Clinic, care and subjectivity: after all, what kind of care are we talking about?

Clínica, cuidado e subjetividade: afinal, de que cuidado estamos falando?

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ABSTRACT This essay discusses the clinical decision-making process and health care, based on the recognition that the human organism is inhabited by an affective body and by an anatomo-clinical body. The therapeutic process requires that these two dimensions be contemplated for health care. The care is not only about organ dysfunction or injury, it must contemplate the whole existence of a person, because he/she is a complex being, who, in addition to his/her most objectively identified health problem, brings his/her life story, filled with expectations, desires, relationships of affection, family and social, produced in a given environment. The authors used cartography, that is, a look based on processes and various factors that produced the issues that are the focus of analysis. The assumption is that the user must be the protagonist of their therapeutic project. It is these issues that are being debated in the text that concludes the need to consider them in a movement of renewal of knowledge and clinical practices for a more comprehensive approach to body and health care.

KEYWORDS Clinic. Primary Health Care. Care.

RESUMO *Este ensaio procura discutir o processo de decisão clínica e o cuidado em saúde, a partir do reconhecimento de que o organismo humano é habitado por um corpo afetivo e por um corpo anátomo-clínico. O processo terapêutico requer que essas duas dimensões sejam contempladas para o cuidado em saúde. O cuidado não se faz apenas sobre a disfunção ou lesão dos órgãos, ele deve contemplar toda a existência de uma pessoa, porque ela é um ser complexo, que, além do seu problema de saúde mais objetivamente identificado, traz sua história de vida, recheada de expectativas, desejos, relações de afeto, familiares e sociais, produzidas em determinado meio. Os autores lançaram mão da cartografia, ou seja, um olhar com base nos processos e diversos fatores que produziram as questões que estão no foco de análise. O pressuposto é que o usuário deve ser o protagonista do seu projeto terapêutico. São estas questões que estão sendo debatidas no texto que conclui pela necessidade de considerá-las em um movimento de renovação dos saberes e práticas clínicas para uma abordagem mais integral do corpo e do cuidado em saúde.*

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Introduction

This text aims to discuss, in a test format, health care focusing on the work of the doctor in the course of the clinical practice in primary care. Product of a research in health network in a city of Rio de Janeiro state, it focuses on the parameters of clinical practice and the values in its exercise, looking at the relations between worker and user. More specifically, it reflects on the act of caring based on the practice of home visiting, which brings the worker closer to the reality of the user, as he/she is faced with his/her life context, home and family relationships, environment, situation socioeconomic status and their ways of life. Thus, it verifies the existence of the person as a set to be observed, inserted in a certain context, and this complexity is the focus of his/her performance, considering that his/her action is not isolated, or unidirectional, but shared with the user and with all put in the care scene. In this sense, the text questions the work that focuses on the care directed only on body dysfunction, or the injury of any organ as its object. Care is the art of producing power in the other, under any circumstance, and, for this purpose, aims to operate on the whole of your organism, considering beyond the biological body what Deleuze called the body without organs, that is, affective[1].

This is possibly the greatest challenge for work and health care, the adjustment of the practices of a health worker or team, for the practice of the clinic in its complexity, beyond the protocols, considering the one who seeks us as a human being with stories, values, expectations, desires, social and affective relationships. This means a break with the clinic's conventional mode of exercise, only as an instrument for acting on the anatomo-clinical body. This is how Foucault[2] will record in his studies about the birth of the clinic, that it is born from the look on the body, discovering its shapes, the colors, the texture of the organs, a unique discovery about the biological mass that makes up this body.

This practice is hegemonic in the field of doing and knowing, with obvious repercussions in every health professional training system. The same references of this clinical practice were established in schools, primary care and hospitals. This logic is hegemonized with the affirmation of the paradigm of Scientific or Flexnerian Medicine, which refers to the model of clinical practice thought from the report of Abraham Flexner, published in the USA in 1910, which evaluated the American medical teaching and suggested its reform to a model focused on biological research, which guided from this episode the work of professionals in the clinic. That clinic founded under the anatomical-clinical body concept formulates the conceptual theoretical set that is based on the scientific method, seeing the body only as a machine, capable of intervention in each part of it, by specialists from the parts of this complex human body (clinic of the body of organs). However, it is not about this clinic that considers only this anatomical-clinical body that we want to reflect on.

Some authors in the field of public health discuss the fact that, in the western world, through the medicalization and disciplinarization of life; health practices were constituted in such a way that scientific knowledge and biological explanation were hegemonic as the sole explanation for human suffering, constituted from certain places of power, totally removing from people the possibility of taking care of their own health, disregarding subjectivity and uniqueness in the ways of leading the life of those who access services[3].

