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# Redefining health communication through narrative intersection: opening closed narratives and co-creating meaning

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We aimed to propose a new conceptualization of health communication that mitigates the limitations of traditional one-way models by introducing a relational, narrative-based approach that emphasizes mutual understanding. This paper critiques existing definitions and proposes an alternative framework by reviewing interdisciplinary literature on Narrative Medicine, narrative identity theory, and health communication research. The paper introduces "narrative intersection" as a concept that describes how divergent narratives engage in dialogic meaning-making. Health communication is redefined as the study and practice of opening closed narratives and co-creating shared meanings through narrative intersections to improve health. This redefinition shifts focus from merely delivering information to fostering dialog and co-constructing meaning. It provides a unifying framework for diverse domains, such as clinical communication and public health messaging, while addressing issues such as resistance to evidence-based recommendations and the spread of misinformation. Narrative intersections offer a grounded, ethically responsive, and practically relevant framework for advancing health communication by emphasizing the importance of dialog, narrative contexts, and the structural conditions that shape the voices that are heard.

KEYWORDS

**health communication, definition, narrative, narrative medicine, story, patient-centered care**

## 1 Introduction

Health communication is central to medicine, public health, and policy because it directly influences how individuals and communities understand health information and make decisions (Schiavo, 2013). However, even when accurate and timely information is provided, people do not always respond as expected. For example, during the COVID-19 pandemic, public health authorities released evidence-based recommendations on vaccines, mask-wearing, and physical distancing. Yet misinformation on social media spread more rapidly than scientific facts, fueling confusion and distrust (Airhihenbuwa et al., 2020; Hu et al., 2023). Similarly, in the clinical context, patients with chronic illnesses often report that their experiences are overlooked or misunderstood by healthcare professionals, leading to frustration, withdrawal, and poor adherence (Cheston, 2022; Zhang, 2024). These challenges illustrate that effective health communication cannot be reduced to simply delivering accurate

messages. It requires engagement with people's experiences, cultural backgrounds, and emotional realities.

In this study, we propose a redefinition of health communication that addresses these limitations. We conceptualize humans as narrative beings who understand themselves and the world through stories. Building on this perspective, we introduce the concept of "narrative intersection," a dialogical process in which divergent narratives—whether those of patients, clinicians, or communities—interact and generate new shared meanings. From this viewpoint, health communication can be defined as the study and practice of opening closed narratives and co-creating shared meanings through narrative intersections to improve health.

This redefinition shifts the focus of health communication away from message transmission and toward relational meaning-making. It underscores the importance of dialog, context, and ethics in clinical practice and public health communication. By centering on narrative intersection, we aim to provide a unifying framework that advances theory and offers practical guidance for addressing urgent challenges such as resistance to evidence-based recommendations, the spread of misinformation, and the marginalization of patient voices.

## 2 The limitations of traditional health communication models: moving beyond one-way transmission

Health communication has traditionally been defined as the unidirectional transmission of information from experts to nonexperts (Ee et al., 2003). For example, the Centers for Disease Control and Prevention (CDC) defines health communication as "the study and use of communication strategies to inform and influence decisions and actions to improve health" (U.S. Department of Health and Human Services, 2005). Similarly, *Healthy People 2010* described health communication as "the art and technique of informing, influencing, and motivating individual, institutional, and public audiences about important health issues," portraying it as a technique for promoting understanding and action on health concerns (U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion, 2005). The National Cancer Institute (NCI) includes a wide range of health communication activities, from patient–provider interactions and public campaigns to policy advocacy and media engagement, but primarily emphasizes outcomes for the receiver, such as increasing knowledge and awareness, influencing perceptions, beliefs, and attitudes, and prompting action (National Cancer Institute, 2001).

Thus, the core of health communication is often understood as delivering accurate information to induce behavioral changes. Even in the most comprehensive definition proposed by Schiavo, based on an analysis of approximately 20 existing definitions, although considerations of bidirectionality and empowerment are evident, a degree of unidirectional thinking still appears to persist (e.g., to influence, engage, empower, and support individuals, and communities) (Schiavo, 2013).

