



Connecting the Micro and Macro Approaches: Cultural Stakes in Health Communication

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Prior to the establishment of Health Communication as an independent field of study, the socio-cultural dimensions of health and illness (patient/health aide relationship, social representations in health, etc.) were largely covered by sociology and anthropology. (Adam, and Herzlich 1994) Jodelet: "These pioneering disciplines have not failed to integrate a perspective of the individual in their approach, while establishing him in his social and cultural enrolment horizon, or in the framework of his relationship with medical institutions and professionals." (2006:1; our translation) However, the recognition of culture in the medical field has already been formulated in 1986 during the Congress of the World Health Organization in Ottawa, Canada. A new health system trend was then defined: the promotion of health that would offer, in addition to clinical and curative services, the recognition and respect of cultural needs. Nonetheless, Jodelet (2006) puts forth the statement that psychology of health was blinded by the game of collective dimensions that intervenes in the individual and public managing of health and illness. Within these dimensions, Jodelet considers culture being almost nonexistent, despite it being a central part of several works in sociology, history, and anthropology, which were concerned with illness and health.

In reading Jodelet's (2006) arguments, it seemed necessary for us to expand upon the theme of culture in the emerging field of Health Communication, particularly by arguing for the development of a multidisciplinary perspective conciliating the micro and macro approaches. In fact, culture is both what makes individuals react and what is generated throughout interactions. (Latour 2005; Sahlin 2000) Consequently, you often see researchers pulling in opposite directions (micro/macro or local/global), directions that seem to be irreconcilable, but ones that we deem important to reconcile. We, therefore, set forth to answer the following question in this article: How can we manage the reconciliation between macro and micro approaches, and thus fully integrate the cultural dimension into a better understanding of the phenomena studied in Health Communication, both at the interpersonal level (patient-physician encounter) and in the larger context of social interaction? In order to do this, we rely on empirical and theoretical contributions, included in the micro and macro approaches. Hence, through the arguments developed in this text, we hope to draw attention to the issues raised by the cultural dimension within the approach of studied phenomena in Health communication.

Anthropology has already recognized the difficulty of conceiving cultures as "separate master systems of signifiers, when it is historically evident that cultures have always borrowed from each other, when our ethnographic evidence demonstrates constantly how boundary-making is continuously challenged and upset in the ongoing interaction between cultures." (Wolf 1996:37-38) An "anthropology of globalization finds its relevance insofar as it understands, from the inside, "this dialectic [between the local and the global] within delimited fields, where preoccupations of the immediate and the everyday are expressed with a perception of a global belonging." (Abélès 2008:8-9; our translation)

The field of medical anthropology has shed light on the significance of culture in a wide variety of clinical settings and health related situations. Bibeau (1997) has proposed to integrate concepts such as cultural complexity and creolization in psychiatry in order to deal with conditions tied to migration experiences. Alvarez, Fortin and Bibeau (2008) have described the process of integrating anthropological perspectives related to intercultural diversity in pediatric clinics in Argentina and Québec. Lock and Crowley-Makota (2008) have studied how culturally informed expectations are at work in Japan, Mexico and the USA when it comes to organ donation and transplantation. In a broader sense, Almeida Filho (2001) set the basis of an ambitious general theory of health connecting the socio-anthropological and the epistemological dimensions of health sciences.

Nevertheless, our interest lies neither in the micro nor in the macro (otherwise the local or the global) *per se*, but rather in their connectedness (Latour 2005). Following a multidisciplinary approach, we build upon a new set of theoretical works and empirical studies that contribute to describing and explaining the connections between the local and the global in different health care related situations and organizational settings. For example, McMurray and Smith (2001) took a macro approach to make a comprehensive account of the impact of globalization on the so-called socioeconomic and health transitions in developing countries. More recently, Callahan and Wasunna (2006) have developed a critical view concerning the tensions between the notions of choice and equity in the context of increasing market driven policies shaping the practice of medicine.

The emerging field of the anthropology of the globalization of health care explores the connection between the micro and the macro (or the local and the global), with particular focus on the role of the transnational pharmaceutical industry as a macro-actor embedded in much localized practices. For instance, Lakoff (2005) has brilliantly analyzed the emergence of what he calls the “pharmaceutical reason” as a determinant influencing the practice of global psychiatry. In the same line, Healy (2006) and Applbaum (2006) have contributed to a better understanding of diagnostic and prescription drug patterns that define mental illness under the pervasive influence of promotional actions pushed by bio-medical industries. On her part, Petryna (2006) has presented a detailed account of the “rising of the global subject” as a direct result of the worldwide expansion of pharmaceutical clinical research.

Against such a backdrop, this paper starts by exploring the role of culture in patient-doctor communication, the primary interaction unit in the context of the medical act. Then, we propose an analytical framework to explain the emergence of the global health sphere, a complex and disjunctive environment that is influencing discourses, perceptions and practices in the health care field. The case of diabetes will serve to illustrate the dynamics of the global health sphere. Finally, we advance the first elements of a theoretical framework that, while acknowledging the role of culture in the interactions between individuals in health care situations, takes into account the macro level shaped nowadays by the disruptive forces of globalization.

