discourse about health, disease, and the body, but he leaves out the crucial role of state bureaucracies in creating medical epistemologies and mechanisms for regulating biomedical communicability (Hammonds 1999, Leavitt 1996, Rosenberg 1962). Latour (1987, 1988) draws attention to the importance of journals, laboratories, networks, and inscription technologies in controlling the circulation of knowledge within medicine and science, but he, too, fails to draw sufficient attention to how they are limited or “cut” by such forces as nationalism and patenting (Rabinow 1996, 1999; Strathern 1996). These mechanisms are designed to promote access for some social sectors to the knowledge and practices needed to become rational

and self-regulating and withhold access from others.

Ethnographers of communication, long interested in social inequality, analyze the specialized forms of competence needed to participate in social life (Hymes 1974). Bourdieu (1991) suggests that forms of communicative competence constitute symbolic capital, locating individuals and populations in social hierarchies; inequalities are reproduced by controlling access to sites for acquiring competence. In the health professions, forms of competence are clearly defined and bounded, and enrollment in schools of medicine and public health constitute scarce commodities. Medical statements use registers or specialized vocabularies that mark them as rooted in scientific settings. Silverstein (2004) suggests that the particular words and linguistic styles speakers use to refer to things and states of affairs effectively convert sociocultural concepts into dimensions of ongoing interactions, at the same time that these invocations constitute “indexes of users’ presumed-upon (or even would-be) relational positions in a projective social distribution of conceptual knowledge” (p. 622). Bourdieu’s notion of a unified “linguistic market” fails to capture how different loci of symbolic and material capital operate in relative autonomy (Appadurai 1996) and how value is created and power exercised as discourse moves between sites. The authority of accounts of epidemics springs from how epidemiologists hybridize multiple discourses, including popular stereotypes that also circulate in rumors, jokes, legends, and other genres (Bauman 2005). Building on Bakhtin’s (1981) notion of heteroglossia, Derrida’s (1988) emphasis on iterability, and research on performance (Bauman 1977), Bauman & Briggs (1990) view discourse neither as free-floating ions of power or signification, nor as tied inexorably to contexts, but as a process in which actors, populations, and institutions secure the right to decontextualize discourse and recontextualize it in different settings and genres. Linguistic anthropologists and literary scholars have

long been interested in intertextuality, and Silverstein (1993) provides a framework for analyzing complex relations between texts. Latour (1987, 1999) and Bowker & Star (1999) explore techniques for transforming scientific objects into forms of classification, measurement, and inscription that can be readily transported between sites and texts. Symbolic capital lies both in learning specialized forms of knowledge-power and securing rights to control their production, circulation, and reception, including acts of mediation (Bauman 2004). For example, a laboratory technician may identify a biosample as containing a pathogen with epidemic capacity, but only a designated official can transform this information into a statement to the press or a change in policy.

The question is not simply of linguistic devices for de/recontextualization but how this process is ideologically constructed and how people are located in relation to imagined communicative circuits. Linguistic anthropologists built on Silverstein's (1979) analysis of language ideologies—socially situated conceptions of the nature and functions of language—in studying how they shape communicative practices and social life (see Schieffelin et al. 1998, Kroskrity 2000). In grasping how epidemics seem to distinguish sanitary citizens from unsanitary subjects naturally, we need to analyze (*a*) how structural violence exposes some people to infection and limits their access to health care, (*b*) how biomedical epistemologies construct populations as irrational, (*c*) how access to the production and reception of authoritative knowledge about disease is distributed, and (*d*) how this communicative process is ideologically constructed in such a way as to make some people seem like producers of knowledge, others like translators and disseminators, others like receivers, and some simply out of the game. I propose the term communicability to draw attention to the productivity of the last two aspects.

The term puns on various senses of the word. Communicability suggests volubil-

ity, the ability to be readily communicated and understood transparently, and microbes' capacity to spread from body to body. I add a new sense to the word in which communicability is infectious—the ability of messages and the ideologies in which they are embedded to find audiences and locate them socially and politically. I speak of spheres of communicability for two reasons. First, hegemony involves the ability to create domains that seem to be unified (to varying degrees) by particular communicative ideologies, practices, and inequalities. Like epistemologies and social-material networks, communicability is crucial for boundary work, for the creation and maintenance of boundaries, and for the regulation of membership (Latour 1987, 1999). Second, spheres of communicability, like publics, are multiple, competing, overlapping, and shifting. The image of the sphere brings to mind this illusion of bounded fields of power without suggesting the sense of totalization and centralization that might be implied by such notions as regime, structure, or order.

