Interculturality and the conjunction of knowledge that gathers health care

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Resumo

O artigo objetiva discutir a atenção em saúde sob uma perspectiva intercultural e laica. A proposição da bioética como interdisciplina, desde Potter até autores contemporâneos, traz consigo forte estímulo à reflexão sobre a atenção em saúde e a premente necessidade de diálogo entre os saberes envolvidos nesta área. A interculturalidade, como proposta de abordagem em saúde, remete ao pensamento de que não é possível exercer a atenção em saúde sem relacioná-la com outros elementos envolvidos além dos biológicos, tais como históricos, sociais, políticos, econômicos, religiosos, culturais, entre outros. Um modelo de atenção em saúde pode ser construído a partir da interpretação de uma realidade, que por sua vez também pode ser construída. Atualmente, os distintos modelos de atenção em saúde existentes se deparam com o desafio de integrar-se entre si, com base em seus saberes diversos, legitimando uma real atenção integral em saúde.

Palavras-chave: Serviços de saúde. Assistência à saúde. Diversidade cultural.

Resumen

Interculturalidad, y la conjunción de saberes que conforman la atención en salud

El objetivo de este trabajo es discutir la salud desde una perspectiva intercultural y laica. La propuesta de la bioética como interdisciplinaria, desde Potter hacia los autores contemporáneos, aporta un fuerte estímulo a la reflexión sobre el cuidado en salud y la urgente necesidad de un diálogo entre los saberes involucrados en este campo. La interculturalidad, como una propuesta de enfoque en salud, nos lleva a la idea de que no es posible ejercer el cuidado en salud sin relacionarlo con otros elementos que intervienen más allá de lo biológico, tales como el histórico, social, cultural, político, económico, religioso, entre otros. Un modelo de atención en salud se puede construir a partir de la interpretación de una realidad, que a su vez, se puede también construir. En la actualidad, los distintos modelos de atención existentes en salud se enfrentan con el desafío de integrarse unos con los otros, basados en sus saberes diversos, legitimando una real atención integrada en salud.

Palabras-clave: Servicios de salud. Prestación de atención de salud. Diversidad cultural.

Abstract

Interculturality and the conjunction of knowledge that gathers health care

The paper aims to debate health care from an intercultural and secular perspective. The proposition of bioethics as interdisciplinary, from Potter to contemporary authors, brings a strong incentive to reflection on health care and the urgent need for dialogue between the knowledge involved in this area. Interculturality, as a possible approach in health, leads to the thinking that it is not possible to exercise the health care without relating it to other elements beyond the biological, such as historical, social, political, economic, religious, cultural, among others. A health care model can be constructed from the interpretation of a reality, which in turn, can also be constructed. Currently, the different health care models face the challenge of integrating with each other, based in the different knowledge, legitimizing an integral health care attention.

Key words: Health services. Delivery of health care. Cultural diversity.

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This article, of essayistic character, proposes a reflection on the need for consideration of aspects of intercultural health care. Therefore, when we mention the health care we refer to the organized set – within a system – of policies which aim to meet the demands of health care of individuals who, otherwise, make up society. This policy, by using different strategies of action, such as programs and plans, will guide the practices that result in health care.

Health practices, therefore, can be understood as the set of knowledge used to recognize or identify a problem related to balance physical and/or mental health of a person, and consequently, design actions which aim to restore this balance. Both practices and health care itself are strongly influenced by cultural, historical, social, political and economic processes. Besides these factors, there are others, which are naturally more subjective, and influence health practices: beliefs and religion.

All these components make the health care to be constituted by dynamic processes, constantly subject to revisions and reconfigurations. Additionally, the practices are carried out from different models, and some of them overlap others, becoming dominant, as in the case of biomedical scientific model. However, from the popularization and the actual user demand for alternative practices of health care, new possibilities of model care arise – including the biomedical model itself gradually starts a blending process between scientific knowledge and alternative knowledge. It is a new configuration of health care, which arises not only focused on biological aspects, but also in other aspects that influence the well-being of individuals, such as socio-cultural, spiritual, economic, and other factors.

Currently, there is no room for biological or sociocultural reductionisms. And if for some time they have been configured alone and with minimal dialogue, they are gradually being reconfigured from the exchange and interdisciplinarity. In the field of health care, it is not different, and new spaces for dialogue emerge, integrating scientific knowledge with those which are called as traditional. This mix favors the inter-relations and complementarity, resulting in consequent intercultural processes.