The Role of Culture in Patient-Doctor Communication

Patient-doctor interaction constitutes a central and critical component of medical care. Interpersonal communication processes are inherent in this interaction since “the accuracy of a diagnosis, the understanding of a health problem, the likelihood of compliance with treatment regimens, and the probability of recovery are all influenced by the personal interaction between the provider and the patient.” (Thompson 2003:93) Evidently, interactional engagement between the patient and the doctor is highly complex as this interaction is influenced by numerous multi-faceted variables. Culture has been recognized as one such key variable of the communicative process that is of direct relevance to provider-patient interaction. (Ahmed 2007; Ahmed, and Bates 2007; Cioffi 2003; Jotkowitz, Glick, and Gesundheit 2006; Kokanovic, and Manderson 2007; Meeuwesen *et al.* 2007; Okamoto 2007; Perloff *et al.* 2006; Surbone 2006; Towle, Godolphin, and Alexander 2006)

Why is Culture Important in Patient-Doctor Communication?

Culture is a pervasive and permeating attribute of human living. It refers to a pattern of values, beliefs, ideas, and symbols that are shared by a group of people. (Gudykunst, Ting-Toomey, and Chua 1988; Samovar, and Porter 1991) Such integrated patterns of human behavior provide people with frameworks within which to define their identities and make sense of their experiences. As Helman (2000:2) argues: “Culture is a set of guidelines (both explicit and implicit) that individuals inherit as members of a particular society, and that tell them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or gods, and to the natural environment.” The growing literature on health

communication and culture sheds light on how culture shapes people's experiences, perceptions, constructions, and understanding of health issues. (Betancourt 2003; Betancourt *et al.* 2005; Bigby 2003; Cioffi 2003; Geist-Martin, Ray, and Sharf 2003; Hayes-Bautista 2003; Helman 2000; Huff, and Kline 1999; Kreps, and Kunimoto 1994; Sharf, and Kahler 1996; Skelton, Kai, and Loudon 2001; Lupton 1994)

Although culture plays an important role in how people communicate about health, considering culture as homogeneous and static is problematic and can lead to misunderstandings resulting in cultural generalizations and stereotyping. Accordingly, anthropologists underline that "culture is not a single variable but rather comprises multiple variables, affecting all aspects of experiences." (Kleinman, and Benson 2006:1673-1674) Recognizing the fluid, overlapping, and interactive nature of culture, Helman (2000:4) cautioned that culture should not be considered in isolation from "its particular context" that "is made up of historical, economic, social, political, and geographical elements." Culture, in this paper, is regarded not just as a local process, but as a global process as well. More specifically, while we view culture as "inseparable from economic, political, religious, psychological, and biological conditions," we also recognize that "cultural processes frequently differ within the same ethnic or social group because of differences in age cohort, gender, political association, class religion, ethnicity, and even personality." (Kleinman, and Benson 2006:1674)¹ This comprehensive understanding of the concept of culture is particularly important to reconcile the local and the global. As Luckmann and Nobles note: "Culture has a powerful impact on individuals, groups, and entire societies, influencing all aspects of human life. Cultures and subcultures provide strategies and methods for coping with life's ever-changing challenges and demands." (2000:23) With these considerations in mind, the paper probes into intersections and/or disjunctions between local and global processes in the context of health communication.

Research indicates that the dyadic communicative process operates differently when the patient and the doctor are from different cultures. Such differences are especially evident in today's multicultural clinical contexts where a health care system has to deal with numerous regional, ethnic, racial, socioeconomic, occupational, generational, and health-status values. For instance, in a study of the communication process between a group of Xhosa-speaking patients and their western medical practitioners in South Africa, Hersleman (1996) identified barriers to effective communication. These barriers to effective patient-doctor communication were identified as sociocultural differences between patient and doctor (class, status, roles, perceptions of health and illness), language difficulty, defensiveness among patients (patients' discomfort in the clinical setting), psychosocial factors (politeness and submissiveness of Xhosa-speaking people), and patient-doctor relationship (discernible racial and associated political differences between patients and doctors). Hence, doctors need to act in the best interest of patients and research increasingly suggests that such care should be culturally appropriate. Galanti (2004) used case studies to illustrate many levels of cultural differences between patients and doctors on issues as varied as nutrition, religion, family support, and response to pain. To avoid conflict and misunderstanding between patients and doctors, Galanti argued for understanding and adjusting to patients' cultural needs by gaining knowledge of their cultural values, family structure, healthcare beliefs and practices, religious beliefs, diet, language and communication processes, and

¹ See also Jackson and Duffy (1998).

psychosocial interactions.