By failing to draw attention to how these ideological constructions produce subjectivities, organize them hierarchically, and seek to position people in the social spatializations they produce, students of governmentality become complicit in rendering invisible how communicability is, like racialization and medicalization, productive. Communicability is a central dimension of self-regulation in that individuals structure their schemes of self-surveillance and self-control by interpellating themselves as producers, disseminators, or receivers of particular types of discourse—or as not being “in the loop.” Overlooking communicability obfuscates relations between governmentality and political economy because access to communicative technologies and symbolic capital are based on and help shape material inequalities, particularly in an age in which information is an extremely valuable commodity (Castells 1996). The linearity of dominant ideologies of communication—the idea that knowledge is produced in scientific or other expert

sectors, disseminated through other spheres, and then assimilated by publics—embodies what Urban (2001) describes as a metaculture of modernity, a progressive unfolding of new knowledge. Focusing on communicability reveals gaps and fissures—which are much more than mechanical failures to transmit messages—that structure means of systematically producing marginalization and subordination. Tsing (2000) argues that anthropologists reify globalization through metaphors of “flow” and “circulation”; metaphorical constructions of the circulation of messages similarly naturalize social relations and inequalities. Rather than regulating preestablished social categories and groups, communicability helps create and structure them. Habermas (1989) analyzes how communicative patterns and technologies constitute a “public sphere” that defines dominant notions of publicness and shapes rights to speak to and for the public. Publics are plural in any society (Calhoun 1992), and public discourses (those addressed to strangers rather than to known individuals) help create the publics they purport to address, as people position themselves in relationship to circulating messages—or just let them go by (Warner 2002). Beginning in the 1970s and 1980s, the field of health promotion adopted a new “imperative”—the use of “social marketing” techniques developed by private firms, U.S.-based foundations and government agencies, and international organizations by adapting commercial marketing methods (Manoff 1985, Reid 2004). By using social marketing, public health institutions attempted to extend their biocommunicable control over public discourse about social issues medicalized as health concerns by drawing on the increasing influence of capital over public culture—as exercised through advertising agencies and the commercial media. Both social marketing campaigns and news coverage of health, which has also expanded greatly in the past decade or so, mediate the perspectives of professionals as well as patients. News coverage and advertising become key parts of

neoliberal schemes of privatization by projecting health care less as a right guaranteed by the state than as a commodity sold by private institutions to “consumers” who make rational, knowledgeable, self-interested choices. Without communicability, Viagra marketing would be impotent. We thus need to ponder not just the content of messages but how the ideological construction of their production, circulation, and reception shapes identities and social “groups” and orders them hierarchically. In the domain of biopolitics (Foucault 1978) or biosociability (Rabinow 1992), we could use the shorthand term biocommunicability, keeping in mind that we are talking about multiple and shifting biomedical spheres of communicability.

Epidemics and Racial Imaginaries

Outbreaks and epidemics—actual or potential—occasion special spheres of communicability. Nineteenth-century international sanitary conferences established global spheres centered on cholera, plague, and small pox. A case of plague requires nation-states to provide the World Health Organization (WHO) with information, within a week, that will be available globally. International public health institutions require governments to create national spheres of communicability for the production, circulation, and standardization of biostatistics. When publics respond to media reports with epidemic fear, public health officials become sought-after sources. Controlling key laboratories and statistical compilation, they become the primary definers (Hall et al. 1978) of emerging narratives about the epidemic. How public health institutions produce knowledge for public dissemination—and any perceived failures to produce accurate, timely information—itsself becomes news. A *New York Times* article on SARS compares “Singapore’s aggressive, open confrontation with a viral enemy” with China’s suppression of information, statistical underreporting, and misinformation (Rosenthal 2003). During epidemics, the

WHO: World Health Organization

organizational structure of health ministries controls the release of information, and constraints on the production and dissemination of information are zealously guarded (Briggs & Mantini-Briggs 2003). Special laws take effect during epidemics; under colonial rule, epidemics occasioned military control (Arnold 1993) and state expansion into heretofore unregulated territories (Ileto 1995). Although quarantines have been generally discredited as public health measures, sharp racial inequalities still make them seem defensible, as HIV-positive Haitians isolated by U.S. authorities in Guantanamo Bay (Farmer 2003) and indigenous communities quarantined for cholera in Venezuela suggest (Briggs & Mantini-Briggs 2003).

When an epidemic is racialized, health professionals and reporters place the production and circulation of knowledge about race within biomedical spheres of communicability. At the same time that popular racial discourses shape constructions of diseases and patients, microbes themselves seem to redraw racial boundaries. These epidemic cartographies can chart new regimes of racism and segregation; Packard (1989) argues that a tuberculosis epidemic—that was rooted in exploitative labor conditions in the South African mining industry—provided an initial rationalization for Apartheid. Not all epidemics get racialized; Legionnaire's Disease and West Nile Virus in the United States did not assume explicitly racial contours. Herein lies a medical dimension of the value of whiteness as symbolic and material capital (Anderson 2003, Lipsitz 1998). When most cases involve people racialized as white, race seldom figures prominently in narratives. Middle-class, heterosexual whites are seldom stigmatized by diseases, but racialized and/or sexualized populations become marked in ways that can long outlive the epidemic. As media feeding frenzies retell narratives, visual images powerfully link racialized bodies with descriptions of the disease. In the same article about SARS in China, the *New York Times* featured images

of cooks cutting up animals not found on U.S. plates and customers selecting live, seemingly exotic animals for their meal (Rosenthal 2003). The photograph in **Figure 1** appeared in *El Nacional*, a leading national newspaper, shortly after the first cholera case was reported in Venezuela. While the professional is caught in an active pose, seemingly trying to reach out and help the child, the woman stares off into the distance, unmoving and seemingly unmoved, thereby visually conveying the stereotypes of the passive *indígena* who lacks agency and the will or ability to help herself or her child. In other words, the two adults' biocommunicable positions are encoded in the photograph. Visual cultural studies is now providing rich insights into the power of visual images in shaping perceptions of health, difference, and citizenship (Cartwright 1995, Reid 1997).

