Challenges for an inter-ethnic clinical bioethics: reflections from the national indigenous health policy

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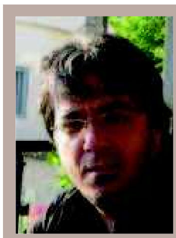
Abstract

The articles analyzes the challenges to build up a clinic bioethics with possibility of working in inter-cultural contexts and/or inter-ethnical, taking as object the relationships established between health professionals and patients, indigenous communities' members, on implementing the National Indigenous peopless Health Care Policy. Two ways are proposed, at theoretical level, for this build up: one way with anthropological content focused in basic Health Anthropology notions, and one way through moral philosophy focused in the Theory of Communicative Action and in the Habermas' Discussion Ethics. Specialization course are proposed, at practical level, encompassing advocated theoretical content, and an urgent curricular reform in health sector graduation courses.

Key words: Bioethics. Indigenous health. Anthropology. Health policy. Culture.



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Clinical bioethics was established with the perspective of a biomedical ethics that intended to surpass deontology and traditional Hippocratic paternalism limits in the interpersonal relations set among health professionals and their patients. The requirements to surpass these limits were set, in one hand, by original ethics conflicts caused by new biotechnologies, such as assisted conception and genetic manipulation - for which the code of behavior and legislation were unable to keep pace with changes -, and, in the other hand, as consequence of changes that occurred in Western societies in the second half of 20th century, from which patients began to demand greater autonomy in decision making involving interventions on their bodies.

Ethics conflicts, under this perspective, most frequently approached by clinical bioethics regarded to patients' refusal to treatment and decision making related to the beginning and end of life, mostly when they involved state of art technological interventions. With the growing bioethics politicization process, in which Brazilian and Latin American authors played a protagonist role, internationally acknowledged, conflict risen in the assistance practices and caused by historically set conditions, such as non-accessibility to health care by individuals coming from disfavored classes or social groups, became to be considered as fields for clinical bioethics work. Some of the typical dilemmas of this new field are those in which a certain procedure is not available to everyone, and it is necessary to decide who will get its benefit or if it will not be available to anyone, and professionals need to decide for an improvised and scientifically legitimated procedure, or still when patient refuses treatment due to cultural incompatibility with local beliefs and conceptions of the health-disease process.

Thus, a clinical bioethics that intends to act in contexts of large socioeconomic and cultural disparities, despite keeping its universe of intervention in this unity and direct dimension of the relationship with a patient and/or their family, it suffers direct influence form the collective dimension of public health policies, as they can set greater accessibility to health care. As these policies allocate health professionals or in contact with people carriers of a health conception diverse from Western, ethical conflicts that will emerge will have very singular features and, therefore, its resolution will depend on competences that are not clearly defined yet in the epistemological scope of clinical bioethics.

This article intends to analyze the challenges to build up a clinical bioethics in this inter-ethnic perspective of work, taking intercultural relationships set between health professionals and members of indigenous communities around implementation of the National Indigenous Health Policy of Brazil as object.

The organization of indigenous health care and the intercultural relationships in assistance

Brazil, according to the National Indigenous Foundation (Funai), is among the countries with greatest ethnic and linguistic diversity. Despite the fact that data are of difficult accuracy, the institutions estimates the existence of 220 differentiated people, while 70 of them are isolated, speaking at least 180 diverse languages derived from 30 common stems[1]. In the last demographic census, carried out by the Brazilian Institute of Geography and Statistics (IBGE) in 2010, 817,000 individuals declared themselves as indigenous, which represents 0.42% of Brazilian population [2].

The loss of traditional ways of living caused by environmental destruction and indigenous land occupation, social exclusion and ethnical discrimination resulting from colonization process are responsible for the fact that indigenous population throughout the world are in greater vulnerability conditions to impoverished health. It is widely acknowledged that these people present, almost invariably, morbi-mortality rates higher than the white population, even when living in the same regions [3].