Various cultural issues facilitate or impede positive relationships between patients and doctors. As argued by Prideaux (2001:186), "an individual's cultural identity affects interactions with the health system and influences health status". In the case of patient-doctor relationships, "differences in education, specialized language use, social characteristics, and power make most doctor-patient interactions similar to intercultural exchanges." (Jackson, and Duffy 1998:xii) Patients may respond differently to illness and treatment issues depending on their background and associated cultural beliefs, values, and practices. For instance, in a study of physician interaction with Australian immigrants with type 2 diabetes (Kokanovic, and Manderson 2007:462), patients described their relationships with doctors as hierarchical which "involved seeking approval and avoiding reproach from their doctors for their successes and failures in diabetes management." Kokanovic and Manderson concluded that the relational and communicative aspects of patient-doctor relationships influence patient responses to diabetes management. Being aware of their own cultural values, doctors should be prepared to deliver health care services that respect and value the cultural identities of patients. Considerable research identified racial and ethnic differences between patients and doctors contributing to health disparities. (Cooper 2004; Cooper-Patrick *et al.* 1999; Cooper *et al.* 2003; IOM 2002; Kaplan *et al.* 1995; Lee *et al.* 1997; Saha *et al.* 1999; Whittle *et al.* 1993); and effective patient-doctor communication as central to quality health care. (Gazda, Childers, and Walters 1982; Meadows 1991; Ruben 1992; Thompson 1996; van Ryan, and Burke 2000)

What can we Learn from Studying Patient-Doctor Communication?

From the onset of research in health communication, patient-doctor communication was a key area of study and it still remains so. (Thompson 2003) In their study of publication trends in health communication, Beck, Benitez, Edwards, Olson, Pai, and Torres (2004:484) found that physician-patient interaction "emerged as the third ranked topic in the health communication articles." According to Thompson (2003), it is important to have a foundational understanding of patient-doctor communication to better understand health communication processes. Although studies have examined patient-doctor communication in relation to culture, it is also important to study various health-related interactions that occur within particular contexts. (Street 2003) Individual health practices are determined in large part by their cultural backgrounds and contexts. These cultural contexts both at the interpersonal level (patient-physician encounter) and in the larger context of social interaction also shape group and organizational dynamics. What happens, however, to health communication when people misconstrue and misconceive cultural likeness and difference and when the cultural dimension goes unexamined? Ann Fadiman's book, *The Spirit Catches You and You Fall Down* (1997), provides a tragic answer to this question. It provides "an in-depth account of the experience of Laotian immigrants seeking health care for their child within the American medical system." (Street 2003:78)

Differences in cultural values and beliefs between the health care provider and the receiver account for many misunderstandings in health interactions

(Cline, and McKenzie 1998). When such differences are not accommodated, poor health outcomes arise. For instance, Fadiman (1997) described the culture clash between the Merced Community Medical Center in California and a refugee family from Laos over the care of Lia Lee, a Hmong child diagnosed with epilepsy. Fadiman explained how the fundamentally different notions of disease that divided the Hmong sense of health and disease from the views of American scientific medicine eventually cost Lia Lee her life. Although Lia's health was in the best interest of both her parents and her doctors, miscommunication between the two cultures led to a tragedy and brings to attention the issues of medical ethics and cultural differences. Through this story, Fadiman exposed the problems, realities, and gaps of language, religion, and social customs in a medical setting. The author argued that health care providers can adapt to improve their ability to care for patients whose background is different from their own. The book underscored the value of time and commitment required to understand another culture's perspective on health and illness and to integrate that understanding into the day-to-day practice of medicine.

The inability to communicate across infinite difference resulted in enduring frustration by physicians and non-compliance by Lia's parents. Lia's case demonstrates the fundamental clash of Hmong cultural beliefs with medical science, which was compounded by confusion and conflict. The miscommunication and reciprocal frustration led to misdiagnosis, mistreatment, and, eventually, the brain-death of Lia. This tragedy occurred despite the well-intended efforts of Lia's doctors and the extraordinary love of her parents because of a rift between opposing cultures that arguably, could have been negotiated. Lia's ailing body became the stage for miscommunication: at the interpersonal level (between Lia's parents and her doctors and consequently between the Hmong culture and the traditions of American medicine) and in the larger context of social interaction (among the Hmong community, Lia's family and friends, and the medical community, Lia's physicians, other medical staff, and social workers, in Merced, California). Lack of understanding of the cultural dimension especially the global processes of cultural production resulted in poor patient-doctor interaction, health care delivery, and health outcomes.

How can we make sure that Lia Lee's story does not happen again? Although there is research (Chong 2002; Waxler-Morrison Anderson, and Richardson 1990) on dealing with patients from specific cultural groups, currently there is no systematic effort to provide a coherent understanding of the local and global processes of cultural production in the context of health communication. Culturally effective health communication demands that the optimal contexts be identified. For example, Ahmed (2007) investigated the function of cultural differences on patient-doctor interactions and the likely impact on evaluations of the quality of health care in Appalachian Ohio, a medically underserved region in the Southern part of Ohio, as a cultural context. Based on quantitative survey methods, a number of important findings emerged regarding patients' perceptions of doctors' accommodativeness in shaping culturally competent health care which is a dynamic and complex interrelated process of recognizing individual differences as well as differences across cultures.