However, it should be noted that the presence of dialogue does not necessarily mean the absence of conflicts, and it is from both dialogue and conflict, that the role of intercultural mediator is consolidated. Because, as Gil points, *if the contact is an inevitability of different cultural process and conflict – communicative and uncommunicative – such as dialogue, is an essential component of this moment, interculturality erects itself as a key strategy for mediation. However, it would be unrealistic to conceive interculturality as an inevitably successful process, as a sort of magic solution that overcomes violence manifests where cultural identity is at stake. Interculturality and its multiple avatars play in the field of mediation of different, but not on neutral field* [1].

In turn, this dialogue takes place not only between different cultures and identities, but also between different fields of knowledge and understanding, or even between different institutional logics, as market logic and the logic of the state, for example. In this context, it is possible to consider the inter-cultural health and the complementarity between different views of the same health issue, which is established through dialogue and exchange. It is the coexistence of different worldviews in a complementary way, without prejudice or imposing of one over the other [2]. The focus of health care becomes not only biological, and not only sociocultural, but biocultural or, even better, *biopsychosociocultural*.

This synthesis of aspects will reflect the whole person, not only the part in which the imbalance point of health is presented. Both the biomedical sciences as the psychosocial started using these interdisciplinary approaches, increasing the quality of care. The advancement in the field of treatment of some diseases in the area of mental health is an example in which recent findings suggest that there may also be a relation of the disease with systemic changes [3].

The impact of these advances may lead to development of more effective drugs. In parallel, the biomedical sciences also use traditional knowledge and practices, aggregating them in the treatment of some diseases and symptoms. The recent introduction of integrative practices in various specialties exemplifies this complementarity. The practice of yoga, for example, has distinguished itself by presenting efficient results in various health problems, including relief from the symptoms of menopause to reduce blood pressure levels. In a recent meta-analysis which evaluated 17 studies involving hypertensive and pre-hypertensive patients, the practice of yoga has demonstrated modest but significant effect on blood pressure. The results suggested that yoga can be offered as a complementary and effective intervention to reduce the blood pressure of hypertensive and pre-hypertensive patients [4]. That is important to remember that these integrative practices have been aggregated to conventional treatments in order to add, not replace, reflecting

precisely the dialogue between the different knowledge and the possibility of complementarity

This absorption of integrative models for biomedical models predominantly scientific illustrates the reality already experienced by the patients themselves, who travel different paths in search of attention and often include therapeutic alternatives. For the patient, the method used in the care process will not necessarily be the most important, but the result achieved, based, in addition to the scientific aspects, on this other broad spectrum of components that influence and shape them. Therefore, it is through dialogue with the patient that the senses of each process or system of care will be built.

Besides the socio-cultural belonging of each person, their beliefs and values also influence the construction of their significant meanings and health. According to these affiliations, the patient will set the course that they will seek for their health care, from the primary to the most sophisticated ones. And further, besides beliefs, there are other factors that may influence this process, such as the explanations based on other meanings, such as, for example, assign a specific temper to the hair color, height, the zodiac sign, among others. It is important to remember that health professionals also have their beliefs and values, but often, although it is expected that health care occurs in an impartial way, these beliefs and values are overlapped and, often, conflict happens between professional and patient because of these memberships and affiliations.

The aspects explained above allow us inferring that some conflicts identified in health care also arise from cultural barriers when professionals and patients disagree about the meanings attributed to the same action or practice. We came across some situations where each one defends their interpretation or their way of living and acting in the world, ranking it as the only correct one. However, from the differences is that we establish this ethics of inter-relationships, in which different views are respected, but without imposing ideas to the other.

The symbolic constructions and interpretations around health issues are beyond the biological aspects and they are contextually represented. So, basically it is to integrate the objectivity of biomedical sciences that contribute with explanations on the operation and activities of the human body, with subjectivity referenced by *corporeality*, which goes beyond the anatomical and physiological aspects. It is worth to recall that, as stated by Durán-Amavizca, humans before being humanely man, he is a body, then the man acts as a subject. Since the term *man,* here, refers to the philosophical category.

For the author, the subjectivity of man is developed out of meanings, but such subjectivity cannot forgo of a body. In turn, this body and subjectivity cannot forgo of the human being who has the body, its organs and emotions in his career as a social, cultural and endowed with language, with which shapes the identity [5]. It is precisely this social and cultural being, endowed with language and a number of particularities, who is configured on the user of health systems and seeks attention by bringing in their experience belonging to groups, societies, cultures, social classes and other possible types of aggregations around a common minimum.