The Ministry of Health (MOH) and the National Health Foundation (Funasa) launched, in 2002, the National Indigenous peoples Health Care Policy (Pnasi) [4]. In its introduction, the need to adopt a differentiated care model is justified aiming at assuring to these people the exercise of their citizenship, regarding health promotion, protection, and recovery. Toward this end, Pnasi points to creation of special services network in indigenous lands, seeking to promote the coverage, access, and acceptability of the Health Single System (SUS) among these populations.

The creation of this special network of services is based in the territorial definition of 34 special indigenous sanitary districts (Dsei) guided by the policy *for a dynamic ethnic-cultural, geographic, populational, and administrative space well delimited*. Pnasi determines that health multi-disciplinary teams of districts shall include indigenous health agents (AIS), nursing technicians, nurses, dentists, and physicians in a setup similar to the Family Health Program (PSF). However, it foresees a systematic participation of anthropologists, in addition to other expert professionals and technicians on indigenous issues at each Dsei.

Basic health care at the indigenous villages is supplied through AIS at health units and with periodic visits by the multi-disciplinary teams.

A second level of basic health care is represented by the hub-bases that can be hubs especially created and located in indigenous lands or in reference municipalities or, as it happens often, merged to already existing basic health care units at the reference municipality where assistance is not exclusive for indigenous, and health professionals are hired by local townhouses through intersectoral agreements.

In its turn, medium and high complexity hospital care should be carried out, according to Pnasi, by means of a reference and counter-reference system supported by the *indigenous health houses* (Casai). Pnasi recommends that e establishment, in these reference hospital centers, of differentiated services which respect indigenous cultural characteristics, to allow the companionship of relatives, visits of traditional indigenous medicine therapists and, even, to adequate internship space with hammocks setup. The indigenous health subsystem management, responsible for Pnasi, was transferred from Funasa by Presidential decree to the Ministry of Health, in October 2010, with the establishment of the Indigenous Health Special Secretariat (Sesai).

Potential ethical conflicts deriving from these meeting promoted by Pnasi among health professionals, patients, and traditional therapists make up for an interesting context to think of a clinical ethics capable to perform in these interethnic relational spaces, established by the extension of access to health for groups and communities that are culturally very different from where those professionals, who are responsible for caring, come from.

Articulation of knowledge and ethical conflicts between traditional and Western health systems

Two particular guidelines, among the eight defined by Pnasi, are of interest to this article's proposal: articulation of indigenous traditional health systems and training of human resources to work in intercultural context.

Brazilian indigenous peoples immense cultural diversity produces multiple forms of daily life and multiple ways of understanding death, life, health, childhood, old age, genders, etc. The symbolic, religious and cosmologic structure of these communities social organization provides the surfacing of own medical systems. As described in Kleiman's classic article [5], medical systems, currently denominated as health systems, are socio-cultural structures in which disease episodes insert and that encompass some common elements, both to traditional system and the modern Western system. Among the elements described by this author as present in every medical systems, we would like to highlight four of them: 1) cultural comprehension of the disease; 2) construction of strategies for choosing healing practices; 3) deliberation on behavior that prevent diseases and improve or worsen health; 4) management of therapeutic outcomes.

Modern Western health system cultural comprehension of disease presents two major paths for foundation: biomedical, based in pathogens and host interactions, genes regulation and deregulation, and other organic functions misfit, and the sanitary, sedimented in social determinants and conditionings of health. However, each hypothesis or data confirmed in any of these paths needs to be legitimated by scientific rationale, based on a deductive chain of relations of cause and effect that seeks, ultimately, universalization of its outcomes.

Epistemic bases that support Western medical system are the same in England, Uganda, Malaysia, or in Brazil. We could state, concerning traditional people, that there is own epistemology for each system. The cultural comprehension of the disease by autochthon medical systems is inserted in a specific cosmology, and therefore, it is not possible any universalizing proposal with significance and results. In general terms, it is common, for example, that both gods and spirits in things, animals, and people are responsible for individual's sickening.

The second element described by Kleimann, the construction of strategies for choosing healing practices is based in Western system, mostly, by the assessment of physiological hypotheses, in which one seeks afterwards the confirmation of intervention proposals through known experiments, such as clinical essays.

