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Bioethics and interculturality in indigenous health care

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Abstract

This article points out sociocultural, theoretical and legal aspects for intercultural bioethics in health care for Indigenous peoples in Brazil. From a perspective that seeks to build bioethical practices suitable for encounters between cultures, the text argues that focusing on soft health technologies can help overcome the difficulties found in a context permeated by coloniality and structural racism. A few experiences of intercultural bioethical practice are presented in the article. Despite referring to the Brazilian context, such experiences can be applied in other scenarios where different cultures meet.

Keywords: Bioethics. Culture. Culturally competent care. Health of indigenous peoples. Public health.

Resumo

Bioética e interculturalidade na atenção à saúde indígena

Este artigo aponta aspectos socioculturais, teóricos e jurídicos para uma bioética intercultural na atenção à saúde dos povos indígenas do Brasil. A partir de uma perspectiva que busca construir práticas bioéticas adequadas aos encontros entre culturas, o texto argumenta que o foco em tecnologias leves de saúde pode ser um caminho para superar as dificuldades encontradas em um contexto permeado pela colonialidade e o racismo estrutural. Algumas experiências de prática bioética intercultural são apresentadas no artigo. Essas experiências, apesar de se referirem ao contexto brasileiro, podem ser aplicadas em outros cenários de encontro entre diferentes culturas.

Palavras-chave: Bioética. Cultura. Assistência à saúde culturalmente competente. Saúde de populações indígenas. Saúde pública.

Resumen

Bioética e interculturalidad en la atención de salud indígena

Este artículo señala aspectos socioculturales, teóricos y legales para una Bioética intercultural en la atención a la salud de los pueblos indígenas de Brasil. Desde una perspectiva que busca construir prácticas bioéticas adecuadas para el encuentro entre culturas, el texto sostiene que el enfoque en tecnologías blandas de salud puede ser una forma de superar las dificultades encontradas en un contexto permeado por la colonialidad y el racismo estructural. Algunas experiencias de práctica bioética presentados neste artículo, aunque sean del contexto indígena brasileño, pueden ser aplicadas a otros contextos de encuentros culturales.

Palabras clave: Bioética. Cultura. Asistencia sanitaria culturalmente competente. Salud de poblaciones indígenas. Salud pública.

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In the intense encounter between cultures experienced in the 21st century, building a theoretical framework and an intercultural medical practice is one of the challenges of bioethics [1,2]. Currently, the encounter between cultures occurs on an even broader and faster level, increasing the creative possibilities and answers to questions that afflict human beings. In health care, bioethics is a key element to establish aggregating relationships between different paths and tackle issues involving health and disease.

This article points out sociocultural and legal aspects that have enabled experiences of intercultural bioethics in health care for Indigenous peoples. The study, which emphasizes cultural issues and is supported by soft health technologies [3], cites perspectives for overcoming obstacles to bioethical practice in contexts permeated by coloniality and structural racism [4-6]. In this respect, the focus falls on implementing intercultural bioethical practices, without neglecting or attributing less importance to the barriers that actually exist [5-8].

Assuming bioethics as a theoretical and practical field that emerges within biomedicine [2,9,10], we will discuss four facilitating aspects of intercultural bioethical practice. First is the dynamic characteristic of culture, further enhanced by intercultural encounters [11]. The second aspect concerns the fact that, despite ontological diversity, there are always possibilities for intercultural dialogue at the pragmatic level [12-14]. The third aspect refers to an impulse that leads members of a collectivity to go beyond the limits imposed by culture itself, questioning ethical principles and established behavioral norms [13]. The fourth and final aspect concerns the structure, organization and culture of modern society, in which social interactions occur displaced in time and space, without the need for people to master everything that the moment involves [15,16]. This non-mastery space allows for the opening of dialogue between medical systems, without biomedicine needing to fully understand other systems.

By reflecting on the health care of Indigenous peoples in Brazil, we will highlight sociocultural aspects that allow for creating and strengthening dialogues between different views on the body and the health-disease process. Another way of understanding this diversity of views, beyond biomedicine, is to observe how soft technologies value elements that escape prevailing perspectives in the health sciences.