Then, it is questioned about how this relationship with the body and its meanings from the cultural diversity that exists in a health care setting is established in fact. For a long time health care was exercised starting from the presupposition that people had common characteristics that became homogeneous, and that health issues could be addressed equally, based on the categorizations that pre-established behavior, symptoms, attitudes and other attributes that made up the membership of this category. A sort of "pasteurization" of human beings is seen, by taking as parameter the characteristics of hegemonic categories.

The proposal which lasted over many years exemplifies this idea, which followed the tendency to meet all the women, regarding gynecological aspects in the same way, i.e. by applying the same treatment protocol, without taking into account particular issues to them. Although all belong to the same gender, and this is common, there are many other features from the group formed by female gender. The particularities of Eastern Women are not the same as Western women, and also among Westerners, we should consider that there are particularities between the European, the African and Latin women, only to name a few examples. But we must also recognize that, among all Latin women, there are other peculiarities. The Latin women of indigenous origin have features that are not found in non-indigenous Latin women, and so we can mention numerous examples of features of groups conformed by several factors, not only by the ethnical ones. These considerations justify that health care is shaped based on a number of factors, which result in turn in individualized attention to each group – but without losing the common focus of attention.

In practice, the service situations may present with varying degrees of complexity from the point

of view of the issues specific to each group, but for example, when a woman of gypsy origin demand for gynecological care, it would be reasonable that their culture be respected and that this service was provided by a female professional, according to the meanings for this group. What may seem strange or unimportant to a culture may not be for another. And these cultural barriers can be overcome through dialogue with the patient; because it is from her the senses are constructed.

As mentioned, the cultural barriers often lead a person to think that their way of life is the only which is authentic, but we must recognize the rights of others. In parallel, neither makes sense to question why they seek health services when they not operate within this dominant logic. However, if we live in plural societies, we should also implement plural care logics, always insisting that it is not to relativize the protocols of attention, but the approaches of attention. In other words, it is not that every health institution develops a specific protocol care for each different patient, according to their particularities. But, it deals precisely considering the plurality of attention and offer different possibilities for service. Examples are some hospitals in Bolivia, which offer the possibility of achieving the childbirth models both in scientific medical model as the model of intercultural childbirth, according to the traditions of the native peoples. The choice of the childbirth model desired is performed by the patient herself and their families, and care teams, both of conventional childbirth as intercultural childbirth remain available for service [6].

In the minds of many people, there is a symbolism which suggests that groups belonging to non-dominant ethnic groups, or have they own healing systems, such as Indians, for example, would not want to receive health care based on biomedical models. However, it is verified that in practice, as well as is a transit of people belonging to hegemonic social classes, who seek both the scientific biomedical model as therapeutic alternatives, people belonging to other classes also use their non-dominant systems of healing, but they seek, when necessary, health systems based on the scientific model. This transience among different models also configures the interculturality in health.

However, this scenario of complementarity does not always is characterized by a path free from tensions and disputes among different groups that defend each practice or care model. The biomedical model is relied on scientific evidences, and it employs practices systematically audited by government agencies or municipalities and collegiate. In parallel, the integrative practices have distinct paths for their application, which are not necessarily accompanied by any regulatory system, and sometimes practitioners underpin their activities more on their own skills and knowledge acquired than in vocational training. This is the case, for example, of healers, faith healers and other ways of alternative therapists. The increasing use of such practices, when they are associated with their recovery by other groups, has led to discussion and even the search for a legislation which could legitimize them.

Categories and identities

To a better understanding of how the territorial limits or some spaces in the area of health are configured, we must enter an even more complex field: the identities. Frequently, the approach in health occurs from the characteristics of the groups, based on a homogenization of the features that would be common, but not rare, disregarding the important role played by *identities*.

Effectively, this is about realizing identities as relational elements, while the difference is established by a symbolic framework, relatively to other identities. In the practical field, it also means that sometimes the identities are taken as fixed and immutable, and *essentialist* claims are taken in order to determine who belongs and who does not belong to determined identity group [7]. In other words, we live amidst categorizations resulted from symbolic representations which will define the identity.

Thus, the identity exists because there is something that does not belong to it. We exist from the other and we define ourselves as we want to. We associate ourselves to an image, a characterization, but the category is defined from various factors, including the socioeconomic ones. The hegemonic categories define the other categories, and the relationships are established upon acceptance of the category. According to Jiménez-Silva, the specificity of the human does not pass only by self-consciousness itself, but by self-mediated consciousness of the other [8], which is also mediated, and especially, by the consciousness of difference, which are ultimately those that make up the identity limit of the us. We exist because the other also exists, and it is through the daily relationships and exchanges that identities and symbolic processes that shape society are established.