Another scientific language, anthropology, is frequently used in appropriating control over racial knowledge, evoking seemingly liberal perspectives in searching for "cultural" features linked to diseases. Cultural characterizations often center on alternative medicine, kinship, food, rituals, and labor (Briggs & Mantini-Briggs 2003, Farmer 1992, Hahn 1985, Menéndez 1981, Santiago-Irizarry 2001, Taylor 2003). Gender, sexuality, and motherhood come together to create imaginations of domesticities (Shah 2001) that target poor, racialized women, the biomedical equivalent of intersectionality in legal domains (Briggs 2002, Crenshaw 1989, Hunt 1999). Using liberal languages of multiculturalism, cultural features are pathologized by linking them to notions of biomedical causation. Cultural representations circulate between medical, legal, and other settings (Briggs & Mantini-Briggs 2003, pp. 314–16; Renteln 2004; Volpp 2000). Although cultural logics claim to reflect direct observation and/or expert knowledge, they often consist of widely circulating stereotypes. These cultural logics point to how medical and public health texts, framed as bounded, specialized, and scientific, incorporate a heterogeneous



Figure 1

A photograph appearing in *El Nacional* shortly after the first cholera case was reported in Venezuela. Photo: Jesús Castillo. Courtesy of *El Nacional* Archives.

range of discourses, including popular stereotypes. Producing narratives of race, disease, and space involves the collaboration of biomedical professionals, public health officials, politicians, reporters, and, often, anthropologists. Such narratives can be firmly in place before an epidemic has begun, thereby shaping epidemiological investigations, prevention and treatment regimes, and long-term effects (Briggs & Mantini-Briggs 2003).²

By placing race within the production of biomedical knowledge, logics of biological contagion seem to encompass social knowledge naturally, creating “immodest claims of causality” (Farmer 1999) that transform

structural violence and policies that foster it into a “geography of blame” (1992) in which culture is the culprit. Herein lies the tremendous value for neoliberal globalization of producing inequalities with the help of biocommunicability; this move draws attention away from global patterns of health and political economy and onto how the losers in health disparities seem to be incarcerated in culture (Appadurai 1988). That “their” bodies should be diseased just seems natural. Critical epidemiology and social medicine approaches in Latin America have been exploring for decades how health policies and practices are shaped by what Breilh (2003, p. 36) refers to as the triple inequality in health of social class, gender, and ethnicity, while helping to normalize health disparities. These scholars have been particularly insightful with respect to the effects, both macro- and microscopic, of neoliberal trade and health policies

²Santiago-Irizaray (2001) shows how cultural logics become woven deeply into everyday institutional practices, even in the absence of epidemics.

(Armada et al. 2002, Breilh 2003, Laurell 1997).

Statistics and maps provide crucial means for naturalizing links between disease and identities. In **Figure 2**, for example, contours of the so-called Third World and its separation from the so-called First World seem to emerge naturally from objective facts of the incidence of cholera—a disease associated with dirt, ignorance, superstition, and the past (WHO 1992). Bowker & Starr (1999) suggest that categories and statistics become immutable mobiles (Latour 1988), that is, packets of information that seem to move around the globe and between genres and institutions without changing their meaning. Embodying Enlightenment fetishism for discourse that seems decontextualized, disinterested, and abstract (Bauman & Briggs 2003, Poovey 1998), statistics erase the complex de/recontextualizations that shape them and

histories of how they were embedded in institutional sites through which they passed (Bowker & Starr 1999). An ironic circularity characterizes the globalization of medical and public-health technologies and the centralization of statistics in the Euro-American metropole: The more these artifacts declare their transparency and objectivity, the more they become bearers of fragmented histories that speak of global inequalities of race, gender, class, and nation (Cohen 1998, Pigg 2001). It thus becomes possible to place the entire world within a single biocommunicable sphere and signal WHO's status as its center; the *Weekly Epidemiological Record* becomes its central archive, constructing individuals, populations, and nations as producers, disseminators, or receivers of biomedical information—or as ignorant bystanders. Attempting to disclose these institutional histories convicts dissidents of the