However, this one-way model has several limitations. First, it tends to disregard the interpretive contexts of recipients, including their cultural backgrounds, personal beliefs, and prior experiences (Han, 2013; Ko, 2016; Schöps et al., 2023). For example, a patient may hear the same medical advice as others but interpret it differently because of past illnesses or cultural traditions. Second, it is poorly suited to patient-centered care, where mutual understanding and respect for patient values are critical for effective decision-making (Siebinga et al., 2022; Jiang et al., 2024; Zhang, 2024). If a patient says, "This illness has taken away my daily life," and the physician only replies, "Your test results are normal," the communication fails to support the patient's needs. Third, in today's multivocal and participatory media environment, unidirectional communication fails to address the dialogical and decentralized ways in which health narratives are exchanged and contested (Neylan et al., 2022; Wang et al., 2022; Ma and Ma, 2025). For instance, during the COVID-19 pandemic, scientific information about vaccines frequently clashed with community beliefs and rumors on social media platforms (Smith et al., 2023).

These limitations are both practical and epistemological. Most existing definitions of health communication are implicitly grounded in a positivist orientation aligned with evidence-based medicine, which assumes that objective data and standardized messages can guide universally appropriate decisions and behaviors (Greenhalgh et al., 2014). However, this perspective overlooks the interpretive processes through which individuals engage with health information within the context of their life narratives. In contrast, Narrative Medicine emphasizes the storied nature of human understanding and the importance of attending to patients' lived experiences, values, and meanings (Greenhalgh and Hurwitz, 1999; Charon, 2001; Zaharias, 2018a,b). From this viewpoint, effective communication is not simply delivering evidence-based content, but engaging in a dialogical process that honors narrative complexity and fosters shared understanding (Côté, 2024; Palla et al., 2024).

While classical definitions of health communication have emphasized one-way transmission, contemporary practice already encompasses robust dialogic and participatory strands. Examples include shared decision making, co-design of health services, community engagement, and patient and public involvement initiatives that emphasize mutual understanding and empowerment. Our critique therefore targets the *conceptual default* embedded in many formal definitions rather than current practice as a whole. The framework of narrative intersection is intended to integrate these dialogic efforts within a broader model that specifies when and how directive and relational modes can be combined most effectively.

## 3 Narrative-based foundations of health communication: addressing the challenge of divergent narratives

Human beings are fundamentally narrative in nature—*homo narrans* (Niles, 1999). We make sense of ourselves and the world through our stories (Fisher, 1984; Bruner, 2004; Adler and McAdams, 2007; Lind et al., 2025). Empirical studies support this view by demonstrating the association between how individuals construct life stories and their physical and psychological well-being (Adler et al., 2015, 2016; Iannello et al., 2018; Thomsen et al., 2025). These perspectives underscore that narrative is not merely a form of expression, but a primary mode of understanding, identity construction, and health-related meaning-making.

However, in practice, engaging in divergent narratives poses a major challenge to communication. Narratives are shaped by

unique experiences, values and cultural contexts (McAdams, 2001; Adler and McAdams, 2007; Thomsen et al., 2025). Consequently, patients' stories often diverge from those of clinicians. This divergence is known as "narrative mismatch" (Allegretti et al., 2010). For example, patients with chronic pain may describe their suffering in existential terms, whereas physicians primarily respond to biomedical categories (Blease et al., 2017; Cheston, 2022). When such accounts are overlooked, patients may feel ignored or invalidated, which can compromise rapport and quality of care (Wakefield et al., 2022).

Importantly, this discrepancy is not limited to clinical practice. Public health communications also encounter narrative divergence. Scientific narratives may conflict with community-held beliefs and cultural worldviews, necessitating dialogical bridge-building rather than top-down persuasion alone (Engebretsen and Baker, 2023). These patterns reaffirm the need to shift from health communication as information delivery to communication as relational meaning-making. In this view, the ability to engage across narrative boundaries and co-create meaning is not a peripheral skill, but a central component of communicative competence in healthcare (Charon, 2008; Zaharias, 2018a,b). This is the conceptual and ethical terrain on which narrative intersection operates, a framework that we elaborate on in the next section.

## 4 Defining health communication through narrative intersection: co-creating meaning across divergent perspectives

Building on the preceding discussion, we define health communication as "the study and practice of supporting individuals and communities by opening closed narratives and co-creating shared meaning through narrative intersection to improve health." This redefinition marks a shift from one-way message delivery to mutual dialogical engagement grounded in the narrative nature of human understanding.

