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From the communication of information to the production of meaning as a strategy for promoting the right to health

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Abstract

Communication in health care has been discussed as a strategy that ultimately fails to promote patients' and users' right to health because it does not consider their prospects or disregards the socioeconomic circumstances in which they live, contributing to the occurrence of disease and suffering. Based on an anthropological approach, communication will be reconsidered here as a process of participatory production of the meaning of reality, promoting a reformulation of the experience of disease and allowing for the identification of the forms of social intervention capable of supporting such a reformulation. Introducing the concept of the right to meaning as a basis for the identification of other rights also promotes the concept of therapeutic efficacy. These concepts will be reconsidered in terms of transformation, not only in terms of possible transformations on the anatomo-physiological plane that can be performed by biomedical intervention techniques or changes in the relationships of meaning that care relationships focused on the right to meaning can promote but in terms of a transformation in the patients' social relationships.Keywords: Doctor-patient relationship, health communication, medical anthropology, therapeutic efficacy, inequality in health.

Introduction

Doctor-patient communication is one of the central themes for reflection that medical anthropology has identified in its analysis of social and cultural dimensions through either knowledge and therapeutic practices or the experience of disease.

The first anthropological studies that systematically challenged the approach to communication in the therapeutic relationship were produced in North America by Harvard scholars (Leon Eisenberg, Arthur Kleinman, Byron and Mary-Jo Good).

These scholars assumed that biomedicine should be investigated as a specific ethnomedicine that is culturally characterized by the exclusive consideration of the biophysical dimensions of a disease (EISENBERGE *et al.* , 1981; KLEINMAN, 1980, 1982; LOCK *et al*., 1988). The latter, however, cannot be reduced to a mere natural reality; specific cultural norms actually qualify a medical problem as a particular state of being. In this spirit, Kleinman and colleagues aimed to consider the same biomedical categories as cultural categories through which particular interpretations of diseases are constructed. Each disease was conceived as a symbolic reality

and medicine as a hermeneutic initiative (GOOD *et al*., 1981a; GOOD *et al*., 1981b; KLEINMAN, 1981).

This scenario provided the background for the proposed distinction between *disease* and *illness* (EISENBERG, 1977; KLEINMAN *et al*.,1978), with *disease* referring to changes in the body's function and/or structure and *illness* describing the experience of suffering for those who experience it personally. *Disease* and *illness* are therefore viewed as two different explanatory models; the first is rooted in the doctor's scientific language and the second in the patient's family and social context.

In this manner, the doctor/patient meeting was reconsidered as a performance in which two different and frequently conflicting cultural constructions of clinical reality are placed on the scene. According to the Harvard authors, these considerations are of the utmost importance because conflicts in medical communication represent the main cause of *noncompliance* and therapeutic ineffectiveness.

One example has been provided by Blumaghen's study (1980) on hypertension in North America, in which popular interpretative models showed that patients perceived the stress and tension that people experience in their lives *(illness)* as the nature of the problem, while doctors defined the problem in terms of blood pressure *(disease).* These different models led to *noncompliance* because once past the critical stages of their lives, patients no longer felt pressured and stopped taking medications prescribed to be taken regularly, given the chronic natures of their diseases.

The way in which the patient's perspective can hinder the formation of a doctor-patient alliance cannot be disregarded when considering the patient's adhesion to a therapeutic regimen. In fact, ignoring the significance of the patient's experience of illness means ignoring how patients interpret the recommendations that they receive during their medical appointments. Therefore, it has been proposed that the doctor-patient relationship include dedicated time to explore the patients' views of the nature of their disorders to avoid possible interpretive conflicts between physician and patient perspectives (KATON *et al.*, 1981; KLEINMAN, 1982).