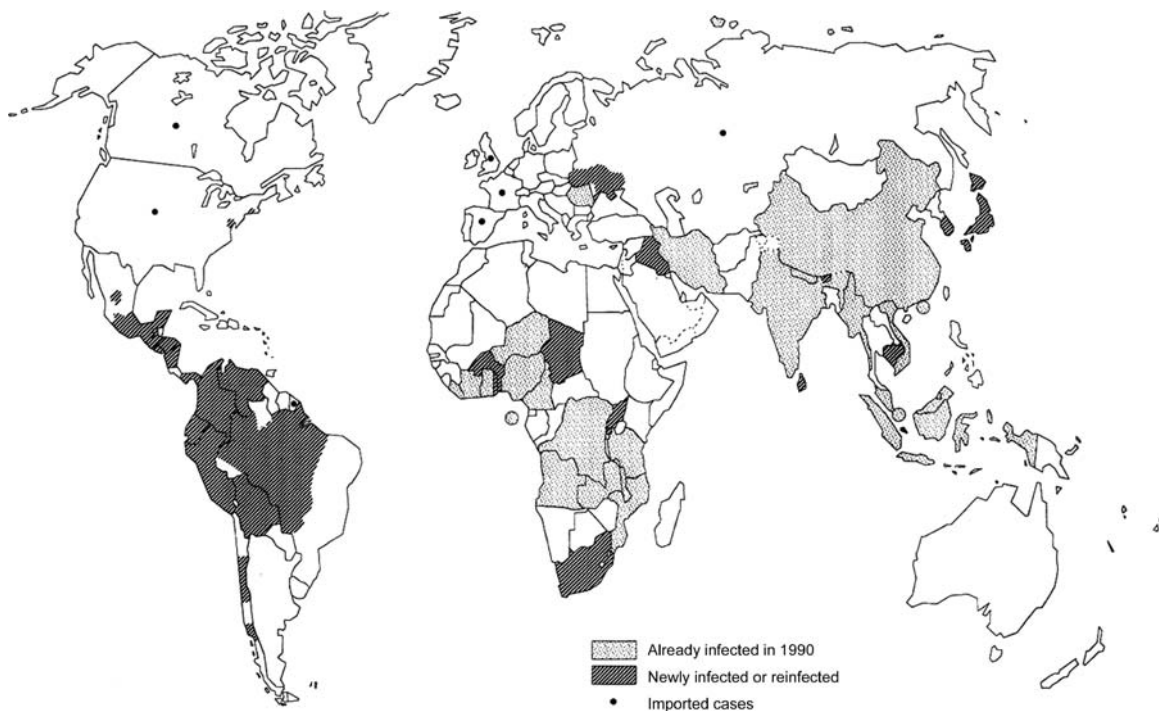


Figure 2

Countries reporting cholera in 1991, based on a map from the *Weekly Epidemiological Record*, Vol. 67, no. 34, 21 August 1992, p. 254. Courtesy of the World Health Organization.

crime of revealing the social and political underpinnings of scientific artifacts, which, as Latour (1993) warns, is tantamount to disqualifying oneself as a modern subject.

Epidemics also catalyze counter-narratives that challenge geographies of blame. Arnold (1993) argues that “tropical medicine” played a crucial role in legitimizing British colonial rule in India. Nevertheless, rumors helped Indian subalterns disentangle the logics and disrupt the medical/military tactics that held colonial medicine in place. Farmer (1992) explores rumors and speculations that shaped how people coped with the HIV/AIDS epidemic in Haiti. Rather than exoticizing narratives focused on sorcery, political intrigue, or accusations that AIDS is a U.S. plot against Haiti, Farmer demonstrates how these accounts enabled Haitians to connect AIDS with the racism and economic exploitation that placed them “at risk” for HIV/AIDS and tuberculosis. Globally circulating conspiracy theories regarding HIV/AIDS have become intimately inflected with racial, class, gender, and sexual economies (Cohen 1999, Fine 1992, Goldstein 2004, Kane 1998). When some 500 people classified as indigenous in eastern Venezuela died from cholera in 1992–1993, conspiracy theories explored effects of racism, global capitalism, and international conflict, whereas official narratives appealed to local cultural and geographic features (Briggs & Mantini-Briggs 2003).³

Communicability is doubly significant in grasping why some narratives are deemed to be scientific and others conspiracy theories. Race and class restrict access to the sites in which symbolic capital is accrued, largely excluding racialized populations from rights to produce authoritative knowledge

of diseases affecting their communities and restricting their rights of reception to passively internalizing the products of social marketing for health and health news as behavioral guidelines. Alternative narratives draw on accessible forms of evidence in challenging logics that hold dominant explanations in place, sometimes by challenging the race-space-disease equations and sometimes by reversing their causal arrows. The racialization of discursive circuits and the racial economies of state institutions exclude these alternative narratives from public circulation, unless transformed into cries for help or expressions of ignorance and willful resistance (Briggs 2004). Occasional successes in publicizing alternative narratives illuminate the political economy of communicability. Middle-class white gay activists were relatively successful in shaping debates about HIV/AIDS research, treatment, and representation; nevertheless, as gays entered mainstream debates, conspiracy theories became less and less central (Epstein 1996). A politics of distrust still flourishes in African American communities, which enjoyed less success in shaping public debates (Cohen 1999, Turner 1993, but see Epstein 2004).

GLOBALIZING MEDICAL EPISTEMOLOGIES

Medical epistemologies and technologies have long been seen as produced in Euro-America for export to less-industrialized countries as bases for regulating bodies and diseases (Briggs 2002), as exemplified by the Rockefeller Foundation’s transformation of schools and health ministries into missionaries of U.S. science, medicine, and capitalism (Brown 1979, Cueto 1994). Cohen (1998) details how the dissemination of the categories of “dementia” and “Alzheimer’s” to India transformed concepts of person and society but granted the right to be elderly largely to the middle class. The HIV/AIDS literature shows that competing narratives are reduced to a dominant scientific account, backed by

³The power of rumor and conspiracy theories in X-raying medical governmentality is hardly limited to epidemics. Schepher-Hughes (1992) explores how rumors enable poor Brazilian women to grasp the political-economy of infant death and challenge official explanations, and White (2000) analyzes how Africans transformed colonial medicine into claims that firemen and other state representatives were vampires who kidnapped Africans.

vast scientific networks and imposed globally through international health organizations, nongovernmental organizations, and leading journals (Epstein 1996, Patton 1990, Treichler 1991). Globalizing knowledge of HIV/AIDS amplifies existing modes of producing sexual, racial, and class difference by superimposing new categories and claims of authority. In Nepal, texts used in HIV/AIDS education were stratified in terms of their provenience, lexical register, degree of detail, and use of English loanwords, thereby creating hierarchies of audiences and knowledges (Pigg 2001).