Particularly relevant to our discussion is a research question posed by Ahmed to examine the extent to which cultural differences play a role in health care interactions in Appalachian Ohio and to assess patients' perception of doctors' cultural competence in health care interactions. To answer this research

question, Ahmed conducted a 3-phase sequential investigation to test a set of hypotheses that stemmed from the research question. In the first phase, scenarios were developed and tested displaying cultural difference or sameness between the patient and the doctor and the doctor's cultural competence or incompetence in health care interactions based on the evidence documented in the literature. These scenarios were pre-tested using a convenience sample of undergraduate students (n= 175) who found the scenarios to be readable and believable and recognized cultural similarities and/or differences with the patients and doctors in those scenarios.

In the second phase, Ahmed used the validated scenarios along with a survey questionnaire, which resulted in the development of a three-factor scale to measure public perception of doctors' cultural competence. In this phase, the role of cultural differences between patient and doctor in the scenarios was examined by measuring respondents' (n= 201) explicit and implicit assumptions regarding doctors' culturally competent or incompetent behaviors. Exploratory factor analysis results revealed that the public perceived doctors to be culturally competent when doctors were aware of patients' cultural differences (nationality, racial background) and when doctors understood the dynamics of cross-cultural differences (spiritual beliefs related to health issues, food and dietary habits, preference of personal title in being addressed). These findings of Ahmed's study add to a growing literature supporting the notion that lack of knowledge regarding culture specific beliefs and customs (e.g. traditional healing, food prohibition, religious beliefs) can impede effective patient-doctor communication. (Sheridan 2006; Spector 2004)

During the third phase, Ahmed examined the role of cultural differences in patient- doctor interactions in an Appalachian Ohio context by refining and further validating the public perception of physicians' cultural competence scale developed during the second phase along with previously validated measures of relevant constructs (i.e., ethnocentrism, fear of physicians, and health professionals' communication accommodation theory goals and strategies). The patient base in Holzer Clinic in Athens, Jackson, and Gallipolis were surveyed (n= 306). Exploratory factor analysis results revealed that participants perceived doctors to be culturally competent when doctors were conscious of macro-cultural issues (e.g., religious practices related to health issues, decision maker in family). This finding of Ahmed's study is consistent with Rao's (2002) study that found physicians in collectivist cultures of Argentina, Brazil, and India often choosing to share health care information with a family member who makes decisions for the patient. Results of the hypothesis in phase three of Ahmed's study – intercorrelations among perceptions of cultural competence, communicative accommodation strategies, ethnocentricity, fear of physicians, and patient satisfaction with the direct clinical encounter – revealed that participants perceived doctors to be culturally competent when the doctors were perceptive of the dynamics of cultural differences related to proxemics and chronemics (e.g., touch issues during the physical exam, time concerns with regard to medical treatment). This finding resonated with the guidelines for using time, touch, and space appropriately when providing health care to different cultural groups. (Lipson, and Dibble 2005) Results of this hypothesis also revealed that participants perceived doctors to be culturally competent when the physicians recognized patients' cultural differences related to language issues (e.g., language skills, translator availability). This finding is consistent with studies that described health care interventions as culturally competent when they included linguistic services, such as bilingual interpreters among other elements of cultural

competence. (Brown *et al.* 2002; Brant, Fallsdown, and Iverson 1999; Yancey *et al.* 1995)

At a general level, the findings of Ahmed's study suggest that cultural differences play an important role in patient-doctor interactions. The findings also provide important insights into the role that cultural differences play in patient-doctor interactions in a specific cultural context, Appalachian Ohio.

The last decade has witnessed a shift towards a relational approach to patient-doctor communication. (Duggan 2006) Considering patient-doctor interaction as relationship-centered (Brown, Stewart, and Ryan 2003; Roter 2000) underscores the importance of both patient and doctor communication behavior within the medical encounter. We argue that, within this highly complex patient-doctor interaction matrix, mutual engagement in communication during the medical encounter may lead to a more satisfactory outcome of the consultation and improve engagement with health services. We also argue that while it is important to be aware of cultural differences and develop cultural knowledge, reconciliation between macro and micro approaches, and thus fully integrating the cultural dimension into a better understanding of health communication is equally important.