Thus, improving the communication between doctors and patients means promoting the effectiveness of the therapeutic system and ensuring patient compliance to doctors' instructions, even regarding the medicolegal considerations that predict patients' involvement in developing their own therapeutic plans. The latter aspect has undergone a progressive reformulation from the model of informed consent to that of informed choice and then to the recent shared-choice approach (CHARLES *et al*., 1997; FELT *et al*. , 2009).

Ensuring patient adhesion to treatment recommendations while sharing legal liability are strategies that offer another aspect of multiple criticality. Is promoting biomedical effectiveness always a good thing—even when, for instance, configuring the medicalization of social phenomena? Is working on communication with patients sufficient to ensure their best interests, even when the factors affecting their health are linked to their socioeconomic conditions (TAUSSIG, 1980; YOUNG, 1982)?

It is clear that focusing on a single aspect of communication is not necessarily the best way to promote the patient's best interest; in fact, it can also produce problematic results.

There is no doubt that privileging a systematic exploration of the patient's perspective as the core of the therapeutic appointment appears to be a fundamental assumption guiding clinicians in their diagnostic and therapeutic work. However, it is also clear that such an exploration is not likely to occur unless the importance of the patient's perspective is recognized: not in terms of piety, charity or generic mutual respect but to ensure that the clinician's work can be accomplished properly.

Therefore, recognizing the patient's perspective with dignity implies the contextual recognition of the cultural nature of biomedical practices. Recognizing the cultural nature of the work itself means not delegitimizing it but becoming aware that a process of cultural selection implicitly operates at the core of clinical reasoning and threatens to overshadow dimensions that could be determinant in therapeutic diagnosis. But, which concept of culture is necessary?

Another communication of information: the right to meaning

An approach based on the analysis of explanatory models aspires to produce an anthropological mode of listening to patients' perspectives to help understand what could otherwise be hidden in biomedical criteria. If the goals of this approach remain valid and correct, the best way to pursue them is by gradually questioning them. One of the unintended consequences of the previous work on explanatory models was the creation of a distorted view of the concept of culture, which suggests that the authors (GOOD, 1994; KLEINMAN, 1995) were precisely the ones who overcame the initial approaches.

Furthermore—and not only in health—culture is frequently conceived as something that we "have" as members of a group, not something that we "make" (in the form of *cultural competence,* for instance: Kleinman *et al*., 2006). The idea of culture, which is understood as a system of socially shared symbols through which we interpret reality, has often generated the idea that patients' interpretations should be referred to a certain cultural model of reference. This expression, the cascade, has nurtured an essentialized view of cultural worlds. This perspective is unable to properly consider the multiple dimensions through which differences are rejected between and within cultural worlds, including, but not limited to, differences in gender, generation, socioeconomics, status, religion and sexual orientation. The highly procedural nature of cultural dynamics is placed in the shadow: in other words, culture is something that humans create and not merely conceptual baggage that we share as members of a group (MARCUS *et al*., 1986). This interpretation does not intend to place the historically deep collective dimensions of cultural dynamics in parentheses; rather, it indicates the need to <u>also</u> understand the dimensions through which cultural individuals creatively appropriate collective repertoires of knowledge and practices, emphasizing the inherently open nature and dynamics of cultural production (ORTNER, 2006).

These considerations assume an eminently practical role when we focus only on the experience of disease. Many studies have emphasized that characterizing the experience of disease to place themselves within a scenario of meaning is often difficult for the afflicted. This difficulty makes the work of those who collide with this absence of a perspective particularly frustrating, even when they are motivated by the best intentions (DE MARTINO, 1958; GARRO, 1992; GOOD, 1994).

Disease, in fact, is not only at the level of the organism; it is also in the body that we are, the body in the world. The idea that the body is exclusively a biopsychic organism to be operated on at a technical level resulted in the elimination of the body as the existential ground of itself and culture (CSORDAS, 1990). We are not merely bodies: the body is an active subject of experience, and preferably, it participates actively in the production of the meanings through which we interpret reality and qualify our own experiences (SCHEPER-HUGHES, 1994; SCHEPER-HUGHES *et al*., 1987).