Efforts to create a uniform definition of death point to the limitations of Foucauldian notions of discourse and governmentality, however, when viewed as totalizing frameworks that shape but are not shaped by objects and events. Critical-care medicine created a category of persons between life and death—whose bodies survive through life-support technologies but whose brains are irreparably damaged. As the organ-transplant industry flourished (Cohen 2001, Scheper-Hughes 2002), bodies became valuable resources for transplant surgeons. Creating a uniform definition of death fosters a communicable sphere that privileges biomedical criteria, particularly brain death, granting physicians decision-making control. In some countries, publics actively contributed to debates, preventing their location squarely within the borders of biocommunicability and limiting the power of transplant surgeons to redefine death in ways adapted to organ procurement (Lock 2002). In the United States, a limited group of physicians and a smaller number of lawyers, bioethicists, and other intellectuals shaped debates; public opinion did not become a site of production (Lock 2002). The controversy surrounding the death of Terri Schiavo in 2005 brought these questions into public debate, albeit largely subsumed within a neo-conservative discourse of the “right to life.” In India, this hegemonic discourse on death was hybridized with supposedly cultural and

religious national discourses (Das 2000). In Brazil, Mexico, and elsewhere, rumors and conspiracy theories sparked popular resistance to laws that facilitate organ harvesting (Scheper-Hughes 1996, 2002), challenging the communicable location of poor communities as producers of organs but not knowledge. Like scientific networks (Rabinow 1999), spheres of communicability are ironically dependent on the events and technologies they represent.

CLINICAL TRIALS AND GENETICS

“Evidence-based medicine” structures current spheres of biocommunicability, privileging medical knowledge produced in double-blind clinical trials as the gold standard for evidence (Epstein 1996). The place of race, gender, and sexuality in shaping medical evidence has shifted dramatically, as Epstein (2003, 2004) shows. Prior to the 1980s, patients recruited for clinical trials were mainly white adult males. Reproducing ideologies of whiteness as biological and social norms (Anderson 2003), researchers assumed that drugs that proved successful in white adult males would work on other individuals. Women and people of color were marked as subjects unable to represent “man.” Premenopausal women were often excluded owing to a paternalistic logic that sought to protect possible fetuses, whereas racialized minorities were marginalized as “hard to recruit.”

The National Institutes of Health (NIH) Revitalization Act of 1993 required that federally funded clinical trials include women and ethnic minorities as subjects and disaggregate statistics by gender and ethnicity. Medicine has long helped construct racial categories (Epstein 2004, Stepan 1982), and sex/gender and race/ethnicity were treated as relevant health indicators largely because they were taken as discernable, fixed, and self-evident (Krieger & Fee 1996). This reorganization of clinical trials resulted, however, in unforeseen

changes in the relationship between difference and medicine. In the 1990s, women, lesbian, gay, bisexual, or transgender people, and racialized minorities turned the new guidelines into what Epstein (2003) refers to as the “inclusion-and-difference policy paradigm,” questioning limits to the generalizability of medical knowledge across social boundaries and developing medical agendas that included the establishment of journals, curricula, and research centers and targeted drug-marketing strategies. The legacy of the unconscionable medical exploitation of African American men in the Tuskegee experiment had produced a mistrust of medical and public health authorities (Freimuth et al. 2001, Gamble 1997); under this new paradigm, voicing concern about becoming experimental guinea pigs was transformed for some into asserting the right to participate in biomedical research. The African American Heart Failure Trial found that a combination of isosorbide dinitrate and hydralize, or BiDil, is effective in reducing mortality and hospitalization rates among African Americans, raising the possibility that drugs will be developed for and marketed to specific racial groups. At the same time that the president of the National Medical Association, an organization of African American physicians, said that he was “thrilled” with these findings (Landers 2004), sociologist Troy Duster (1990) reiterated his warning that a return to biological and medicalized notions of difference could open a “backdoor to eugenics.”

Social movements attempted to appropriate some of the communicable power of the state, seeking to control medical representations of their members. The result, which built on the success of AIDS activism (Epstein 1996), helped shift the communicable positions of these populations from that of passive, defective receivers to active participants. This power came, however, at a highly communicable price. Social movements focused on gaining access to the privileged locus of knowledge production—health research—and being counted, literally, in statistical rep-

resentations rather than the less prestigious loci of prevention, treatment, and community organizing. By trying to shape the control that the state and health institutions exert, advocacy organizations became more dependent on the state and health professionals. Their ability to generate alternative, critical vocabularies and programs of action diminished as identity categories became increasingly medicalized through physiological notions of difference (Epstein 2003, 2004). Social movements gained discursive power through medicine only at the cost of accepting medical communicability and its capacity to define power in terms of one’s location in imagined sites for the production, circulation, and reception of medical knowledge.