Sociocultural bases for intercultural bioethics

Even in a context of health actions permeated by coloniality and structural racism, whether by direct or subtle imposition of biomedicine over Indigenous medical practices [6], or by the lesser attention given to Indigenous and Black communities [5], one can observe experiences of intercultural bioethical practice, situated at a more elementary level of social interactions.

The term "coloniality" refers to the process of domination of mentalities in which non-Eurocentric references are considered inferior and dispensable for humanity's development [4]. Begun in the colonial period, this process continued with the independence of the colonies, and we can feel its effects to this day. In the health field, for example, coloniality reduces non-biomedical medical practices to beliefs, and its specialists to sorcerers or charlatans. In the case of Indigenous medical practices, the words "shamanism," "witchcraft," "shaman" and "witchdoctor" shows the place these medical systems occupy in the Western world [17].

Structural racism involves two movements. The first concerns the Eurocentric basis of Western medicine's conceptions of the body and health-disease process. Thus, some diseases that, for sociocultural or genetic reasons, specifically or more intensely affect Indigenous populations or African descendants have not received due attention, resulting in the exclusion of these groups from healthcare [5].

Paradoxically, the second movement refers to the fact that health actions, if they consider these particularities, are accused of racializing Brazilian society, even though medicine already considers other diversities, such as gender (men's and women's health) or age group (older adults and child health) [5]. Based on these two movements, racism undermines the already scant attention that Indigenous and Black people receive from the health system and its professionals [18].

In the context of interaction between cultures, the concept of interculturality stands out:

In the field of Indigenous health, the notion of interculturality is generally used to characterize the contexts of care, relationships and communicative processes established in the contact between two different cultures – the Indigenous one and the Western one [19].

In general, authors differentiate critical interculturality from functional interculturality [6,7,20]. While the former questions structural aspects that underlie the domination, exclusion and erasure of diversity, the latter seeks rearrangements that emphasize coexistence in the midst of diversity within the current sociopolitical context. Thus, while the critical perspective questions the current society, laying bare coloniality, its effects and its relations with other ideologies, the functional perspective, based on multiculturalism, does not question the origin of coloniality and the relationships it establishes with other ideologies [6,20].

In this article, we critically reflect on experiences of intercultural bioethics in Indigenous health care, considering the unfavorable conditions imposed by the social, political and cultural context.

Cultural dialogue at the pragmatic level

Instead of understanding culture as a totality closed in on itself, with its own logic and unintelligible to another culture, which would render intercultural dialogue impossible [12], anthropology – and especially the French school [21-23] – points to the possibility of communication and intelligibility across cultures, given the universality of categories of understanding or collective representations (time, space, causality, totality, etc.) through which the human mind apprehends the world.

From this perspective, the same structural working scheme, shared by all of humanity, would be expressed differently in each human grouping: *Lévi-Strauss's structural relativism emphasizes the unity and mutual intelligibility of human cultures* – as *long as we look at the different cultural systems as transformations that operate according to universal mental principles* [24]. Insofar as it assumes the existence of human unity, this structural relativism thus affirms the possibility of dialogue between cultures.

Although different cultures may diverge on explanations about things or ethical and moral values (that is, on their ontologies), in certain situations these cultures can dialogue at a pragmatic level, for they want the same result, even if they use different ways to achieve it. It is, therefore, in the existence of *"pragmatic principles of reason" in all of humanity* [25] that lies the key to intercultural dialogue, that is, the possibility that worlds can dialogue without one being reduced to the other. After all, there is a universal human capacity to move from one world to another, and *through this capacity we can, so to speak, mold one ontology inside the other and make it intelligible even without believing what the other says* [25].

Cultural systems are based on "truths" that gain effectiveness in the pragmatic sphere; thus, different world systems can agree on certain pragmatic consequences of their postulates, without there being a correspondence between these postulates or between the respective worldviews [26]. In the health field, for example, many cultural particularities concerning the health-disease process exists, but all medical systems aim, at the pragmatic level, to restore health and reduce discomfort [27,28], even if to achieve such objective they resort to different methods [17].