We use *closed narrative* to denote an account that (a) excludes alternative framings, (b) resists uptake of disconfirming or complementary information, and (c) confines next actions to a narrow, predetermined script. Conversely, a narrative is *opened* when at least two of the following markers can be observed during interaction: stance shift (acknowledging uncertainty or multiplicity), reframing (introducing a new interpretive lens), uptake cues (active paraphrasing or echoing), option-set expansion (joint articulation of multiple next steps), and shared language emergence (borrowing each other's words). These five indicators function as minimal diagnostic criteria for identifying narrative intersection.

Figure 1 illustrates this conceptual shift. Panel A shows the traditional one-way model, in which information flows from experts to recipients. Panel B contrasts this with the narrative intersection model in which patients, clinicians, communities, and authorities bring their stories together and create a new understanding.

Narrative intersection means that divergent stories—whether clinical, personal, or cultural—encounter each other and generate new meanings. In other words, communication becomes a space in which stories clash, converge, and evolve into interpretations that no single voice can produce. This process is of ethical significance. Treating patient stories as valid knowledge can counter not only the structural injustice between patients and healthcare providers but also specific forms of epistemic injustice, such as testimonial and hermeneutical exclusion (Kidd and Carel, 2017; Jonas et al., 2025). Recognizing and engaging with patients' stories affirms their dignity and ensures equity in communicative relationships. For example, when a patient says, "My life is over because of this illness," a clinician's engagement may open space for a new meaning, such as, "This experience, though painful, can still hold value"(de Sire et al., 2023). Clinicians may also reshape their professional narratives through these encounters, broadening their care beyond biomedical logic (Huang et al., 2021). Such reciprocal transformations demonstrate that narrative

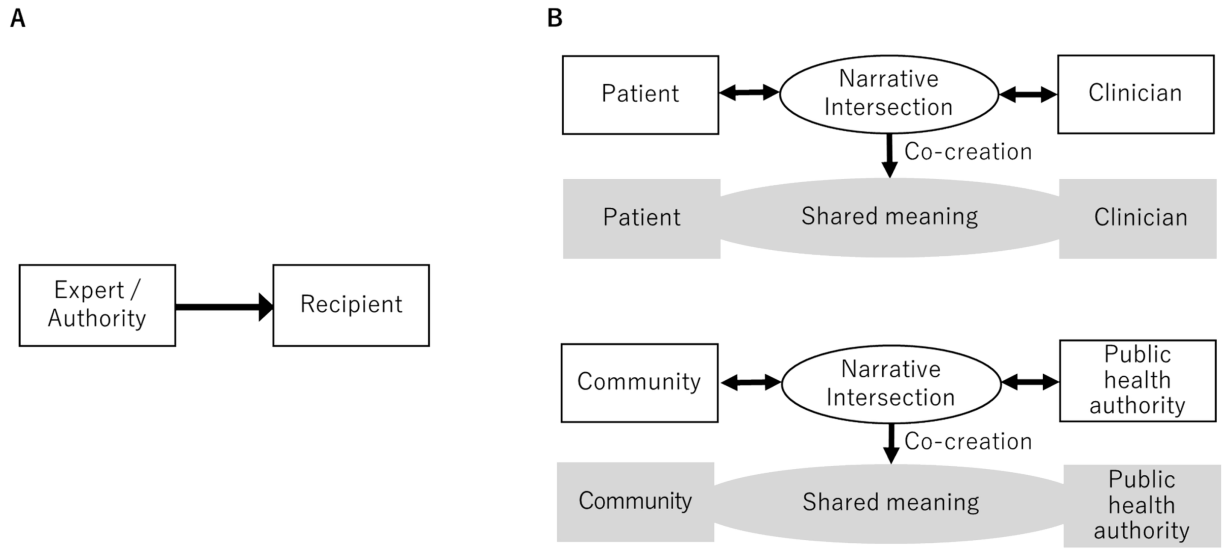


FIGURE 1
Traditional vs. narrative intersection models of health communication.

intersection is not only a practical tool, but also an ethical commitment to justice, respect, and the recognition of patients as knowers.