An anthropological perspective considers man as biologically incomplete because information transmitted on a biogenetic level is not sufficient for guaranteeing our survival. It is only within a social group that welcomes us that we learn the conceptual tools and techniques that allow us to actively orient ourselves in the world. As Francesco Remotti (2011) noted, we are facing a second social birth, which is configured in terms of the process of human cultural achievement. In this sense, human nature should be understood as constitutively cultural. It is clear at this point that our dependence on specific processes of cultural construction, which view difference as an irreducible element of humanity, is universally human.

However, the way in which we experience the world is characterized as a profound elimination of the collective and historicocultural dimensions of human nature. This elimination is rooted in the very nature of the cultural processes by which human beings are molded. These processes occur informally through practical exposure to the social world from which we incorporate values and symbolic forms and through which our molding and thus our attitudes when confronting reality simultaneously develop. Thus, we can speak of an ontological complicity between subject and world because we interpret reality through the cultural processes of our molding. In other words, we relate to the world through the processes of our cultural molding.

The body is not a marginal "element" in the process of constructing reality and concealing our generative role. On the one hand, knowledge and social order are naturalized through their inscriptions in their bodies; when penetrating into lived experience, historicity and contingency retreat from the sphere of consciousness. It is through this process of incorporation that the social order takes on the appearance of naturalness and necessity, and the sociopolitical processes that support it are overshadowed by the immediacy of the lived experience. On the other hand, we perceive the world as a culturally informed body, perceptually interpreting it, even before making it an object of explicit linguistic and cognitive reflection. As suggested by the phenomenological perspective, we perceive the world with intention (we give it meaning) before we categorize it. Because this process is precategorical, pre-objective, preconceptual and precisely perceptual (but not precultural!), humans are artifacts of the cultural construction of reality without necessarily being aware of it (CSORDAS, 1990; KIRMAYER, 1992).

In itself, a crisis in the body produces a crisis in our own being in the world, weakening the bodily roots of meaning. It is clear that we cannot reduce the nature of cultural processes to a mere dimension of subjective experience; however, we should consider the experience in terms of the extent that it is lived in cultural processes. By weakening the experiential dimensions of meaning—its corporeal roots—disease produces a truly silent crisis; however, it is constitutive in the production of the meanings through which we experience reality as if it were endowed with a sense of autonomy. In this context, the experience of disease generates a process of dissolution of the experienced world, i.e., of the network of intersubjective

relationships that implicitly sustain our typical experience of/in the world (GOOD, 1994; SCHUTZ, 1973).

Although Ernesto De Martino (1995) teaches us that multiple human experiences are characterized during this process, through which our presence in the world may be called into crisis, if the characterization of the experience of disease is precisely a crisis of our role as cultural actors, it would hardly be possible to proceed with a mere extrapolation of the patient's perspective. Instead, the characterization of disease will be produced in a manner consistent with that view of culture: an intersubjective process of production of meaning through which we interpret reality and qualify our experiences.

If culture is an intersubjective process, the doctor-patient relationship must be reconsidered as a context in which actions are taken toward the co-construction of meaning, which emerges as a cultural practice. From this perspective, we can attempt to rethink the concept of the "patient's best interest". If disease weakens the assumptions on which our everyday existence rests and forces us to renegotiate new ones, it is clear that the process transcends the body and the individual, affecting the network of intersubjective relationships in which personal experience is procedurally defined. Therefore, the patient's best interest cannot be protected by his involvement in decision making through informed consent because it calls into question the intersubjective horizon of meanings, whose focus can define how much the patient's own wellbeing costs and identify an option inside an equally produced meaning.

Therefore, acting in the patient's best interest means engaging in the common process of co-construction of meanings of the experience of disease; this focus can lead to possible choices. This process is not accomplished through informed consent or by mechanically applying bioethical principles; rather, it must be built together with the patient. It means creating an alliance between health professionals, patients and family members to allow them to work together, according to their respective competences, to determine the best decision in light of the reconstruction of a failed meaning process.