Culture under continuous construction

Despite the varied theoretical perspectives, it can be said that "culture" corresponds to a set of meanings shared by individuals in a collectivity. Such meanings are attributed to the things that make up the reality perceived by these individuals through bodily senses (sight, hearing, touch, taste, smell) and ideas. An inherent characteristic of every cultural system is that it organizes the world and makes it intelligible to the community, allowing the community to express it through individual thinking and actions [11,29,30].

Another inherent characteristic to every culture is the dynamics of transformation, which does not depend on the encounter with other systems. A cultural system, as something that is not frozen in time and space but transformed with and by history, is only effective when it continues to organize the world and make it intelligible [29,31]. If meanings lose their ability

to help understand an event (which can be generated internally or by an external agent, such as a phenomenon of nature or another culture, etc.), the collectivity reworks these meanings to recover the effectiveness of the cultural system [29].

As Lévi-Strauss notes, except for very short periods, *human societies have never been isolated* [32]. For him, the encounter between cultures contributes to the dynamics of transformation, diversifying both the possibilities of responding to empirical situations and the questionings themselves.

Following this path, we can recognize three moments of the cultural encounter: curiosity for others (knowing, understanding and learning); review or strengthening of one's own certainties; and singularization by the production of differences, resulting in cultural diversity. The dynamics of internal transformation and its potentiation by the encounter lead to the improvement and sophistication of some dimensions of human life.

Some cultures are more geared towards the transformation of their environment by technology, others by spirituality, others by kinship systems and social organization, others by relationships with nature, and so on [11,21]. As such, it makes little sense to claim that some cultures are more advanced than others, because each of them has become more sophisticated in one direction, and hierarchization can only correspond to a particular point of view, which elects a specific aspect to inform the comparison.

Another characteristic of culture, complementary to that pointed out by Lévi-Strauss, is noted by Santos [14], for whom every culture is unfinished or imperfect. Such incompleteness, however, *is not visible from within this culture, as the aspiration to totality leads to taking the part for the whole* [33]. In this regard, the author uses the concept of "diatopical hermeneutics" to understand intercultural encounters, which *maximize the awareness of mutual incompleteness through a dialogue that unfolds, so to speak, with one foot in one culture and the other foot in another* [33]. Although completeness can never be achieved, recognizing the existence of gaps in the cultural system opens up possibilities for intercultural dialogue, through which new knowledge is collectively construed.

Ethical drive and trust in the unknown

It is agreed that human beings need to undergo socialization processes to learn behavioral rules and gain recognition as members of a collectivity. The ethical drive [13], however, takes human beings beyond this standardization imposed by culture, which can be called *paranature, that is, a second nature or non-biological, parabiological programming, implanted in us through the process of socialization and coincident, therefore, with our own humanity* [34].

The ethical drive, present in all cultures, results from the incompleteness and inconsistencies of the cultural system itself. Awareness of these incompleteness and inconsistencies encourages some members of a community to seek other paths and solutions to the challenges posed by reality. Thus emerges *the drive that feeds us the desire to distrust our beliefs and listen to what the other has to teach us – a constitutive drive not only of ethical aspiration, but also of cognitive availability* [35].

The ethical drive moves towards the uncertain because it moves towards a world where cultural "truths" may not guarantee the order of things. In the health field, for instance, as the Western medical system is based on Newtonian materiality [27], the ethical drive can lead to the search for therapies not recognized by biomedicine, such as those classified as alternative and complementary medicine, based on elements that transcend materialist perspectives [36].

Differently from this drive that leads us to question culture itself, in modern society, trust in previous experiences is a key element to act in situations where one does not have control over everything [15]. Sophistication, centrality and scientific dependence have displaced social relations from the time and space in which they occur [15,16]. If, in a pre-modern society, time was the present, and space was where the present was experienced, we currently relate to people who are not present here and now, but who direct our actions (over the phone, for example, or other technologies).