Genetics is the new privileged epistemology for the scientific production of medical and racial knowledge. It has, through amniocentesis and other techniques, reshaped how potential parents imagine and manage reproduction (Rapp 1999) and claimed the status of ultimate arbiter of regimes of truth in criminology and law. Genomic research has become an important focus of anthropological inquiry (see for example Rabinow 1996, 1999, Rapp et al. 2001, Taussig et al. 2003). Announcement of draft sequences of the human genome in *Nature* and *Science* provided the occasion for public assertions of a new sphere of biocommunicability. Nobel Prize winner and Caltech President David Baltimore (2001) declared in *Nature* that genomics has opened “the book of life,” and he suggests that no one can escape the obligation to interpellate himself or herself in the genomic sphere of communicability: “We are creating a world in which it will be imperative for each individual person to have sufficient scientific literacy to understand the new riches of knowledge, so that we can apply them wisely.” Some genomic researchers claim to have scientifically measured the biological relationship between racial populations (Royal & Dunston 2004), that this information is invaluable to medicine (González et al. 2003), and that geneticists need to educate researchers, clinicians, and

a public that has been misinformed by the popular press (Collins 2004). Critics counter that genetic variation is too insignificant and medically useless to warrant its inclusion within genomic biocommunicability (Cooper et al. 2003), showing that even powerful scientific spheres of communicability are not monolithic.

Scientific attempts to use this new biocommunicability in defining diversity—and efforts to disrupt it—are illustrated by the Human Genome Diversity Project (HGDP). Organizers proposed documenting and preserving genetic diversity by obtaining samples (inter alia) of “isolated indigenous populations” before they “vanished” (Cavalli-Sforza et al. 1991). Proponents, who believe themselves to be defenders of racial equality, seemed dumbfounded when indigenous and other organizations deemed the project to be biopiracy (Hayden 2003), vampirism, and colonial exploitation (Jaimes Guerrero 2003). Reardon (2005) argues that the HGDP added another chapter to the legacy of attempts by scientists to claim that their work occupies a neutral, objective, nonpolitical space and can provide definitive accounts of racial difference. The organizers were so blind to their own participation in genomic biocommunicability that they could not understand why racialized minorities might object to being situated at the bottom of a new sphere of communicability or that anthropologists would not want to become interpreters of culture in exchanges between genomic producers of knowledge and providers of genetic samples. Political economies of race and ideological constructions of communication were replicated in the notion that indigenous communities would as gladly give away rights to the production, circulation, and reception of genetic information as their own blood. Illustrating the rapidly shifting and unpredictable dynamics of biopolitics and biocommunicability, IBM Corporation and National Geographic recently announced a five-year project that aims to collect 100,000 genetic samples “to reconstruct a ge-

nealogy of the world’s populations” (Wade 2005).

CONCLUSION

I argue that imaginations of communicative processes create categories, subjectivities, and social relations and position people hierarchically within them. Ferguson & Gupta (2002) argue that one of the ways states are constructed is by spatializing them as above or around society. Spheres of communicability also play a crucial role in imagining states and citizens. Hall et al. (1978) demonstrate how state officials become “primary definers” in media stories; the state gains communicable power by generating the sense that officials produce authoritative discourses of crime, politics, immigration, and education. Asking officials for sound bites seems as natural as casting others as victims, perpetrators, or bystanders. Notions of state, citizen, and “illegal alien” are shaped by everyday acts of creating hierarchies of communicability.

I have mapped how communicability positions scientific objects and people in contradictory fashions. As work in science studies suggests, it takes technologies, laboratories, theories, inscription devices, and journals to produce knowledge, place it into discrete categories, and make it seem so decontextualized that it can travel between texts and countries without losing its stability, meaning, transparency, and authority (Latour 1987, 1999; Bowker & Star 1999). Sites—and people associated with them—rather get constructed as fixed communicable loci. Some become locations for producing knowledge. Other places become loci of reproduction, translation, popularization, and transmission; press officers, health promoters, and reporters are supposed to work here under the tutelage of knowledge producers. Others can only receive information. Persons who assimilate knowledge cognitively and bodily become sanitary or biomedical citizens, whereas those who are judged to fail—often no matter

what they say or do—become unsanitary subjects.

The more easily objects of scientific knowledge can circulate through spheres of communicability, the less freedom people seem to enjoy in traveling between communicable loci. Leading scientists can take a step down the communicability chain, reproducing knowledge in “popular” publications and broadcasts, often generating collegial suspicion. It is much more difficult to move “up” the chain. The power of communicable borders to facilitate circulation of knowledge and scientific objects and obstruct that of people strikingly parallels the reconfiguration of national borders as open to capital and goods and selectively closed to people (see Nivens 2002). Communicable inequalities operate microscopically, in shaping where people are placed within clinics in relationship to charts, computers, and diagnoses, and macroscopically, in shaping who gets to be a doctor, who gets to define health and disease, who receives access to health care, and, ultimately, who lives and dies (Hunt 1999; Vaughan 1991; Waitzkin 1983, 1991). Communicability operates through coercion (such as quarantines, medical examinations of immigrants, and prosecutions for fetal endangerment), policies and guidelines (immigration and welfare “reforms” and NIH funding guidelines, for example), and governmentality.