Narrative intersection is not intended to replace directive communication in all contexts. In time-critical, high-consensus risk communication—for instance, outbreak control or anaphylaxis management—rapid one-way messages are primary. In contrast, when values, identity, or lived experience are central (e.g., chronic illness, end-of-life care), narrative intersection becomes the preferred mode, facilitating mutual understanding and trust.

## 5 Theoretical and practical implications of narrative intersection: reconstructing health communication for a complex world

This section outlines the theoretical and practical implications of redefining health communication through narrative intersections. The following discussion first considers the theoretical contribution of this framework from an analytical perspective and then turns to its practical applications in clinical practice and public health communication.

Previous studies have emphasized the role of narratives in health. Kleinman (1988) noted that patients and clinicians have different explanatory models of illness. Narrative Medicine highlights the importance of listening to stories about illness (Charon, 2008). Frank (2013) described the typologies of illness narratives (Frank, 2013). Research on narrative persuasion has examined how stories shape attitudes (Dudley et al., 2023; Okuhara et al., 2023).

Our contribution goes further. Rather than concentrating on the content or persuasive power of individual stories, we highlight the relational process by which divergent stories meet and transform into one another. For example, a patient with chronic pain may say, "The tests show nothing is wrong, but this pain controls my whole life." When a clinician acknowledges this experience and reframes it as, "Your pain is real, and together we can find ways to manage it," the resulting dialog generates a new, shared meaning that validates the patient's story (Naldemirci et al., 2021; Rosen, 2021). Theoretically, this example illustrates that narratives are neither static nor self-contained but relational and dynamic. Meaning arises through these encounters, where differences and conflicts become opportunities for transformation. This view resonates with dialogical perspectives (Bakhtin, 1981) and social constructionist accounts of meaning-making, which stress that understanding is always co-produced within an interaction. By adopting narrative intersection as an analytical lens, health communication shifts from focusing on isolated narratives to examining the dynamics of encounters, offering a more comprehensive framework for both theory and practice.

Narrative intersections are highly relevant in clinical practice. Shared decision-making, for example, is often framed as a rational weighting of risks and benefits (Elwyn et al., 2013; Siebinga et al., 2022). However, in reality, patients and clinicians enter these conversations with different stories about the illness, treatment, and future (Thomas et al., 2020; Waddell et al., 2021). For example, a patient with a chronic illness may prioritize maintaining daily activities, whereas the clinician may emphasize treatment outcomes alone (Evangelidis et al., 2017). By explicitly acknowledging and negotiating these divergent narratives, decision making can move beyond abstract statistics to a process of co-constructing meaning that respects patient values. Thus, the narrative intersection provides a practical framework for improving trust, adherence, and satisfaction with clinical encounters.

Narrative Medicine and dialogic theories have powerfully underscored the ethical and relational value of listening to patients' stories. However, these frameworks often remain at the level of ethos—emphasizing *why* dialog matters—without specifying *how* to recognize, facilitate, and evaluate it in practice. The concept of narrative intersection advances this conversation by offering an interactional process focus with concrete recognition criteria (e.g., stance shifts, reframing, uptake cues) and assessment possibilities for when stories genuinely engage and co-create shared meaning. Thus, narrative intersection transforms a narrative *attitude* into an operational framework for observing and cultivating dialogical meaning-making.

This framework also extends to public health communication. For example, it clarifies why accurate health information is often rejected, whereas misinformation spreads more easily (Zhou et al., 2021; Vellani et al., 2023; Langdon et al., 2024). The issue is not only the content of the message but also its fit with people's existing narratives. When information clashes with the recipient's worldview, it is likely to be rejected. When dialog creates a shared narrative, it opens space for change. Reproductive health and aging involve competing perspectives shaped by cultural values and social experiences. Discussions about reproductive rights often pit biomedical risk framing against community-based narratives of morality and family (Parker, 2020). In aging societies, public health advice regarding frailty or dementia may conflict with older adults' stories of independence and dignity (Gheorghe et al., 2024; Marnfeldt and Wilber, 2025). Narrative intersections help explain these clashes and provide a dialogical approach to address them. By engaging communities in mutual storytelling, public health professionals can create shared narratives that foster legitimacy and trust among diverse populations.