We spend the day inside houses that we do not know how to build, part of our communication takes place through devices we have no idea how they work or how they are produced, and we travel in vehicles whose mechanisms we do not

know. Even so, we are reassured and believe that everything is under control: we are confident that the room will not fall on us, that our voice will be heard on the other end of the line, and that the car will run as expected.

The key aspect of everyday relationships in the contemporary world is the trust we devote to things. Although not absolute, such trust is based on previous results observed through experience or science, without the need to know the mechanisms that lead to the expected result. Trust has as its objects the mechanism itself (electricity, for example), the knowledge that underlies it, and the person who built it (e.g., an engineer). Trust, therefore, has replaced the spatiotemporal presence in relationships, organizing and making things and processes intelligible [15].

In medicine, this occurs on many levels and in different ways. Regarding tests, for example, from the simplest to the most complex, physicians have no control over the construction and operation of instruments (x-ray, ultrasound, etc.), nor do they know how the software that allows the use of these equipment is developed. Physicians are not interested in knowing the mechanisms of machines that enable and guide their action, but just be sure that they are working correctly, without harming the result of the intervention.

Legal aspects for intercultural bioethics in health care for Indigenous peoples

Established in 1990, the Brazilian Unified Health System (SUS) offers free health services to the entire Brazilian population [37]. At least in legislation, this system considers the specificity of Indigenous cultures (a result of demands by Indigenous movements that found support in the system's principle of equity). Thus, the Brazilian State has legal-administrative devices and strategies in place to meet the demands of native peoples.

A specific chapter for Indigenous peoples was included in the SUS legislation in 1999, obliging health care to consider the reality and cultural specificities of these peoples. The text provides *a differentiated and global approach, covering aspects of health care, basic sanitation, nutrition, housing, environment, land demarcation, health education and institutional integration* [38].

Currently, Indigenous health care is organized by the National Policy Indigenous Peoples' Health Care (Pnaspi) [39], whose implementation responsibility falls to the Special Secretariat for Indigenous Health (Sesai), directly linked to the Ministry of Health [40]. Result of political clashes between Indigenous movements and the Brazilian State, Pnaspi is a detailing of the chapter on Indigenous health in SUS. This policy reaffirms a complementary and differentiated model of service organization – *aimed at the promotion, protection and recovery of health* [40] –, aims to ensure the recognition of Indigenous citizenship within SUS, details the organization of the service network in Indigenous lands, seeking to bring the service closer to the communities, and works on the acceptance of the health system in this population.

For the Pnaspi strategy to be effective, a special action is needed that considers cultural particularities and different realities of each nation (geographical, historical and political), using *appropriate technologies by adapting conventional Western forms of service organization* [41]. Accordingly, this special service network has as its pillar the Special Indigenous Sanitary Districts (Disei), which today total 34 units across the country, operating in rural and urban contexts. Each district organizes a network of services that covers all levels of complexity and is articulated with SUS care units that are not exclusively focused on Indigenous peoples. The Disei framework includes professionals from various areas of health, as well as anthropologists and educators, who form multidisciplinary teams [39].

Important figures in Disei are Indigenous health agents and nurses, who work in health posts located in Indigenous lands. Besides these professionals, community service is carried out by a multidisciplinary team that periodically visits the villages and works at health posts.

The system of care for native peoples also has base centers that are usually located in municipalities close to villages, within basic health units aimed at serving not only Indigenous people, but the entire local population. Depending on the degree of complexity, care is provided in a SUS service unit, base center or not.

Pnaspi establishes that, at all levels of complexity, one should encourage care that considers *dietary restrictions/prescriptions*, *monitoring by relatives and/or an interpreter*, *visits by traditional therapists*, *installation of hammocks*, *among others*[42]. Another service instance is the Indigenous Health Houses (Casai), which provide support to Indigenous people who leave their villages and go to the city for treatment at basic health units or at Casai itself.

In the scope of less complex care, in many regions Sesai establishes partnerships with non-governmental organizations, Indigenous or not, which are responsible for the care through the transfer of financial resources from the State.