Culture and Health Communication in the Global Context

The Emergence of New Mediation Instances

Health communication situations, including the interpersonal exchanges between patient and doctor, should be also studied in a larger context. Street (2003:64) proposes to approach communication in medical encounters from an **ecological perspective**. Street's ecological model is an attempt to explain how doctor-patient communication can be affected by "interpersonal, organizational, media, political-legal, and cultural environments." Another perspective assumes that these processes, both from a micro and macro level, are affected by multicultural contexts where "people from distinctly different cultures live, come into contact, and interact with one another to form a new way of life, both dynamic and different from each of its parts or cultures." (Kar, Alcalay, and Alex, 2001:ix) The multicultural approach of health communication acknowledges that "behavioral risk factors are deeply rooted in culture, and access to health care is strongly affected by the compatibility between the cultures of the provider and users of health care." (Kar, Alcalay, and Alex 2001:79) Following the paths of both the ecological model and the multicultural approach, we propose to develop a comprehensive framework to explain how people's perceptions, interactions and consumption related to health and illness are influenced by the flows of ideas and goods circulating in the world. Our aim is to describe the emergence of a global cultural space that is shaping public perceptions of health issues and affecting health communication processes. Social representations of health and illness, usually influenced by the cultural framework constituted by the family and immediate social networks, very well described by Moscovici (1989), Herzlich (1969) and Jodelet (1989), are now nourished also by the flows of global culture and affected by the multiplication of mediation instances. (Martín-Barbero 1993)

The connections between globalization and health have been mainly studied from an economic perspective. McMurray and Smith (2001) have documented the material consequences of global dynamics in the health of people. Theories of development have also contributed to understanding the close ties between economical and health policies (Copper Weil *et al.* 1990) and the negative effects of structural macro-economic adjustment measures on the poor. (Le Franc 2000; Thomas 2000) Kim, Shakow and Bayona (2000) analyzed the consequences of the privatization of healthcare services in developing countries, while multilateral agencies have tried to calculate the impact of financial crises on social spending and the overall costs of medicines. (PNUD 1999; WHO 1999)

All these initiatives have certainly contributed to a better understanding of the quantitative consequences of the global flows of people, products, services and money on the health of populations. However, there is a need to explain how globalization is shaping social representations and discourses on the body, notions of wellness, the definitions of disease and the field of therapeutics. The study of the symbolic dimension of health and illness in the global sphere is still a work-in-progress.

We propose analyzing the emerging health planetary sphere by adapting some of the key concepts advanced by anthropologist A. Appadurai (1996) in his attempt to define globalization as a disjunctive process between economical, political and cultural domains. This particular analytical framework contributes to overcoming the epistemological gap between the socio-economic and cultural approaches that try to explain the consequences of the so-called globalization of the health of societies. By integrating the material and symbolic dimensions of globalization, Appadurai's **global landscapes** illustrates how emerging mediation instances are touching the life and shaping the imagination of millions of people worldwide, including social representations of disease and notions of wellness.

According to Appadurai, the global is

[...] a complex, overlapping, disjunctive order that cannot any longer be understood in terms of existing center-periphery models...I propose that an elementary framework for exploring such disjuncture is to look at the relationship among five dimensions of global cultural flows that can be termed (a) *ethnoscapes*, (b) *mediascapes*, (c) *technoscapes*, (d) *finanscapes*, and (e) *ideoscapes*. (1996:32-33)

Appadurai calls these landscapes **imagined worlds** that have neither a purely emancipator nor a disciplinary effect. **Ethnoscapes** refer to the constant flux of people in the global world, including immigrants, refugees and tourists. **Mediascapes** are constituted by the symbolic and technical capacities of production and broadcast contents worldwide by creating world representations. **Technoscapes** are defined by the configuration of mechanical and informational techniques (including the biotech) not only affecting economics but also cultural representations and the flow of information. **Finanscapes** are represented by the circulation of global capital in the context of a system favoring financial speculation. Finally, there are the **ideoscapes** where the dialectic between institutional (national and supranational) and non-institutional players (NGOs and alter-globalization movements) reflects the power/counter power dynamics on the global scene.

Based on these categories, we have identified five landscapes or dimensions that are shaping the global cultural framework influencing public perceptions

and attitudes toward health and illness: i. **migrations**, ii. **therapeutic markets**, iii. **the media environment**, iv. **health politics** and v. **multilateral networks**.

Migrations flows are playing a growing role in the global imaginaries related to health and illness by their material and symbolic consequences, sometimes creating an apocalyptic representation of lack of control and crisis escalation. Common language has expressed eloquently the contingencies between population flows and the emergence of diseases. The so called “Spanish flu” and “Asian flu” are not only illustrations of the geographical origin of these ailments, but classifications containing social and cultural interpretations of the epidemics, including prejudices and phobias against foreigners. These population movements have an increasing influence on public perceptions, not only because “the foreigner” can bring disease home, but also because of the socio-economic consequences of migration. This increase and acceleration of migration are also linked to some epidemic trends such as HIV-Aids, Avian flu, SARS, among others. Alongside migration, there are other population flows related to public health issues. “Sex tourism” is a good example of this trend, certainly challenging the control of sexually transmitted diseases worldwide. The material consequences of the flow of populations in health care are also connected with the social imaginaries of diseases and the pathological in general, influencing policies and discourses of exclusion and inclusion.