The choice of practices in the traditional systems is based, normally, in transmission of knowledge sustained by secular empirical observations (through generations) or in mystical inspirations of community members who hold traditional knowledge (medicine man or shaman), Who have the capability to contact the divine and spiritual world from which they get therapeutic guidance, either to use vegetation or animals or for prays and chants that seek healing.

The third element is found In the same sense, that of deliberation about behaviors that prevent diseases and improve or worsen health. While in Western system, this deliberation is based in scientific sustained hypothesis, some of them confirmed by clinical epidemiology studies, in the traditional systems these deliberations are inherited from ancestors also, based in medicine man's authority and inspired by spirits and gods

Finally, the management of therapeutic outcomes is done in the Western system through laboratorial exams and subsequent visits, while the usual in the traditional system is the establishment of a godsend-debt relationship, in which the healed subject begins to have social commitments with the healer. The existence of behavioral and food prescriptions for the recovery phase is common to both systems.

Leaving Kleiman's classification aside, another major concept for comprehension of the traditional health systems is the *symbolic effectiveness*. It is a concept developed by Levi-Strauss [6] to describe the healing and sickening processes mediated by a structure of signs inserted in the tradition of a people and that involve collective conscience and collectiveness stand. These signs culturally introjected reveal themselves as capable to exert strong influences over the health or behavior of its members. The witchcraft phenomena described by Levi-Strauss, for example, show situations in which an affected individual (and the entire community), believing in the effects of witchcraft, starts to behave according to the reality of this belief, which ends up by imposing such a significant symbolic force over the bodies that subjects visibly get sick and they may even die if a therapeutic intervention, also culturally guided, is not capable to nullify the effects. This sickening and healing mediated by symbolic effectiveness process still has the feature of being inaccessible to Western medical system, both from the diagnosis and therapeutic stand point.

Another factor that needs considering is the way how the diverse traditional people have related through time with the Western medical system. There are descriptions that in the colonizing process, people with daily and direct contact with the white culture, and which has been the target of many health programs supplied by the State got to know and valuate the Western system, becoming increasingly higher the search for medical-hospital services [7]. Sometimes, the use of supplied biomedical techniques is different from the indicated by scientific rationality. For example, it is reported the case of drugs, of which many people appropriate, whose use does not follow medical prescription, but rather their own and traditional conception about using external substances with healing power [8]. These interaction spaces between medical systems have been conceptualized as *intermedicality*.

Articulation between Western health knowledge and practices and traditional practices of involved communities is considered by Pnasi as indispensable to achieve improvements of health status of the indigenous peoples, in as much as, according to it, this objective cannot be achieved by merely imposing biomedical knowledge and technology, devaluating or simply ignoring local knowledge and practices. Thus, Pnasi announces that the respect for conceptions and values related to health-sickness process singular to each people is a principle that pervades all of its guidelines. Under the same view, the World Health Organization (WHO) published the document WHO traditional medicine strategies 2002-2005 [9], in which traditional health system are defined as a set of preventive and diagnosis practices, in addition to spiritual and body therapies based in utilization of plants and animals, may have empiric or symbolic effectiveness. In accordance with WHO, with their incorporation to the official health systems, the traditional medicine could contribute to reduce morbi-mortality rates, expanding the access to health services.

Deficiencies in health training of human resources for the intercultural work and the clinical bioethics stand

Articulation of health systems in daily practices, however, is not done by decree. It is necessary to consider that, for example, university background of managers and, mostly, health professions is generally built on the bases of the scientificist determinism original to epidemiology and to biomedicine. If we undertake a brief visit to the websites of the major Brazilian universities we will see that health professionals' undergraduate programs usually do not include sound contents in health anthropology, which appear almost exclusively in graduate programs in related areas. In parallel, the ethical-humanist training axis now is recommended by the Ministry of Education as one of the guidelines for changing curricular grid of health courses are far from wide implementation in the national territory, highlighting that the teaching of the US principialist model in bioethics discipline still predominates – often indicated in literature as incapable to provide answers to intercultural conflicts.