Therefore, this process consists of performing an operational synthesis between the living body and the body objectified by medical science through the personal involvement of professional actors and the professionalization of the personal figures interacting with the patient. To this end, Sally Gadow (1980) discusses *existential advocacy,* i.e., the need for relational ethics in which health care workers, together with patients and the topics that are relevant to them, are involved in the process of reconstruction of a meaningful world to guarantee the patients' right to make choices that are appropriate to the value attributed to each situation.

Specifically, the narrative approaches in medical anthropology (GOOD, 1994; MATTINGLY, 1998; MATTINGLY *et al.*, 2000) have dual objectives: to facilitate the analysis of the processes of dissolution of the experienced world, leading to the understanding of what a particular grief experience means to those involved, and to promote patients' active participation in the production of meaning, through which meaning is given to an unprecedented form of experience of/in the world (GADOW, 1980; MOL, 2008).

If the explanatory models imply an approach aimed at examining the patients' conceptions of the nature of their pain, narrative approaches invite us to participate in the intersubjective process of constructing the meaning of an experience (produced from the same models). This operationally translates into a programmatic and systematic attempt to put the patient in the

position to explore his own "conceptions" and create his own perspective. Thus, the patient's perspective should not be taken as "anything" that should be regarded or respected at the beginning of a negotiation but as a product to be intersubjectively produced and a narrative of the process that will take place.

Because many doctors resist this approach—arguing that in addition to the risk of burnout, addressing the personal dimension of suffering results in a risky level of involvement that can weaken one's professional judgment—Sally Gadow shows through her research experiences that exactly the opposite is the case. The dual process of personalizing the professional and professionalizing the personal increases not only the patient's level of satisfaction but also the doctor's. In this case, the burnout experience would be produced less by personal involvement than by the discomfort experienced in response to the violence present in the abstraction of the disease as a mere pathology. In other words, if we open ourselves to personal dimensions without knowing how to value them in the therapeutic relationship, a deep dissatisfaction emerges regarding their elimination due to a reductionist and universalizing attitude. If, however, one is committed to promoting patient involvement in the process of meaning production in the patient's own disease history, the frustration of having to reduce the experience to mere organic processes vanishes, replaced by the deep satisfaction of having fully done one's job.

Thus, the narratives must be understood as a tool for promoting the patient's *action* in the production of meaning. This approach describes the experience of disease, accepting the inevitability of a diagnosis and making consistent choices regarding new requirements instead of becoming distressed. These studies have provided an opportunity to radically rethink the foundation of therapeutic efficacy in terms of the development of meanings capable of radicalizing a renewed presence in an unforeseen world (after all, the experience of transformation that is culturally defined as healing can never provide a return to the initial existential situation).

In the medical context, efficacy is generally defined in relation to the success of a particular therapeutic intervention, ignoring the fact that other factors contribute to its definition (PIZZA, 2005). In itself, diagnosis is a process of the production of meaning through the experience of disease and contributes to its effectiveness in both identifying the level at which to act therapeutically and defining the meaning of the lived experience of disease. This consideration leads to the awareness of how the dimension of meaning is central and fundamental and how it is involved with disease, even if the medical system expels it from its explicit ideology. Thus, the inability to give meaning to our own problematic experiences emerges as the very source of the crisis, weakening our own ability to act: in which direction to move, what to do, if we are not aware of the nature of the problem, if it has no meaning?