Therapeutic markets are creating new niches for health consumption, which are simultaneously shaping public perceptions, attitudes, and expectations regarding the prevention and treatment of different conditions and diseases. The birth of so-called “life-style” medications is the best example of this trend. Companies identify a profitable market niche in order to find a therapeutic solution for conditions affecting the development of personality, self-esteem, and body image. This process calls for educating the public about the “new condition” in order to create demand for the medicine that will control it, but not necessarily cure it. By conveying global messages related to their innovative therapies, bio-medical and pharmaceutical industries are promoting similar consumption patterns in very different cultural and socio-economic contexts in a process that can be described as the **commoditization** of health and illness. (Nahon 1999) Nevertheless, the expansion of the demand has had in some cases a boomerang effect: side effects of drugs are booming in recent years in what seems to be the natural consequence of the rapid expansion of consumption. The hybridizing process of global landscapes is also influencing markets. The practices and products inspired by alternative healing and New Age trends are gaining official recognition, in an integration process between orthodox medicine and so-called “natural” options, sometimes in disruptive cohabitation. (Hunt, and Lightly 2001)

Media are offering fiction and non-fiction contents shaping social representations of and discourses on health and illness that are acting in a disjunctive way. The media is contributing both to the development of more critical views and the promotion of consensus around policies and modes of health consumption. Narratives, particularly those presented by television, have a strong persuasive effect. (Signorielli 1993) The media is a privileged source of information on health and medical issues for the public. The media and cultural industries are also sources of esthetical and social models having a close connection with health, wellness, and illness. The expansion of the media has several consequences. The multiplication of information sources and points of view can lead to more individual autonomy, since this can

contribute to developing a critical perspective on health care institutions, medical practice, and the healthcare system. But it is also clear that the expansion of media influence works also in favor of the development of new pharmaceutical and bio-medical markets since these industries can directly reach the consumer without the barriers of medical and institutional mediations.

Health politics shaped by the global agendas of international institutions are contributing to the legitimization of local policies favoring a growing role for the market in health care and the individualization of health issues. This **culture of individualization** of healthcare is closely linked to the proposition that the market is a good regulator of health systems and competition should be promoted in order to offer better services to the consumers. (Banque Mondiale 1993) As a result of this new dialectic between public and private sectors in health care, the definition of a “new universalism” proposed by the World Health Organization has emerged. (WHO 1999:38) The new paradigm says that healthcare services should be provided to everybody. However, it also states that governments cannot secure all the services because of the scarcity of financial resources. The institutional prescription is to increase the participation of the private sector and look for more macroeconomics efficiency.

Multilateral networks, integrating traditional international institutions and NGOs, have an increasing impact on global debates about access to medicines and healthcare, promoting worldwide awareness of conditions and challenges in the health field. (Moran, and Wood 1996) New networks are facilitating cooperation between organizations. For instance, HealthNet, an Internet based platform, allowed doctors from Central Africa to share information about the Ebola outbreak in 1995. (PNUD 1999) Power relations between institutional and non-institutional players are influencing political choices in cases such as HIV-Aids (Lee 2000), abortion (Crane 1994), and the control of population growth. (Lee, and Walt 1995; Dodgson 1998)

Applying the Model: The Case of Diabetes

The current perception of a growing diabetes “world epidemic” is an exemplary case for applying the proposed global health analytical framework. Being a disease related both to genetic predisposition and life-style risk factors, diabetes offers an interesting case to observe how some global trends, including the emergence of global medical discourses and consumption patterns are shaping perceptions, expectations and behaviors of various populations about the disease and its treatments.

First, **migration processes and population interaction** in multicultural environments are playing a critical role in the increase of diabetes prevalence in some regions and is affecting the way the disease is treated. It is known, for example, that populations of Hispanic origin in the United States have relatively higher diabetes prevalence than other groups. (Hunt, Valenzuela, and Pugh 1998) This is often explained by a combination of genetics and food habits, particularly new habits developed in the context of the USA, where this population has more access to junk food. An extensive review about research on culturally relevant issues for Hispanics with diabetes by Caban and Walter (2006) found that personal models of illness varied across groups of Hispanic/Latino origins and were influenced by levels of acculturation. A

recent study by Caban *et al.* (2008) identified the emergence of new themes among Hispanic/Latino populations with diabetes, showing how socio-cultural processes are influenced by a combination of mainstream medical/pharmaceutical discourses and more localized personal concerns. “New concerns” include, among other topics, the effect of diabetes on sexual health problems, perceptions about the link between depression and diabetes, intergenerational issues and their impact on participants’ beliefs about diabetes, and perceptions of discrimination and discontinuity in healthcare.