Pnasi, as mentioned, has specific guideline for human resources training, mostly dedicated to knowledge transmission of the Western systems to indigenous health agents, although it refers also to the need of undertaking capacity building and specialization courses in anthropology related topics for involved health professionals

In our view, in addition to irregularity in undertaking these course, short duration course hardly are capable to modify all of a rationale developed during professional training.

It is not rare to find in local practices scope of managers and professionals responsible for indigenous health care total lack of knowledge of the differentiated cultural matrix that supports indigenous medical systems and justify their practices. Additionally, the outsourcing process in health care rendering of indigenous c communities is pointed as responsible for molding services in order to meet the priorities of State policies without considering communities' participation and interest [10].

Thus, it becomes usual among local managers the comprehension of the health-sickness process connected to a certain extent to France's 20th century hygienist view, sustained in the *poverty-ignorance-disease* cycle, responsibilizing the behavior of groups in socio-cultural or economic disadvantage by diseases and epidemics that victimize them. The core objective to implement policies from this perspective becomes to ordain the demand for management of bodies and behaviors, seeking for a health ideal such as understood by State administrative authorities and /or their technical-scientific representatives. Therefore, the conception that the civilized must work to evolve the *primitive* and that the *scientific* knowledge should clarify and/ or validate *local* knowledge still is frequent in health actions implementation process.

This ethnocentrism in carrying out health actions local planning is responsible for the decontextualization of behaviors, simplification of demands, and generalization of individuals' and their collective needs.

Concerning the caring practices, it is usual that health professionals to see diagnosis or therapeutics practices of indigenous traditional systems as elements of the context that should be tolerated or, at most, incorporated as ancillary, but not exactly articulated [11]. For this very reason, there is a trend to classify traditional practices as *complementary* or *alternative practices*. In other instances, traditional medicine practitioners are simply disconsidered or disqualified while partners capable of intervention over the situation. Fortunately, Brazil counts on some successful experiences in articulation of knowledges, showing the importance of instruments such as Pnasi. In order to exemplify the importance of this type of instrument, we will bring a brief report of successful case, widely disseminated in layman press, although still without published academic report.

In February 2009, a child from Tukano ethnic group was intern in a children emergence unit in Manaus, after been attacked by a '*Jararaca'* snake. She underwent several small surgeries to withdraw necrosed tissues, and had indication for right foot amputation. The father requested entrance of the medicine man to administer traditional medicines in affected region and to carry out prayers and rituals, but the request was denied by the emergence unit management. He appealed, then, to the Public Attorney's Office of the Republic and got the right to take the girl out of the hospital and to take her to an indigenous health center where she only received the medicine man's care. A few days later, the director of Getulio Vargas University Hospital, also in Manaus, looked for the father to propose a joint treatment of Western and indigenous medicine inside an intensive care unit (ICU).

Consequently, the medicine man started to go inside the ICU every Day to carry out a ritual that involved the use of prayers and herbs, and the child continued to use anti-venom for snake serum, analgesic, antibiotics, and surgical dressing. It is worth stressing, still, that the ICU accepted medicine man's requirement that nurses assisting the child could not be pregnant or in their period, and that they could not have had sexual intercourse in the previous 24 hours. According to E*poca* magazine report [12], that interviewed medical director and the Public Attorney of the Republic involved in the case, three days after the simultaneous treatment, the child was feverless, the healing process had evolved enough and indication for amputation withdrawn.

What matters in this case is not if all physicians began to believe intimately in the possibility of the symbolic effectiveness of prayers and of requirements related to nurses, or if they suppose an empirical effectiveness of used herbs, by means of some active principle not known by science. What matters is that – objectively – patient's safety and wellbeing were achieved during treatment and the outcome gotten with the articulation of knowledges was clearly positive.

Articulation between traditional and Western knowledges presents a bioethical dimension that has been neglected, both by specific literature and by health anthropology and collective health literature. Clinical bioethics typical conflicts – such as those referring to patient's treatment refusal, acceptance of behavioral changes, decision making linked to beginning and end of life or election of patients to benefit with procedures not available to all - will be even more difficult to solve in this inter-cultural context. Additionally, other conflict, original to this context, may reach professionals in a very singular way, such as infanticide practiced by some of the indigenous peoples, related to twinning or ill-formation, and needing shared inter-cultural ethical solution [13,14].