Clearly, the symbolic dimensions of effectiveness were not viewed as an alternative to biomedical effectiveness, given that in reality, they are always present, even in those areas that are culturally marked in technical terms. If these symbolic dimensions are always present and inform even the most reductionist biomedical practices, they become aware of the open workspace that was otherwise blocked. Voluntarily or involuntarily, medical action participates in the processes of symbolic production that narrative approaches seek to reconcile within conscious action, specifically focused on involving patients in the process of the production of meaning with an emphasis on decision making. This process means expanding the scope of the

term "therapeutic efficacy" to include both the possible transformations that therapeutic intervention techniques can produce at the anatomo-physiological level and the changes related to the relationships of meaning that are renegotiated following the process of dissolution of the certainties generated by the crisis of the body in the world.

According to the arguments made thus far, it is clear how the central issue of this study is linked to the relationship established between experience and the production of meaning, whose focus is less on the communication of information to produce a transformation of experience than on the very production of meaning. Another distinction, which is both theoretical and operative, can be perceived between narrative approaches and explanatory models. The latter may be an achievable product, but experience is qualified as the process of production of such products. Thus, patient participation is critical, favoring conditions that provide clarity for the patients regarding the core issues at stake in their own experiences of disease (again, one should recall that this is not necessarily present due to the practical and implicit nature of the cultural processes that we view as active subjects in experiential dimensions, as previously reported, not merely as linguistic and cognitive features).

At this level, medical anthropology can emerge as a strong dialogue partner in biomedicine. In the latter case, significant changes can be produced through intervention techniques on the plane of the biopsychic organism; anthropology should offer tools to promote the symbolic dimensions of self-transformation through which the terms of its own existence are renegotiated.

A possible objection that these arguments may indicate is that doctors' working hours hardly allow them to invest in their relationships with their patients to facilitate the process of experience development. Once again, we must reconfigure the terms of the subject. If we actually consider the therapeutic process as a whole, the research in the medical-anthropological field indicates the exact opposite. Investing fully in this relationship produces greater efficiency in the medical system. In other words, investing in favor of symbolic efficiency reduces the total time spent on the therapeutic process, configuring a virtuous synergy between efficacy and efficiency. Clearly, to achieve such synergy, an intervention is needed in favor of both the formation and reorganization of services, which is consistent with the possibility of the practical execution of these principles.

In short, acting in the patient's best interest and promoting his/her right to meaning coincides with promoting the physician's best interests, ultimately increasing the efficiency of the health care system.

Focusing on these considerations causes a radical reconsideration of the topic of communication in the doctor-patient relationship. Ensuring that the patient adheres to the doctor's recommendations is no longer the issue; the primary commitment shifts to ensuring that the patient can produce a perspective.

Right to meaning and cultural differences

If the right to meaning emerges as a key dimension in the doctor-patient relationship, it plays a key role, even when compared to other types of therapeutic knowledge. In fact, reductionism produces both the elimination of the patient's perspective and the risk of delegitimizing different views of clinical reality. This theme emerges as a central topic in operational terms

when the production of meaning for the experience of disease should be promoted with foreign patients who invoke horizons of meaning that are culturally distant from our typical symbolic references.

To characterize the therapeutic relationship with foreign patients, it is necessary to explicitly reflect on the dynamics that are always present but that occur unconsciously when dealing with patients who exhibit a strong implicit involvement with the silent assumptions that are founded on our way of being in the world.

Therefore, it is necessary to explicitly reflect on the symbolic dimensions that are always present in the doctor-patient relationship to qualify doctors' meetings with foreign patients. The risk is that the strong scientific ideology of biomedicine can lead professionals to translate cultural differences as errors, leading to a weakening of the intersubjective dynamics of co-construction of the meaning of experience, as previously discussed. Again, a series of dichotomies implicitly shape our practical attitudes toward we/others, science/belief and truth/error.

Health services often ask for anthropologists' advice regarding the challenges that they encounter with foreign patients whose interpretations and behaviors are difficult to relate to the clinical rationality of biomedical knowledge. The same applies to contexts of cooperation in health. The attitudes observed in these two areas are frequently similar. Cultural difference is considered an obstacle to achieving therapeutic efficacy, as it occupies a foremost position in communications aimed at promoting the compliance of foreign patients or the cooperation of populations interested in health interventions with the recommendations of biomedical professionals. For the doctor-patient relationship, communication is always conceived as a one-way process aimed at configuring users in terms consistent with the premises of the intervention agents.