Pnaspi points out that one must recognize the effectiveness of Indigenous medicine and the right of these peoples to their culture. Following the World Health Organization's (WHO) definitions, the policy reserves a specific topic for articulating the national health system with traditional knowledge, recognizing that every human society builds its own understanding of the health-disease process.

Pnaspi draws attention to the fact that *the improvement of the health status of Indigenous peoples does not occur by simply transferring biomedical knowledge and technologies to them*, *considering them as passive recipients*, *lacking in knowledge and practices related to the health-disease process*[43]. Articulation with traditional forms of knowledge, such as Indigenous knowledge of ethnobotany and pharmacopoeia, *should be encouraged to improve the health status of Indigenous peoples*[44].

Pnapsi's intercultural characteristic has already been analyzed by Lorenzo[45] and Ferreira[6], among others. But it should be noted that, despite the legislation, in practice many professionals, or even the health system itself, perpetuate prejudice and exclusion, albeit unintentionally, making the practice of a truly intercultural health care unfeasible[6]. Even because there is little space in academic biomedical education to discuss sociocultural aspects and their relationship with health-disease processes[45,46].

Health care for native peoples cannot be seen only from a technical-administrative perspective. We must consider how Brazilian society perceives these peoples and the specificities of different Indigenous realities.

Soft technologies in intercultural bioethical practice

Another important mechanism is the *Universal Declaration on Bioethics and Human Rights* (UDBHR)[47], whose proposals contribute to an effectively intercultural bioethical practice. Concerning decision-making, article 18 of the UDBHR establishes that *every endeavor should be made to use the best available scientific knowledge and methodology in addressing and periodically reviewing bioethical issues*[47].

Without entering into discussions about moral imperialism[1,2,8-10,48,49] or about intervention bioethics[50], we emphasize here the relationship between bioethics and humanization of medicine[51], understood as care that respects the patient's dignity by focusing not on the disease, but on the individual who is ill. This means that the humanization of medicine proposed by bioethics does not pay attention *exclusively to the technique*, *procedures or medications*, *but to those and human relationships involved in the medical act*[52].

In this sense, it is important to consider the multi, inter and transdisciplinary character of bioethics[51]. By aiming at the humanization of medicine, bioethics emerges as a *multidisciplinary* discipline, involving professionals from different areas. When these professionals share their knowledge and appreciations about the patient, considering a wide range of reflections, the approach can be considered *interdisciplinary*. Finally, bioethics can be *transdisciplinary* when the therapeutic process is guided not by juxtaposing knowledge from different disciplines, but by a creative perspective that goes beyond the limits of each specific knowledge involved.

To support care in intercultural contexts, and given the impossibility of fully using the patient's primary/native medical system, we propose that, by considering the use of the best scientific knowledge and methodologies available, as recommended by UDBHR, soft technologies can be as relevant as hard or soft-hard technologies[3].

Merhy[3] classifies health technologies into three types: soft, which build human relationships of attachment, trust, embracement, empowerment, autonomy and understanding of the patient's afflictions and points of view; soft-hard, which are

already structured procedures of health work, such as the medical clinic or, according to our understanding, herbal medicine practices or other traditional healing techniques used by Indigenous peoples; and hard, materialized in the technological equipment for tests and more invasive procedures.

These definitions, widely used by Brazilian researchers, provide the basis for health policies and actions, such as the SUS National Humanization Policy (HumanizaSUS)[53], which emphasizes the inclusion of soft technologies in the system. Such policy follows WHO's definition of health by highlighting the importance of elements that go beyond biomedical aspects of the body and the health-disease process[54].

Soft technologies enable dialogue between those involved in care, seeking to understand how social interactions occur and how communities conceive reality and relate to it. Such technologies, therefore, play a key role in intercultural bioethical practice. And if, as advocated by the UDBHR, it is the patient's right to access the most advanced scientific knowledge, health systems cannot turn a blind eye to what these tools propose, especially in a context of intense cultural encounter[10,55]. Pnaspi itself is an example of a public policy that manages to highlight the knowledge produced by soft technologies.