Bioethical epistemology interdisciplinary feature will express in this clinical space through the need of intersecting knowledges originated from the two disciplinary traditions. De umIn one hand, sound notions of health anthropology are necessary involving assisted people cosmology, life and death conception, the forms of symbolic construction of bodies, the understanding of health-sickness process, and information about local healing practices, in addition to mastering some key theoretical features, such as the above described concepts of *symbolic effectiveness*, and *intermedicality,* just to mention some of them.

In the other hand, bioethical training shall be funded with moral philosophy elements that seek dialogue foundation for ethical relationships.

A proposal for the dialogue foundation of ethical decisions in inter-cultural contexts

We are talking hereto precisely about contemporary ethical trends that, acknowledging the impossibility to apply confirmation methods that are universally accepted to determine what is right and wrong, consider that to make an ethical decision necessarily implies in establishing free dialogue spaces, involving at least two individuals capable to act and communicate, who are implicated in certain common situation to regulate.

Jurguen Habermas', German philosopher, theoretical contributions are among them [15,16]. This author announces his theory as, partially, a reformulation of Kant's ethics. In this new proposal, the universal norms of behavior would not be proposed any longer by isolated reflection of just one conscience that is projected in alterity as wished by Kant's categorical imperative, and begin to be proposed through moral arguing and by the search for mutual recognition of the validity of arguments by those participating in a discussion. In this sense, the concept of universality hereto does not have Kant's abstract feature, but relates directly to each and every stakeholder in a conflict or action to be regulated.

This proposition, according to Habermas, surpasses ethnocentrism risk. If all stakeholders of a situation to be regulated are represented in a dialogue space allowing free standing to everyone, the decision and consequences derived from it shall be evaluated by all concerned. Thus, decision making about action or social practice escapes, according to Habermas, both from the risk of an abstract and ethnocentric universalism and the risk of inoperative relativism, which does not contribute for ethically acceptable solutions in established conflicts, when a one single action involves subjects and groups with different cultural and ethical references, as it is usual in health practices derived from public policies.

In this case, to solve conflicts in clinical bioethics that arise from these inter-cultural contacts, it is necessary, among health professionals, their patients and families, to set dialogue spaces with features mentioned above, and that indigenous health councils themselves, responsible for the social control of actions, are set and work under this perspective. In order to such model to be functional, it is important to acknowledge that values originated from a single culture will not be able to guide ethically acceptable actions in a different culture, and it is necessary that dialogue becomes the construction path or Discovery of common values to diverse world view that are involved in a caring action to be implemented.

Certainly, the features of dialogue spaces described by Habermas refer to theoretical conception of an ideal situation of communication, through which he seeks to base his moral theory. Application issues have even greater challenges. One of them is the assurance of a democratic dialogue practice in spaces that are pervaded, historically, by power games, such as the formally established institutional spaces.

Another challenge relates to the fact that Habermas' theory was developed taking the European linguistic forms as basis, and one cannot assure that these standards are applicable to linguistic structures of large number of traditional communities, both not only in Brazil and in the entire world [17]. Habermas, however, defends himself by stating that his theory is based on components of daily speech acts, considered universal by him, such as: 1) the recognition or not of the content of truth by the group in the statements set forth by a determined social actor; 2) the necessities of adequacy of these truths to behavior norms inherent to involved cultures; and 3) recognition, by the group, of truthfulness and authenticity of the one who sets forth the argument.

Even if real application of an ethics theory to dialogue spaces opened around health care still requires many efforts with high level of complexity, it does not seem that there is another way to ethically base an inter-cultural decision about ethical conflicts of assistance practices other than free dialogue among those involved with the actions to be implemented.