At this point, the possibility of recognizing the right to meaning cannot go beyond the prior autoreflexive recognition of the also-cultural nature of our medical methods; once again, the intention is not to discredit these methods but to recognize their cultural selectivity. Only then will it be possible to seriously question the meaning conveyed by therapeutic speech and culturally different experiences of suffering.

Let us consider the case of Janice, a 17-year-old Nigerian girl who illegally immigrated to Italy. She was violently thrust into prostitution but managed to escape and report her Italian partner and tormentor. Social services provided safe housing and placed her in a protection program, but her companions soon forced her to leave the family home where she lived: she was possessed by a spirit called *Mami Wata.* When she was seen at the Center for Mental Health, her experience was diagnosed as a form of psychosis.

When we mechanically adopt medical categories, we project specific images of the person, reality and knowledge that will not necessarily help us understand the value and meaning of that patient's experience of suffering. The spirit of *Mami Wata* is often depicted as having the appearance of a mermaid, but it incorporates elements of both genders. It has pale skin adorned with jewels and symbols of abundance, wealth and prosperity. Those who wish to obtain personal fulfillment and economic success can establish a pact with the spirit, which will, in turn, demand fidelity and a share of the success achieved through its mediation. The fact that Janice was possessed by this particular spirit at the very moment at which she left

prostitution is highly significant. When the spirit was no longer profiting, it disturbed her because their pact had been violated. The girl had the chance to go to Europe, an icon of success and personal achievement, but the spirit no longer participated in the profits of her presence in the West (because Janice stopped working). Her entire migratory route was put at risk through the failure of this significant project and her confrontations with extreme difficulties.

At this moment, the spirit appeared as a constructed practical interpretation, a body technique through which Janice critically positioned herself against the social processes in which she was caught (QUARENTA, 2008). The body emerged as an active subject, translating the uneasy relationship between subject and world through her cultural molding processes. From this perspective, possession will not be understood through the language of psychopathology, and even therapeutic action will not produce an appropriate transformation of the experience.

In this case, the narrative approach is precisely designed to engage the patient in the process of exploring his/her own ideas. This process is configured in terms of the intersubjective process of intercultural construction of the meaning of the patient's experience, whose focus should be reformulated for both diagnosis and therapy. Without the primary objective of explaining the patient's perspective, what else could be said but that she was possessed by a spirit? Instead, focusing on her participation in an intercultural process of dialogue-based exploration of her experience can reveal a key that may otherwise never have access to the sphere of language and thus explicit reflection, lingering only in the folds of the lived dimensions of the experience of suffering.

We now turn to a different context that highlights the way in which communication fails to achieve its objective in the context of health cooperation. During my research experience in Northwest Cameroon, AIDS (acquired immunodeficiency syndrome) was interpreted by many as a form of State witchcraft (QUARENTA, 2003, 2004, 2006, 2010). National and international agencies were busy in the years before the advent of antiretroviral drugs; therefore, the World Health Organization's (WHO) Global Program on AIDS delegitimized these interpretations as being related to traditional local beliefs that replaced the correct interpretation of the phenomenon in biomedical terms. Because a treatment option was not yet available at the time, the only way that the WHO had identified to fight the epidemic was prevention through information campaigns. Once again, the cultural assumptions typical of biomedical reductionism are found at the core of these initiatives. The programs' goal was to provide accurate information on the nature and transmission of HIV (human immunodeficiency virus) to generate changes in sexual behavior. This strategy was clearly based on a rational model of human action, which favors the individual level. Behavior is no more than the calculation of cost/benefits, which, when the correct information is provided, leads the interested parties to act appropriately.