My argument is not that communicability constitutes a totalizing system that reaches everywhere and shapes all social relations and modes of thought and action. Spheres are multiple, standing in relations of complementarity and competition. Their penetration is never complete—they are rather “cut” (Strathern 1996) and constrained by limits, some of which they themselves impose by virtue of their own boundary work. Some social sectors lack the symbolic resources needed even to construct themselves as marginal. Ironically, while they regulate how scientific objects and events can be discovered and reported, spheres of communicability become dependent on those very objects and

events (Rabinow 1999). Epidemics and organ transplants, for example, offer opportunities for extending biocommunicability, but they render existing formations precarious and lead to their critical scrutiny and possible transformation. In another apparent contradiction, communicability is contingent on people’s willingness to interpellate themselves in suitable ways—lest would-be spheres become irrelevant or ridiculous. Nevertheless, the ability of individuals and communities to place themselves in communicable circuits, to draw on available technologies, to position themselves in favorable locations, and to resist oppressive spheres is shaped by and shapes access to capital, symbolic and material. In short, I have tried to present a new map of the relationship between culture and social structure, one that avoids simple homologies between cultural content and social relations or notions of overdetermination (assertions that a particular cultural form intrinsically belongs to a certain type of structure). I have tried to pinpoint the dynamic process that is established between discursive practices—including their ideological construction—and social relations, particularly social inequality.

Fighting back involves more than questions of content. I cite cases where poor people of color in Africa, Asia, the Caribbean, Latin America, and the United States talk back creatively and articulately to institutions (respectively, White 2000, Arnold 1993, Farmer 1992, 2003, Briggs & Mantini-Briggs 2003, and Epstein 1996); they expose assumptions and political practices that hold structural violence in place. Unless we transform ideological constructions of how knowledge is produced, circulated, and received, routes of circulation, and how people are positioned, we will be unlikely to promote effective alternative formulations or effectively support efforts by oppressed and marginalized popular to insert their voices into public debates. Farmer (2003, p. 17) argues that “human rights abuses are best understood (that is, most accurately and

comprehensively grasped) from the point of view of the poor.” If we, as researchers, project voices into public debates without attempting to change the communicable positionality of people who bear the brunt of health disparities, we run the risk of only reproducing our respective places in social hierarchies. Obtaining a seat at the communicable table is easier for people who possess symbolic and material capital, such as middle-class white U.S. gay men, than for working-class women or African Americans. The cost to social movements of mounting effective resistance can involve being drawn into dominant communicable spheres—a loss, as it were, of incommunicability (Epstein 1996, 2004).

One could think that these effects of power are limited just to questions of language and communication; perhaps we should direct our attention to the real action—germs, labs, and politics. This response replicates an important basis of modernity and modern inequalities. At the same time that autonomous spheres of nature and society were created in the seventeenth century (Latour 1993), a distinct sphere of language was invented (Bauman & Briggs 2003). Like the science/society divide, making language seem autonomous from political and natural realms involved work organized around practices of purification. Implicit hybrid links between language, nature, and society imbued this language ideology and speech forms characterized as embodying it with power. White elite European males become the unmarked embodiments of communicable power just as they became the unmarked subjects of modernity (Chakrabarty

2000, Pateman 1988). Hiding how new genomic sequences or medical diagnoses are embedded in and transform biocommunicability is a crucial part of making science and medicine seem disinterested, decontextualized, and independent of politics and social relations. This ideology has been used by linguists and other social scientists to reduce communicability to language and communication and to make it seem peripheral to social, cultural, political, and scientific issues. Blindness to communicability is just as rooted in political economy as communicability itself—in naturalizing these spheres, scholars protect their own (heterogeneous and shifting) positions of relative privilege within them.

If erasing communicability is crucial for maintaining its capacity to produce and naturalize inequalities, then demonstrating its operation in medical, legal, criminal, and other domains is necessary to challenge the production of categories and social hierarchies within them. To be sure, the political-cum-theoretical work required to transform spheres of communicability is no easier than that needed to intervene in medical, legal, educational, labor, or other domains. Confronting spheres of communicability involves much more than promoting new communicative practices—it involves radical changes in the distribution of capital and power just as much as efforts to challenge racism and health disparities. What I am suggesting, however, is that it is just as important. Indeed, it will be impossible to make significant headway in these seemingly separate spheres without also transforming spheres of communicability.

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Contents

Frontispiece
Sally Falk Moore xvi

Prefatory Chapter

Comparisons: Possible and Impossible
Sally Falk Moore 1

Archaeology

Archaeology, Ecological History, and Conservation
Frances M. Hayashida 43

Archaeology of the Body
Rosemary A. Joyce 139

Looting and the World's Archaeological Heritage: The Inadequate
Response
Neil Brodie and Colin Renfrew 343

Through Wary Eyes: Indigenous Perspectives on Archaeology
Joe Watkins 429

The Archaeology of Black Americans in Recent Times
Mark P. Leone, Cheryl Janifer LaRoche, and Jennifer J. Babiarz 575

Biological Anthropology

Early Modern Humans
Erik Trinkaus 207

Metabolic Adaptation in Indigenous Siberian Populations
William R. Leonard, J. Josh Snodgrass, and Mark V. Sorensen 451

The Ecologies of Human Immune Function
Thomas W. McDade 495

Linguistics and Communicative Practices

New Directions in Pidgin and Creole Studies <i>Marlyse Baptista</i>	33
Pierre Bourdieu and the Practices of Language <i>William F. Hanks</i>	67
Areal Linguistics and Mainland Southeast Asia <i>N. J. Enfield</i>	181
Communicability, Racial Discourse, and Disease <i>Charles L. Briggs</i>	269
Will Indigenous Languages Survive? <i>Michael Walsh</i>	293
Linguistic, Cultural, and Biological Diversity <i>Luisa Maffi</i>	599