According Tadeu da Silva, we know that identity and difference are the result of a symbolic and

discursive production process. The identity, as the difference, is a social relation. They are not simply defined, they are imposed, and they do not live harmoniously side by side in a field without hierarchies, they are disputed. Therefore, identity and difference are closely connected to the power relations [9].

As pointed Gutiérrez-Martínez, since its beginning, the term identity had been defined as a process that builds day by day, through capturing specific IDs. For the author, although the notion of identity had already been described as a constant, continuous, and mobile process, which is open on its social surrounding and contextualized, brought up a notion of static, fixed, closed identity, with essentialist characteristics, permanence and wholeness [10].

The understanding of identity processes in the field of health is of utmost importance, in terms of influencing directly the relational processes, particularly between health professionals and patients. However, sometimes, if one realizes prominence of the essentialist features, such as biological and ethnical factors, for example. In a very frequently way, the field of sexuality is treated in this way with such rigidity and high qualifying level that the true nuances between the predetermined categories are seen obscured or clearly and severally denied.

Thus, cross-cultural factors are to be considered. No culture denies the existence of the body, but sexuality and sexual practices are not universal and people are constantly reinventing their sexuality, and sexual identity. Therefore, sexuality should be taking into account and not be based on the norm, but it should be considered the construction from the people themselves.

It is necessary to rethink these immutable categorizations, allowing the legitimization of identity processes from belonging feelings, and not from the set of dominant categories, which are sometimes responsible for the demarcation of the body boundaries. The creation of the categories frequently starts from stereotypes. Certain bodily features frame images that demarcate the boundaries of the body.

Thus, skin color, hair type, body and facial conforming allow knowing cultural images. And often a stereotype dictates the behavior that is followed by identification learned, in other words, acquired from everyday interactions, because they are part of a society. In parallel, in some situations, you learn to build new notions of identity to live on domination, resulting in *(re)new meanings* or collective representations. For some authors, identities, as a tool for reflection, became a concrete tool to understand the daily and complex activity of the human beings in constant interaction [11].

Historically, these assignments based on biological characteristics justifying discriminatory and exploitative actions, including the construction of a classification of society in the so-called "races". But according to Pena said, the advances in molecular genetics and the sequencing of human genome allowed the detailed examination of the correlation between genomic variation, biogeographical ancestry and physical appearance of people, showing how labels previously used to distinguish "races" have no biological significance. It is easy to distinguish phenotypically a European of an African or an Asian, but such ease disappears completely when we look for evidences of these "racial" differences in their respective genomes.

Given this evidence, we should make every effort towards an *unracial* society, that values and cultivates uniqueness of the individual and in which everyone can be free to take, by personal choice, a plurality of identities, rather than a single label imposed by society. For the author, racism did not come from the invention of the races, it preceded this invention, and the only biologically coherent division of the human species would be achievable in six billion individuals, each unique in their genome and history of life [12]. The wise words of Sérgio Pena stimulate that we can think increasingly about how this category invented served, and continues serving to impose illusory and fictitious distancing and leading to discrimination.

Interestingly, the appropriation of an argument based on biological aspects was used to justify discrimination, through the construction of "race" category, but it is precisely from the advances in genomic knowledge that also a biological argument allows defending the lack of races. This is a unique example of the application of scientific knowledge for the common good of society. It is up to us to disseminate this important knowledge and apply it in practice.

In this sense, it appears that there is a concern of the academy to provide relevant and appropriate information on ethnic issues and their implication in the field of health. In a recent article published in the *European Journal of Public Health* key principles for conducting research on ethnicity and health were proposed, precisely by the fact that there is substantial evidence that the experiences of health and health care may vary with ethnical characteristics. Understanding these experiences is needed to tackle ethnic inequalities in health field [13].

Diversity, culture and knowledge

We all conform diversity, but, frequently, when we talk about diversity, we think about the different, without realizing that we may also be the different for another. The diversity is composed by the variability; that is why we all conform it. Society and its regulatory requirements lead to categorizations and polarizations.

In health, this polarization is presented even in speeches, built from interpretations. The experience of the disease (suffering) will always be culturally determined, i.e., from the cultural relations. The recognition of the meaning of this experience is an interpretation from the experience of each one of us. The patient will notice the disease and build interpretations from experiences which are not limited to the disease [14]. On the other hand, professionals manage their own explanatory model based on the concepts known and their meanings, their knowledge and model built.