These initiatives have created a perception of local culture as a risk factor. However, they have also favored the specific effort to change individuals' sexual behaviors without considering the decisive socioeconomic and political forces, both local and global, that provide the context for and limit individuals' abilities to take action.

On a deeper analysis, however, the perception of AIDS as a form of witchcraft can be understood as an interpretation that identifies economic inequality as a cause of the

epidemic. The form of witchcraft discourse presented as responsible for the AIDS epidemic is grounded on local conceptions, according to which power is often obtained through illicit means: in a context characterized by limited assets, the accumulation of wealth and success by some is viewed to take place at the expense of others. In this sense, local forms of witchcraft discourse appear as interpretative practices through which blame is placed on social inequality and power differences. Several authors have highlighted how new conceptions of witchcraft integrate the mysteries of the market economy into their representations to explain the growing inequalities produced by this economy. It is in this sense that modernity and witchcraft appear to be closely linked in Cameroon and other places in Africa (COMAROFF, 1993; GESCHIERE, 1997; QUARANTA, 2006).

Although cultural assumptions are recorded in international and local prevention protocols, the interpretation of AIDS as witchcraft does not appear as a form of denial or lack of understanding. On the contrary, it is a culturally connoted language that indicates the institutional and political processes that are considered responsible for the inequalities and expose those less privileged to the risk of AIDS and, ultimately, death.

Thus, it is clear that communication will never be able to understand local needs unless it adopts this autoreflexive strategy. Knowing how to place medical categories into an anthropological perspective, then, emerges as the first step to recognize the right to meaning and initiate a dialogue-based relationship in which difference is not a denial of the truth but a source of knowledge to be investigated to better understand what is being said when AIDS is referred to as a form of witchcraft. Only then will we be able to understand what we cannot implicitly share at the experiential level, observing how local perceptions are sensible and consistent with perspectives that specifically identify the social determinants of health and the main mechanisms of the diffusion of HIV transmission in sub-Saharan Africa (QUARENTA, 2006).

Once again, the narratives of disease can be a useful tool for understanding the meaning scenarios in which experience becomes significant, i.e., to understand how social experience is culturally designed in the implicit urgency of experience. Therefore, the goal is to place the patient in the condition of situating him/herself in a network of meanings and being capable of creating a report. This report is always partial, revisable and procedural, but it has the advantage of translating the urgency experienced in terms of discursive communication that can be manipulated in the relationship.

To understand what is at stake in the experience of disease of patients whose symbolic references (implicit and explicit) are different from ours, we must explore the cultural means by which experience is qualified. In doing so, we can hardly rely on typical cultural patterns (Moroccans believe this, Nigerians think that, Italians...?); instead, we open ourselves to an intersubjective exploration from which meaning scenarios emerge as qualifiers.

In short, one must assume that cultural differences should not be understood solely as different ways of interpreting reality but as different ways of experiencing reality. Once again, communications understood as the transmission of information will not promote changes in patient behavior or experience but will encourage more active participation in the process of production of meaning. However, this participation will not necessarily be enough to meet the patient’s health needs, as we will discuss below.

Beyond the right to meaning: disease as a social process

The two cases described above—the possession by *Mami Wata* and the witchcraft interpretation of AIDS in Cameroon—clearly demonstrate how through its reductionism, biomedicine results in the elimination of the socioeconomic dimensions of disease, whose focus on merely promoting the right to meaning is insufficient. The Global Program on AIDS failed both because it tended to differentiate the social processes of the disease and its transmission (depoliticizing them) and because it overshadowed the dynamics (both individual and collective; cultural and economic; social and political) that produce contexts of risk. By attributing the misconceptions of social actors to the latter (to be modified through the communication of biomedical information), the program produced a view of the local culture itself as a risk factor lacking the decisive local and global political and socioeconomic forces that provide the context for individual action.