International Anthropology and Regional Studies

Caste and Politics: Identity Over System <i>Dipankar Gupta</i>	409
Indigenous Movements in Australia <i>Francesca Merlan</i>	473
Indigenous Movements in Latin America, 1992–2004: Controversies, Ironies, New Directions <i>Jean E. Jackson and Kay B. Warren</i>	549

Sociocultural Anthropology

The Cultural Politics of Body Size <i>Helen Gremillion</i>	13
Too Much for Too Few: Problems of Indigenous Land Rights in Latin America <i>Anthony Stocks</i>	85
Intellectuals and Nationalism: Anthropological Engagements <i>Dominic Boyer and Claudio Lomnitz</i>	105
The Effect of Market Economies on the Well-Being of Indigenous Peoples and on Their Use of Renewable Natural Resources <i>Ricardo Godoy, Victoria Reyes-García, Elizabeth Byron, William R. Leonard, and Vincent Vadez</i>	121

An Excess of Description: Ethnography, Race, and Visual Technologies <i>Deborah Poole</i>	159
Race and Ethnicity in Public Health Research: Models to Explain Health Disparities <i>William W. Dressler, Kathryn S. Oths, and Clarence C. Gravlee</i>	231
Recent Ethnographic Research on North American Indigenous Peoples <i>Pauline Turner Strong</i>	253
The Anthropology of the Beginnings and Ends of Life <i>Sharon R. Kaufman and Lynn M. Morgan</i>	317
Immigrant Racialization and the New Savage Slot: Race, Migration, and Immigration in the New Europe <i>Paul A. Silverstein</i>	363
Autochthony: Local or Global? New Modes in the Struggle over Citizenship and Belonging in Africa and Europe <i>Bambi Ceuppens and Peter Geschiere</i>	385
Caste and Politics: Identity Over System <i>Dipankar Gupta</i>	409
The Evolution of Human Physical Attractiveness <i>Steven W. Gangestad and Glenn J. Scheyd</i>	523
Mapping Indigenous Lands <i>Mac Chapin, Zachary Lamb, and Bill Threlkeld</i>	619
Human Rights, Biomedical Science, and Infectious Diseases Among South American Indigenous Groups <i>A. Magdalena Hurtado, Carol A. Lambourne, Paul James, Kim Hill, Karen Cheman, and Keely Baca</i>	639
Interrogating Racism: Toward an Antiracist Anthropology <i>Leith Mullings</i>	667
Enhancement Technologies and the Body <i>Linda F. Hogle</i>	695
Social and Cultural Policies Toward Indigenous Peoples: Perspectives from Latin America <i>Guillermo de la Peña</i>	717
Surfacing the Body Interior <i>Janelle S. Taylor</i>	741

Theme 1: Race and Racism

Race and Ethnicity in Public Health Research: Models to Explain Health Disparities <i>William W. Dressler, Kathryn S. Oths, and Clarence C. Gravlee</i>	231
Communicability, Racial Discourse, and Disease <i>Charles L. Briggs</i>	269
Immigrant Racialization and the New Savage Slot: Race, Migration, and Immigration in the New Europe <i>Paul A. Silverstein</i>	363
The Archaeology of Black Americans in Recent Times <i>Mark P. Leone, Cheryl Janifer LaRoche, and Jennifer J. Babiarz</i>	575
Interrogating Racism: Toward an Antiracist Anthropology <i>Leith Mullings</i>	667

Theme 2: Indigenous Peoples

The Effect of Market Economies on the Well-Being of Indigenous Peoples and on Their Use of Renewable Natural Resources <i>Ricardo Godoy, Victoria Reyes-García, Elizabeth Byron, William R. Leonard, and Vincent Vadez</i>	121
Recent Ethnographic Research on North American Indigenous Peoples <i>Pauline Turner Strong</i>	253
Will Indigenous Languages Survive? <i>Michael Walsh</i>	293
Autochthony: Local or Global? New Modes in the Struggle over Citizenship and Belonging in Africa and Europe <i>Bambi Ceuppens and Peter Geschiere</i>	385
Through Wary Eyes: Indigenous Perspectives on Archaeology <i>Joe Watkins</i>	429
Metabolic Adaptation in Indigenous Siberian Populations <i>William R. Leonard, J. Josh Snodgrass, and Mark V. Sorensen</i>	451
Indigenous Movements in Australia <i>Francesca Merlan</i>	473
Indigenous Movements in Latin America, 1992–2004: Controversies, Ironies, New Directions <i>Jean E. Jackson and Kay B. Warren</i>	549

Linguistic, Cultural, and Biological Diversity <i>Luisa Maffi</i>	599
Human Rights, Biomedical Science, and Infectious Diseases Among South American Indigenous Groups <i>A. Magdalena Hurtado, Carol A. Lambourne, Paul James, Kim Hill, Karen Cheman, and Keely Baca</i>	639
Social and Cultural Policies Toward Indigenous Peoples: Perspectives from Latin America <i>Guillermo de la Peña</i>	717

Indexes

Subject Index	757
Cumulative Index of Contributing Authors, Volumes 26–34	771
Cumulative Index of Chapter Titles, Volumes 26–34	774

Errata

An online log of corrections to *Annual Review of Anthropology* chapters may be found at <http://anthro.annualreviews.org/errata.shtml>