Intercultural bioethical practices in the care of Indigenous peoples

Let us look at three examples that can serve as initial inspiration for bioethical practices in contexts of cultural encounters. These examples show the importance of soft technologies and intercultural dialogue at the pragmatic level, without the need for mutual understanding to be integral.

The first experience took place in São Miguel das Missões, municipality of Rio Grande do Sul. In 2011, after a request from the Guarani Mbyá people, the Federal Public Ministry brokered an agreement between the *São Miguel Arcanjo Hospital Association and the "Tekoa Koenjú" community so that the health professional and the community representative can work in harmony*[56].

A hospital wing was set aside for the care of Indigenous people. There, after the doctors examine the patient and carry out the treatment according to conventional medicine, the shaman can intervene with therapies specific to the Guarani Mbyá medical system: *if the shaman wishes, healing rituals can be performed with a pipe, prayers and herbs. The idea is that, through the union of medicine and faith, the patient's recovery occurs fully*[56].

The second experience, already explored in other articles[17,45,57], took place in Manaus, capital of the state of Amazonas. This experience articulated medical knowledge to restore the health of a Tukano girl bitten by a snake and taken from her village to a hospital in the city. After a few days in the hospital, the girl's relatives took her from the hospital because they disagreed with the biomedical treatment (which included amputating her leg) and the hospital management's refusal to help in the treatment with *bahese and medicinal herbs*. These traditional procedures *did not exclude medical treatment, which should continue, but without amputation*[58].

Amidst accusations that the girl's relatives were hindering medical treatment, threats to report the case to the Child Protective Services, and prosecution by the Indigenous people, the director of another hospital – the Getúlio Vargas University Hospital – offered the opportunity for joint treatment, with both biomedical and Indigenous procedures. Once the invitation was accepted, after some time, the girl recovered and returned to her village.

This event brings us to the third experience. One of the cured girl's relatives is Tukano anthropologist João Paulo Barreto. After actively participating in this process, João Paulo created a space where health care is provided by Indigenous healers: the Bahserikowi'i (also known as the Amazon Indigenous Medicine Center), founded in the city of Manaus in 2017.

The Bahserikowi'i offers service provided by Tuyuka, Tukano and Dessana healers based on Indigenous medical systems. The center is also a space for training Indigenous healers in traditional knowledge and techniques, ensuring that new generations of specialists continue their work in the urban area[59,60]. Despite being conceived with native peoples in mind, most of those assisted

in Bahserikowi'i are not Indigenous [61], probably because the center is located in the city.

João Paulo Barreto emphasizes that the goal is not to question the official health care model, but to offer other therapeutic paths. Thus, *the Indigenous Medicine Center is one more option, a channel that enables the public to choose treatment through Indigenous technologies based on parameters other than those of Western medicine* [62].

Indigenous medical systems assume that, like them, conventional medicine also has limitations. As cacique Ariel Ortega explains, *when we have a fever, the flu and other illnesses, we go to the hospital, but the white man takes care of the body, we of the soul* [56]. Such statement shows that Indigenous peoples recognize Western medicine, but also recognize the effectiveness and importance of their own medical practices, and are open to integrating medical interventions aimed at restoring health.

Professionals who care for Indigenous patients should pay attention to the fact that, as João Paulo Barreto points out, *Indigenous conceptions of disease and health are not restricted to the biological aspect. This is the point. Rather, they involve cosmopolitical aspects that condition the practice of good health. It leaves the narrow understanding of something biological and connects the individual in a web of relationships with other beings, with the waimahsã, with animals, with specialists, with their relatives and other people* [63].

In the Terena people's medical system, for example, the healer's diagnosis includes how the disease should be treated. Some illnesses are treated by traditional means (herbal, spiritual) and others by conventional medicine. For others, still, it is necessary to combine traditional and Western methods.