In health, in general, when we talk about care, the term is given a sense already consecrated in common sense, that is, a set of procedures technically oriented towards the success of a certain treatment, which is

dictated by professionals for the 'patients' who come to them in the services.

However, care for us is not just a set of resources, therapeutic measures and procedures that allow the implementation of a Therapeutic Project. It's more than that. Caring demands the use of various types of technologies in the scope of health services, and, when considering the existence of the person in the world, requires thinking about the environment, the daily stressors to which the user is subjected, family and community relations. Any analysis, therefore, must be multidimensional, taking the experience of living as the focus of risk analysis and the care plan to be implemented.

Ayres considers care

> [...] as a philosophical construct, a category with which one wants to designate simultaneously, a philosophical understanding and a practical attitude towards the meaning that health actions acquire in different situations between two or more subjects[4(74)].

He tells us of the already relatively well-known positive and negative effects of the transformations of contemporary medicine toward progressive scientificity and technological sophistication. Starting from a hypothetical proposition about this question, he states that the current crisis of legitimacy in the forms of health care organization may be due to the fact that medical therapy was losing its interest in life, losing the link between its technical procedures and its contexts and practical purposes that originate and justify them, that is, the production of life.

Merhy[5-7] brings us another important reflections on care, and he advocates the idea that care is the product of health work; and as such, it has an immanent technological dimension. According to the author, the core of care production is in the work process and its technologies. It classifies technologies as hard, light-hard, and light, considering their application to machinery and instruments, technical knowledge, and relationships respectively. As relationships concern the subjectivity inscribed in the worker who operates the care technologies, whether individual or collective, we can infer that the production of care is dependent on the act of the worker and, as such, has the relevance of living work. This is the great asset of care, and in which its extraordinary instituting power dwells.

Living work brings possible instituting agencies, precisely because its main attribute is freedom; because it is a work at its exact moment of creation and production, the decision about the work process, in act, is the worker's own relationship with the user. Thus, it is observed in this scenario the self-managed exercise of work, placing a range of possibilities in the conduct of the therapeutic project that will also be in the order of the desire of the worker in his relationship with the user.

Generally, when a health professional thinks about care, the immediate application of technologies for the physical and mental well-being of people comes to mind. In general, science produces knowledge about diseases, technology transforms this learning into knowledge and tools for intervention, health professionals apply these knowledge and tools, and health is produced, without considering what this user feels or desires, who often don't even allow himself/herself to desire.

> We need to be clear that not everything that is important to well-being can be immediately translated and operated as technical knowledge. We should be aware of the fact that almost never, when we watch other people's health, our presence in front of the other comes down to the role of simple knowledge applicator[4(84)].

Technology is not just the application of science, it is not simply a way of doing, but it is also, as such, a decision about what things can and should be done, therefore,

> [...] We have to think that we, health professionals, are building mediations, choosing within certain possibilities what we should want, be and do those we assist – and ourselves[10(86)].

> 'Caring is to meet the other to accompany him, and together promote and foster a good life for all' [...] is an ethical proposal that is not limited to the enunciation of rules; rather its ideal is a relationship activity[8(122)].

Care as an ethical proposal, and not as an isolated act of care or health care, refers to the attitude, way of being, the way a person founds and builds his/her relationships with things, with others, with the world and with himself/herself. This attitude is one of occupation, concern, radical accountability, sensitivity to human experience and recognition of the reality of the other, as a person and as a subject, in their uniqueness. It is not a matter of disregarding the fact that when someone seeks a health service, he/she is in demand and therefore a potential "object of knowledge and intervention". This is one of the roles of health professionals. "However, nothing and no one can subtract from this same individual as an aspirant for well-being, the last word about their needs"[4(84-85)].

We cannot define for each other a therapeutic project without considering their life history. It is not up to us to decide which life is worth living. This choice is up to the user, which can be mediated by professional technical knowledge, but not only prescribed by him/her. Knowing a little about the life history of people who come to us is fundamental in the care process. The problem is that most of the time we do not even consider the other as a subject, but as a mere object of our practices. We cannot limit the art of caring only to the creation and manipulation of 'objects'. Caring is more than prescribing, diagnosing, is not losing the dimension of the other as equal, subject in the relationship that establishes with you in life, in health services.

> The care field cannot be reduced to the field of clinic, it is pure light, dialogical, relational technology, it is the world of wisdom and not of knowledge. The clinic that pretends that everything is clinical can be a disaster, it expands, but does not break, continues serializing behaviors, protocoling healthy life forms, 'correct' behaviors, dictated by professionals[11(11)].