This redefinition unifies the diverse domains of health communication through a single lens. Clinical communication, community-based initiatives, and public health can all be viewed as sites of narrative intersection and meaning co-creation. In patient–provider communication, a narrative intersection may explain why trust and treatment adherence improve when dialog occurs (Waddell et al., 2021). Peer communities and online forums also function as sites where patients share stories to inform, validate, and connect with each other (Kohl et al., 2024; Aldarwesh, 2025). Public health communication faces similar dynamics when scientific messages clash with community worldviews, such as in vaccine communication (Dickinson et al., 2025). In any of these cases, the narrative intersection offers a dialogical approach that enables mutual storytelling, builds trust, and fosters reciprocal understanding. This is especially important for marginalized communities, whose voices have often been excluded.

While narrative intersection emphasizes mutual understanding, it does not imply moral equivalence among all narratives. Two ethical guardrails guide its responsible use:

1. Integrity guardrail: Narrative intersection must never compromise factual accuracy, public safety, or human rights. Dialog aims to *understand* harmful narratives, not to *endorse* them.
2. Equity guardrail: Engagement should prioritize marginalized voices and protect those harmed by misinformation or discrimination.

TABLE 1 Decision grid for choosing communication mode.

| Context | Narrative openness | Harm potential | Recommended mode | Example |
|---|---|---|---|---|
| High urgency (outbreak, acute risk) | Low | High | Directive | Anaphylaxis, outbreak control |
| Moderate urgency, misinformation present | Partial | Moderate | Hybrid (directive + dialogical) | Vaccine hesitancy |
| Low urgency, value-based divergence | High | Low | Dialogical (narrative intersection) | Chronic illness care, end-of-life discussions |

In situations involving misinformation, clinicians and public health practitioners should distinguish between understanding the worldview behind a harmful claim and validating the claim itself. Narrative intersection can be used to uncover the emotional or identity-based concerns that sustain misinformation (e.g., fear, distrust, belonging), while directive communication remains essential when false claims pose imminent harm.

Table 1 shows the decision grid. This grid provides a practical heuristic: as urgency and harm potential increase, communication should shift toward directive clarity; as narrative openness increases, dialogical engagement becomes more appropriate. These ethical boundaries ensure that narrative intersection strengthens, rather than undermines, evidence-based communication.

Finally, certain challenges remain. Methodological innovation is required, as tools to assess the degree of narrative disjunction or shared meaning are underdeveloped. Future work should focus on qualitative and process-oriented approaches, such as narrative, dialogical, or conversation analyses, to evaluate meaning co-creation in real settings. Interventions that facilitate narrative intersections, especially in clinical and public health contexts, should be designed and tested.

However, some theoretical questions remain. Narratives are socially situated and shaped by broader structures. Power asymmetries, cultural hegemony, stigma, and systemic discrimination influence which narratives are heard or dismissed (Rosen, 2021). Future research should examine how these structural conditions shape the possibility of narrative intersection. By addressing these barriers, the framework could be refined to promote equitable and inclusive communication.

## 6 Conclusion

This study argues that health communication must be redefined to address the complexity of contemporary health challenges. Traditional transmission models, while valuable in certain contexts, are limited because they reduce communication to the delivery of information. Our analysis shows that such models overlook the interpretive, relational, and ethical dimensions of how people engage with healthcare.

We propose narrative intersection as a unifying perspective that reframes health communication as the co-creation of meaning across divergent stories. This framework highlights that communication is not a linear process, but a dialogical encounter in which new understandings emerge. By recognizing human beings as fundamentally narrative in nature, this redefinition integrates insights from multiple domains and provides a more comprehensive foundation for research and practice.

Redefining health communication through narrative intersections provides a unified, ethically grounded framework. It moves the field beyond one-way transmission to dialogical meaning-making and affirms dignity, equity, and respect for diverse voices. This redefinition reorients health communication toward a more inclusive, reflexive, and human-centered future, marking a necessary shift in the 21st century through mutual understanding via narrative intersections.

## Data availability statement

The original contributions presented in the study are included in the article/supplementary material, further inquiries can be directed to the corresponding author.

## Author contributions

TO: Conceptualization, Funding acquisition, Writing – original draft, Writing – review & editing. HO: Writing – review & editing. RY: Writing – review & editing. YK: Writing – review & editing.

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