The creation of a hospital wing for therapeutic action by Indigenous specialists and the juxtaposition of Indigenous treatments to those provided for by biomedicine are experiences in which intercultural dialogue takes place within the Western health system. In it takes place a type of transdisciplinary intercultural bioethical practice that goes beyond the disciplines consecrated by science, recognizing the possibility of efficacy of Indigenous traditional treatments that go beyond materiality as the origin of the disease [5,17], acting as collaborators in biomedical procedures.

In the second example presented here, biomedical therapy – which indicated limb amputation to prevent major illnesses – was modified by considering Indigenous knowledge. Although the concession was due to the specificity of the case (involving a snake bite, a situation that Indigenous people have been dealing with for a long time), we must acknowledge that health professionals sought to humanize the care by including other perspectives.

The third example reports an interesting case of intercultural encounter in which the Indigenous medical system is an attractive and contact element. At Bahserikowi'i there is no type of direct or indirect imposition for non-Indigenous people to decide to include Indigenous knowledge in their therapeutic itinerary. An in-depth analysis of the mechanisms that lead these people (about 99% of the public, according to João Paulo Barreto [61]) to seek the Indigenous Medicine Center would, therefore, be necessary. Based on the sociocultural aspects discussed here, however, we may suggest that the reasons for this search include openness to the Other and the ethical drive.

Difficulties with intercultural experiences in health refer to coloniality and structural racism – social, political and cultural conditions that create obstacles to intercultural bioethics. Our hypothesis is that the experiences presented here overcome such obstacles because they are situated at a more elementary level of human and social interactions.

In all three experiences, the ethical drive, which encourages to go beyond the safety of thought and behavior patterns of one's own culture, leads professionals and patients to consider the possibility that their knowledge is incomplete and to bet on new experiences and knowledge. This bet on the Indigenous medical system can be compared to the bet we make when we allow ourselves to be guided by unknown processes that, for example, provide us with diagnoses through tests.

The difference lies in the depth of uncertainty, for although we ignore how tests are processed, hard technologies follow scientific principles that are part of Western culture, reason why we are accustomed to relying on these technologies. Confidence in Indigenous therapies, on the other hand, requires a greater effort of detachment and support from the

premise that medical systems aim to recover the sick. This deeper bet stems from the ethical drive [13].

The dynamic character of culture and pragmatic dialogue open possibilities for intercultural bioethical contacts that are not restricted to illnesses and physiological processes. Humanizing, these contacts value important sociocultural elements in the therapeutic path. This is especially evident in the first two experiences, in which Indigenous therapies work side by side with biomedical therapies. In these processes, soft technologies are fundamental, as they seek to understand aspects that, despite escaping biomedical understanding, contribute to restoring individual and collective health.

Although they can serve as examples, the experiences described here have particular characteristics, and each context must be treated as unique. It should also be noted that these experiences may have limitations and be object of criticism. We chose to present them, however, for we believe them to be a good starting point for reflecting on intercultural bioethics.

Final considerations

This article highlights four sociocultural aspects that provide the basis for intercultural bioethics: the dynamic character of culture; the possibility of intercultural dialogue at the pragmatic level; the ethical drive that urges us to go beyond our own culture and everyday action; and trust in the unknown, without mastering all the variables involved. Despite elements that may make bioethical practice in intercultural contexts difficult or impossible, these four aspects open up possibilities for encounters.

We emphasize the importance of soft technologies for building this intercultural bioethical practice, for they bring elements that escape the positivist analysis prevalent in health sciences. If, on the one hand, biomedicine details and allows us to understand the functioning of human physiology through hard technologies, on the other, soft technologies can help us to understand elements of the health-disease process that exists outside the materiality of the patient's body. After all, this process also depends on the relationships that patients establish with their surroundings (family, society, environment, spirituality, behavior, food, work). Combined, soft and hard technologies can ensure better results in restoring health or mitigate discomforts caused by illness.

As for the Brazilian public health system, soft technologies are already recognized as essential in serving Indigenous peoples. Although our reflection focuses on the Brazilian Indigenous universe, we believe that this recognition can be applied to other contexts of cultural encounters.

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