Second, there is a very dynamic and competitive **therapeutic market** around diabetes. The recent introduction of inhaled insulin and the development of new oral drugs show the industry’s interest in a growing global market. The expansion of the diabetes market is influencing prescription habits among doctors and creating demand for innovation in a context of increased consumption of services and products. (Alexander *et al.* 2008) Furthermore, the changing definition of the “diabetes category” towards “pre-diabetic” conditions such as so-called “insulin resistance” and “metabolic syndrome,” has opened the door to comprehensive treatments including those for high blood pressure, high cholesterol and abdominal obesity. (Desprès, and Lemieux 2006; Balkau *et al.* 2007) Medical discourse on diabetes has evolved from a glucose-centered metabolic disorder toward a combination of risk factors and conditions needing more complex prevention, diagnostic and treatment approaches.

Third, **media** is consecrating more time and space to diabetes related stories, claiming that the world is facing a global epidemic and promoting different types of innovation, from new glucose monitoring devices to new pharmaceuticals. Recently the media has been interested in stories about the side effects of diabetes medication, contributing to the debate on the safety of prescription drugs and the marketing practices of pharmaceutical companies. The case of the ACCORD study (Action to Control Cardiovascular Risk in Diabetes) helps to understand the critical role that news media is playing in the day-to-day clinical setting. According to reports of the study conveyed by international wire services and highly influential newspapers such as the New York Times, lowering “too much” the level of glucose in patients with type 2 diabetes increases their risk of dying of cardiovascular complications. (Kolata 2008) The ACCORD story revealed the paradox of a media discourse that promotes therapeutic improvements that are creating, at the same time, uncertainty in medical practice. A quote by Dr. Richard Kahn from the American Diabetes Association exposes the disruptive effect of these kinds of media reports: “It’s profoundly disappointing. This presents a real dilemma to patients and their physicians. How intensive should treatment be? We just don’t know.” (Stein 2008)

Fourth, **health politics** are affecting the way diabetes is diagnosed and treated. The so-called “rationalization” of health care is resulting in practices focused on treating “acute” episodes of the disease that neglect more holistic and preventive approaches. This double discourse – conveying tensions between administrative decisions and actual clinical conditions – is clearly present in a study based on interviews with Canadian doctors working in the diabetes field. (Nahon-Serfaty 2009) Physicians acknowledged the need to promote life-style changes that will eventually improve the quality of life of patients, while accepting the fatalistic view that the “only solution” in the “real world” is to prescribe a set of drugs to deal with the complications associated with the condition. The same research showed how medical discourses respond to a competitive rationality dominated by corporate, scientific and

political actors who are guiding policy choices and decision-making processes in the public sphere.

Fifth, **international institutions** are contributing to the definition of standards for diabetes diagnosis and helping to raise awareness about the disease. Besson *et al.* (2009) have studied the role of the World Health Organization (WHO) in what they call the “construction of the diabetes world epidemic,” by lowering some of the thresholds that define who is a “diabetic” and even “pre-diabetic” patient. In that sense, the International Diabetes Federation (IDF), a worldwide alliance of over 200 diabetes associations in more than 160 countries, has developed an extensive campaign to put diabetes on local public health agendas, helping in an indirect way to promote the interests of other players, such as pharmaceutical companies, who are always willing to expand global markets.

As the diabetes case shows, the global health sphere is a source of disjunctive forces influencing cultural trends frequently going in opposite directions. While it is certainly true that migration is exasperating the health situation of several population groups, it is not less valid to assert that the information circulating through the media and the intervention of multilateral stakeholders are raising global public awareness about illnesses and injustices affecting these populations. On the one hand, the logic of competition among therapeutic markets is pushing for more consumption while, on the other hand, it is also creating opportunities to open the dialogue between patient and doctors about the best options to prevent and treat diseases. This dialectic between the local and the global should be analyzed more deeply in order to better assess the emerging cultural environments affecting health communication both at the interpersonal (micro) and social (macro) levels.

Discussion / Conclusion

As we have seen, the areas of difficulty within the field of Health Communication cannot be examined without reference to the “social” as such. Health Communication, like other fields, rests on complex socio-cultural processes and it is important to take into account both micro and macro levels of analysis. We must, in fact, keep in mind that health interventions, whatever they may be, are first and foremost social relationships, which in turn rest on social constructs. (Gadrey 1996) This process works in such a way that medical practice, as we have seen previously, becomes an art that is deeply ingrained in the practitioner’s individual experience, which forms the basis of his/her decision-making. This individual experience teaches the practitioner that his/her efficiency, defined as his/her capacity to obtain “good” results, also depends on his/her capacity to “resolve problems” (Gadrey 1996:123) that have led a certain patient to seek his/her expertise. Although, the attainment of this result, the **health-output**, finds its inception in the odds that the practitioner will adapt his practice to different situations. Therefore, as we have mentioned earlier, the health field is strongly affected by individuals’, patients’ heterogeneity. Indeed, research lead by sociologists, psychologists and anthropologists has clearly demonstrated that the quality of an intervention depends completely on the way we communicate, the way we take care of the speaker. Individuals, namely patients, are not all homogeneously sensitive to certain health problems as Dodier (1993:122-123) has shown in his study of the perception of pain. This is note-worthy,

since it concurs with health sociology and anthropology findings that illness, healing, even the representation of pain², stem from socio-cultural factors related to age, sex, social class, level of education, etc. (Dorvil 1985)