Final considerations

There is almost a consensus regarding beliefs, diversity of world views and the traditional practices of self-attention are stands considered as ethically correct in the relationships established by health professionals and their patients, independently of being an inter-ethnical relationship – precisely the kind of relationship that has been least discussed within clinical bioethics scope. The cultural diversity represented by the large quantity of indigenous peoples in Brazil offers a very interesting context to reflect on the buildup of a clinical bioethics capable to work in the inter-ethnic relationships promoted by public policies that aim to ensure the supply of Western health goods and services to historically excluded traditional communities.

The indigenous peoples were taken herein as object of this reflection, but it applies to other communities established by historical-cultural identity tiés, such as, for example, the '*quilombolas*' (descendants from runaway slaves) communities, carriers of traditional health systems enclosed in religious and cosmological references of '*candomble*'. Similarly, other health care actions promoted by other health policies (either state or international agencies) that seek for the extension of health care to other traditional communities in Latin America, Africa, and Asia, would benefit from a clinical bioethics based in mastering of basic notions of health anthropology and of a ethics theory replacing principles preset by training in argumentation practices targeted to inter-cultural buildup of values and in inter-ethnically shared decision making.

If in the field of control of new technologies and of collective health the Latin American and Brazilian bioethics have been acknowledged as producers of theoretical trends that target their reflection and proposition for the ethical conflicts that emerge from the historically determined social injustice, they seem to be fit to take the first steps toward building up a clinical bioethics with greater capability of solving inter-ethnical ethics conflicts regarding health care as well.

In the specific case of Brazil, the need of internalizing health care to locations where geographic barriers to access are more stressed, it is a problem that SUS has faced in past 20 years, and for which the formulation of public policies will need to provide concrete answer in coming years, under the threat that principles in which the system is based, such as those from the university and integrality, remain definitively committed.

It is necessary, therefore, a very large practical effort to set specific coursed within the perspective outlined in this article, aiming at better training professionals formed by the old models of health education, such as set forth by Pnasi itself. Notwithstanding, it is necessary to highlight that the future of a proposal from such order only materializes with a deep curricular reform in undergraduate level, in which bioethical contents interlinked to health anthropology contents may be transmitted from practical experiences supplied to students. The paths for pedagogical buildup of this proposal extrapolate the objectives of present article. What matters is that this differentiated training and the opening of these inter-ethnical dialogue spaces on health care are not seen as utopia, but rather as a new paradigm for professional education.

Resumo

Desafio para uma bioética clínica interétnica: reflexões a partir da política nacional de saúde indígena

O artigo analisa os desafios para a construção de uma bioética clínica com possibilidade de atuação em contextos interculturais e/ou interétnicos, tomando como objeto as relações estabelecidas entre profissionais de saúde e pacientes membros das comunidades indígenas em torno da implantação da Política Nacional de Atenção à Saúde dos Povos Indígenas. No plano teórico são propostas duas vias para esta construção: uma de conteúdo antropológico centrada em noções fundamentais de Antropologia da Saúde; outra de filosofia moral centrada na teoria da ação comunicativa e na ética da discussão de Habermas. No plano prático, são propostos cursos de especialização contemplando os conteúdos teóricos defendidos e uma urgente reforma curricular dos cursos de graduação na área da saúde.

Palavras-chave: Bioética. Saúde indígena. Antropologia. Política de saúde. Cultura

Resumen

Desafíos para una bioética clínica interétnica: reflexiones a partir de la política nacional de salud indígena

El artículo analiza los desafíos para la construcción de una bioética clínica con posibilidad de actuación en contextos interculturales y/o interétnicos, tomando como objeto las relaciones establecidas entre profesionales de salud y pacientes miembros de las comunidades indígenas en torno de la implantación de la Política Nacional de Atención a la Salud de los Pueblos Indígenas. En el plano teórico son propuestas dos vías para esta construcción: una vía de contenido antropológico centrada en nociones fundamentales de Antropología de la Salud y una vía en filosofía moral centrada en la Teoría de la Acción Comunicativa y en la Ética de la Discusión de Habermas. En el plano práctico, son propuestos cursos de especialización contemplando los contenidos teóricos defendidos y una urgente reforma curricular de los cursos de graduación en la área de la salud.

Palabras-clave: Bioética. Salud indígena. Antropologia. Política de salud. Cultura.

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