In his book *Ticiotl*, Viesca-Treviño offers us a trip to the past and a deep study of the medical concepts of the ancient Mexicans, by approaching the history of pre-Hispanic medicine, and its denial with the arrival of the Spanish. The author shows irreparably, through narrations recorded by the Spanish authors such as Nicolas Monardes, Francisco Hernández, Fray Bernardino de Sahagún, among others, such as the knowledge of indigenous healers, and consequently their medicine, was categorically disqualified as existing entity.

As an example, he reports that while Monardes requested that they went to markets to ask the indigenous people about their wonderful medicine and its use, seeking to give continuity to their medical knowledge with the knowledge of indigenous medicine. Hernández, ten years later, completely denied this last one, identifying it as inept and ignorant. In his view, it was not possible to ask native doctors which their medicines were and what they were for, but it was necessary to reinterpret them and reclassify them according to the Galenic standards, which were in force at the time.

Thus, indigenous medicine, its concepts, its collection of knowledge, its bases of beliefs were declared missing, and they were no longer seen as a knowledge to become ignorance. The truths and knowledge seem to be relative and only valid for the person who created them and one whose cultural filters allow appropriating them and take their meaning. The European conquerors and early settlers of New Spain did not realize that could even exist another different medicine of the one exercised in Europe [15].

The previous example clearly illustrates the way how the hegemonic power of the categories also determines which knowledge will be considered as valid. In other words, the biomedical model historically surpasses power relations and grant validity to certain practices, which are eligible as legitimate. For those which are not compatible, disqualification, denial and oblivion is left.

Therefore, it is not possible to think about the various knowledge types without considering the context and power relations. The interculturality seeks to promote a contextualized dialogue from the experiences of each counterpart, attempting to an effective communicate, not just a superficial one. For this, there are factors that contribute to intercultural communication in the broad sense, such as knowing the other's culture, recognizing their own culture, eliminating or neutralizing prejudices, being able to establish empathic relationships and learning to recognize the meta-communication: the one which is not evident.

Additionally, there are factors that make intercultural communication difficult, such as ignorance, universalization from own concepts and overvaluation of the differences [16]. The contextualization becomes imperative when we address issues related to health, especially if we examine historically as arise and establish new diseases. In the case of colonized countries, for example, epidemic processes, which were introduced from biological and cultural exchanges amongst ethnically different civilizations, are easily identifiable. The history of biological process, and also of the evolution of the disease, does not happen isolated from the social and cultural context in which space and time it arises, grows and matures [17]. Therefore, it is also necessary to recognize that the traditional or the alternative medicine responds to different historical moments, which probably was not considered by Hernández, when the pre-Hispanic knowledge was disqualified.

Currently, the existence of the various ways to understand health and disease, to diagnose and treat them is an undeniable reality in most human societies. This variety is called medical, therapeutic or pluralism care. In nearly all human groups there are several care instances and therapies that can be used by their members to solve their health problems. The definition and valuation of their own health problems and their relationship to the social, economic, political and cultural context can be

understood in the context of the study of pluralism care [18].

Before the realization of social plurality, as well as cultural diversity, it is necessary to consider this pluralism to promote dialogue among different knowledge, since the common goal between them is precisely seeking balance or state of health by care. And if there are different paths to reach this care, it is not possible to deny them, but share them.

The relationships between society and medical practice have always existed in all ages of humanity. The way that such links materialized is subject to surroundings that they had in each season, both society and medicine [19]. It is up to the actors involved in the field of this knowledge regarding health care to promote interculturality, because this implies that they are in a different world and even live together in relationships of negotiations and reciprocal exchanging [20].

Final considerations

The reflection proposed in this paper was to draw attention to the importance of considering the plurality of forms of care and health care, according to different views and interpretations, within interdisciplinary perspective. When Potter proposed bioethics as a new ethical science which combines humility, responsibility and interdisciplinary and intercultural competence that enhances the sense of humanity, surely it was not purely rhetoric, but it has an appeal to the consideration of this plurality and the true joint among sciences and humanities [21].

This contribution, in the sense of drawing the attention to the importance of the conjunction of knowledge, sometimes is forgotten or taken as less important than the current advancement of scientific knowledge. But even the advancement of knowledge, it is inserted into a historical social, cultural, and economic context, among others, which will influence it. And, if this context is taken into account, the process certainly will be more fruitful.

In the current context, and according to the tendency of integration among all types of knowledge, it is essential to encourage the professionals involved in the health care and in the production of knowledge on the present field to consider this plurality and realize that diversity comes to add – and not to aggregate. The decontextualized science, without exchanging with other areas, becomes an outdated model, with limited applicability. In this sense, intercultural in health has a significant role, which can favor not only the integration of knowledge, but also a theoretical justification and practical to implement new views from old knowledge.

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