Consequently, we can highlight an important point – that illness and the health service upon which a patient calls, derives from very complex social processes that prevent any thoughts of homogeneity and standardization of health care. Not only are patients' sensitivities divergent, but they also come into relation, interaction, differently with health professionals. As mentioned previously, every case is unique and should be considered as such. Therapeutic effectiveness, as well as clinical and therapeutic efficiency (Bonneville 2003, 2005, 2006), stem from the quality of the interaction within the healthcare service. In short, these considerations demonstrate the extent to which the socio-cultural dimension of health interventions, whether it be micro or macro, is vital to better understanding the complex dynamics at play in the Health Communication field.

While bringing together different works (Ahmed 2007; Nahon 1999; Nahon-Serfaty 2009) and research results in the Health Communication field, we sought to decompartmentalize micro and macro analyses, which is necessary, in our view, for understanding the cultural complexities and issues within the Health Communication framework. The idea is to develop an approach that, while monitoring the level of interactions between individuals, will not lose its original context (the global) as a whole (Knorr-Cetina and Cicourel 1981). Latour (2005) shows how a macro-sociological phenomenon can be present in micro-episodes where agents' structuring practices ensue. In other words, throughout their interactions, individuals construct collective representations that can be generalized and progressively become constitutive elements of macro-sociological phenomena. Furthermore, micro-interactions do not develop in a social void. In fact, analysis of micro-social phenomena must be related to greater contexts. As Giordano (2006:156) has stated, while citing Weick: "This does not signify that the social interactions are local, as it were, an independent auto-production of all frameworks [...]. The meanings that the actors co-construct are not auto-created. The micro-analysis does not go without macro-inputs." (1990:583) It is for this reason that we think that to grasp the entire complexity of cultural issues in the communication process (within the health context), we must focus our attention on the actors (and their interests) and on the system. And just as Latour (2006:259; our translation) points out: "The macro is neither 'above' nor 'below' the interactions: they add themselves on like another connection that feeds off of them, but also nourishes them."

Our objective in this text was to focus on the significance of exploring these two perspectives (local/global or micro/macro) and above all to show that this is not the result of their simple addition, but the result of a more integrative approach, where the value lies in bringing out the entire complexity of cultural issues in the Health Communication field.

² One of the first studies having addressed this issue is that of Mark Zborowski which demonstrated in 1952 that the representation – thus the signification – of pain varies from one ethnic group to another.

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Résumé/Abstract

Depuis le congrès de l'Organisation mondiale de la Santé à Ottawa (Canada) en 1986, on a reconnu le rôle structurant des différences culturelles dans les orientations des systèmes de santé. Cela a constitué un pas important dans la compréhension de la place du patient dans la promotion de la santé et des soins médicaux. Les chercheurs tiennent compte de l'importance des facteurs socioculturels dans ce champ complexe d'activités humaines et sociales qu'est le domaine sanitaire. Cependant, la culture est encore un élément marginal dans les institutions médicales malgré les constats faits de son importance tant en psychologie, en sociologie et en anthropologie. Cet article traite du rôle de la culture dans le champ de la « communication et de la santé », à partir d'une perspective multidisciplinaire, en essayant une réconciliation des approches micro et macro. Nous proposons de répondre à la question suivante : comment peut-on concilier le micro et le macro et ainsi intégrer la dimension culturelle dans les phénomènes étudiés dans le champ de la « communication et de la santé », tant sur le plan interpersonnel que dans le contexte plus large de l'interaction sociale? La réponse à cette question demandera d'explorer les contributions empiriques et théoriques de différents domaines.

Mots clés : Communication et santé, culture, soins de santé, mondialisation

During the Congress of the World Health Organization in Ottawa, Canada (1986), the structuring role of cultural differences was highlighted in the context of health system orientations. This event constituted an important step towards the way in which patients are being taken care of and participate in the promotion of health. Accordingly, researchers consider the socio-cultural factors as being crucial when taken into account within the complex field of human and social activity that comprises the health care field. But culture has long been considered, and still is today, as being marginal in prominent health establishments, despite numerous reports being conducted on the subject in psychology, sociology or anthropology. This paper addresses the role of culture in the field of "Health Communication" notably in claiming the development of a multidisciplinary perspective, reconciling the macro and micro approaches, between the local and the global. In this article, we propose to answer the following question: How can we manage the reconciliation between the macro and micro approaches, and thus fully integrate the cultural dimension into better understanding the phenomena studied in Health Communication, both at the interpersonal level (patient-physician encounter) and in the larger context of social interaction? Answering this question will require exploring the empirical and theoretical contributions of different fields.

Keywords: Health communication, culture, healthcare, globalization

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