As emphasized in the consolidated anthropological literature, in reality, the use of gender-economic exchange models is not understood as a product of local traditional beliefs but as the result of limiting the subject's ability to act (FARMER *et al*., 1996). Accordingly, AIDS is often attributed to the individual incorporation, at the biological level, of structural violence or the form of violence produced by forms of social organization characterized by deep inequalities. This silent violence enters the lives of those who occupy the most marginalized segments of such social organizations and manifests in very different results, such as infectious diseases, malnutrition, high mortality rates and low life expectancies at birth. If structural violence penetrates the flesh, limiting the subjects' ability of action, then it is by improving the latter ability—rather than by changing behaviors—that one can act to contain the spread of the epidemic. In fact, socioeconomic inequalities produce suffering by both limiting access to services and contributing to the occurrence and distribution of diseases. At this point, we can describe real *pathologies of power* (FARMER, 2003), from which biomedicine reaps the individual traits and outcomes that were integrated through its reductionist speech without focusing on the process that constitutes the broader reality.

In other words, understanding that speaking of AIDS in terms of a form of witchcraft means indicating inequalities is not adequate if we do not act accordingly to promote socioeconomic rights. Even in Janice's case, merely understanding that the experience of possession represents a cultural practice through which criticism is created and incorporated into her own life circumstances does not produce a transformation of experience if one does not simultaneously act to promote an individual's ability to renegotiate the terms of their own social existence. Clearly, reconsidering communication in terms of its participation in the production of the meaning of reality is not enough if we do not act on the social circumstances in which individuals live and act.

The difficulty that foreign patients often experience in following treatment recommendations does not actually depend on their cultural conceptions. Instead, it depends on dynamics that can be attributed to the precariousness of their social existence, the economic and legal difficulties of their life circumstances and ultimately the acceptance of the ways that we have frequently excluded them at the social and normative levels (MARTINO, 2012).

Placing a committed intercultural perspective ahead of the promotion of the production of meaning in the patients' experience of disease can foreground relevant dynamics requiring

forms of action and the activation of services that could not be predicted by focusing exclusively on the anatomical and physiological dimensions of experience.

Once again, we can invoke the concept of efficacy. In Janice's case, the re-initiation of her migration route through her job placement satisfied the spirit that bothered her. In the case of AIDS in many sub-Saharan African contexts, forms of *empowerment* aimed at promoting socioeconomic rights—such as microcredit for women's organizations—have provided individuals with an increased ability to negotiate the terms of their sexual relationships and, more generally, their own social relationships, significantly affecting the fight against the spread of contamination (SCHOEPF, 1991, 2001).

Conclusion

If recognizing the right to meaning is not sufficient, the opposite is also true. If our actions are motivated by our confidence in our knowledge of others' best interests (i.e., patients, foreigners or nonforeigners and communities interested in cooperation in health) and are convinced of the universal validity of our cultural categories, we risk promoting useless or even violent actions.

The topic of communication should be reconsidered in terms of promoting the right to meaning by involving patients in the production of meanings from their own experiences, providing a foundation for understanding which initiatives should be taken to implement the transformation of experience.

If disease emerges as a complex social process of which biomedicine captures individual dimensions, the effectiveness of biomedical interventions on the final result may be limited or affected by the absence of an appropriate action to promote the transformation of experience.

Therefore, the concept of effectiveness cannot be reconsidered solely in terms of changes on the anatomo-physiological plane that can be achieved through biomedical interventions or only in terms of the transformations in relationships of meaning that can be promoted in relationships of care focused on the right to meaning. It must also be considered in terms of the transformation of the patients' social relationships.

In other words, working on the product without questioning the process that put it into practice means that even the most efficiently conducted intervention will not necessarily be effective.

Rethinking the subject of doctor-patient communication as an opportunity for the co-construction of the meaning of clinical reality may then arise as grounds for a more efficient determination of the necessary resources to promote the right to health, not only by meeting the patient's and physician's best interests but also by strengthening the entire therapeutic process.

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