In thinking about the production of care as a meeting of affections in action, we bet on the production of encounters in which the other is no longer simply the object of projecting pre-established images, in which I (health professional) can execute my 'clinic'; and may become a living presence, with which we build our territories of existence. This vulnerability to the other depends for its support on the activation of a specific power of the sensitive, which Rolnik[12] called the vibrating body. She states that, according to recent neuroscience research, each of our sense organs carries a dual capacity, one cortical and one subcortical.

> The first one corresponds to perception, which allows us to grasp the world in its forms, and then, to project upon them the representations we have in order to give them meaning. This ability, which is familiar to us, is, therefore, associated with time, the history of the subject, and language. With it rise the figures of subject and object, which establish a relationship of exteriority with each other, which creates the conditions for us to be situated in the map of existing representations and move in it.
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> The second, which because of its repression is more unknown to us, allows us to grasp the otherness – quality of what is other – in its condition as a field of living forces, which affect us and are present in our body in the form of sensations. The exercise of this capacity is detached from the history of the subject and language. With her, the other is a presence that integrates with our sensitive texture, thus becoming part of ourselves. Here

> the figures of subject and object dissolve, and with them that which separates the body from the world. This second capacity of our sense organs, which the author called the vibrating body[12(12)].

The clinic, as hegemonically practiced in 'Flexnerian' medicine, is a product of the eye retina, is one of the dimensions of care, in the field of hard and light-hard technologies. There is always someone teaching, prescribing something to another. But care also operates in the vibrating body, it is from the world of sensations and affects, consisting predominantly of light, relational technologies. In the field of sensation, the other is a presence that integrates with our sensitive texture, thus becoming part of ourselves. Thus, the figures of subject and object are dissolved, and with them that which separates the body from the world. This 'activation of a power of the sensitive' is what we understand as one of the important components of care.

Health practices in primary care are almost always based on 'health surveillance'; and its protocols, dictated by the programmatic actions (women's, children's health, hypertensive and diabetic control etc.). These processes are ordered by a reduction in the core competencies of health professionals, in which more and more well-structured health acts prevail, which do not make clear who commands who: if the worker commands his/her knowledge, or if the protocol knowledge commands the worker.

Methodology

Seeking to unveil health care practices in meetings between health professionals and users, in addition to the perception of the eye retina, this essay uses cartography as a way to contact the object, and, in relation to it, produce the data for analysis of what is observed. The choice of cartography is justified because it is a way of research that seeks the production of meaning in daily work as other meanings are produced in this same process. It recognizes reality as an open map that is processed in rhizomatic networks, that is, those produced in the dynamic movement of life and its daily life, which are neither linear nor protocol, but produce the world, and produce with it at the same time, from the connective flows that operate between the subjects in the micropolitics of health work[13].

Kastrup[14] states that cartography is a method that aims at following a process, not representing an object. Generally speaking, it is always about investigating a production process. From the outset, the idea of developing the cartographic method for use in field research in the study of subjectivity departs from the goal of defining a set of abstract rules to apply, as it is a method that does not seek to establish a linear path to reach an end. Cartography is always an *ad hoc* method (for this or that specific purpose).

However, its construction on a case by case basis does not prevent us from establishing some clues that aim to describe, discuss and, above all, collectivize the experience of the cartographer. Kastrup draws attention to the importance of the functioning of attention in the cartographer's work. It is not a question of seeking a general theory of attention in the cartographer's work. The idea is that, on the basis of the construction of knowledge through the cartographic method, there is a type of attention functioning that was, in part, described by S. Freud with the concept of floating attention: "recommends the use of attention where selection is initially suspended, whose definition is to 'pay equal attention to everything'[14(16)]. This open attention, without specific focus, allows the capture not only of the elements that make up a coherent text available to the analyst's conscience, but also of the material "disconnected and in chaotic disorder"[14(16)]. The function of attention is not a simple selection of information. Its functioning is not identified with acts of focusing to prepare the representation of the forms of objects, but is

done by detecting signs and circulating forces, that is, the tips of the ongoing process, which are often imperceptible to the 'eye retina', but may be noticeable to the 'vibrating body'. An 'attention to the prowl', a concentration without focus, according to Gilles Deleuze[15].

Another important clue to the use of the cartographic method reminds us of Kastrup in bringing the concept of 'suspension' to the scene:

> [...] which means the bracketing of judgments about people and the world. Suspension constitutes an attitude of abandonment, albeit temporary, of the recognitive attitude, said naturally by phenomenology. It is a suspension of the realistic cognitive policy, where knowledge is organized from the subject-object relationship[14(17)].

The author also reminds that cartography is a method of cognition conceived from a constructivist perspective, that is, there is no data collection, but from the beginning, a production of data, in which the cartographer is also part of this process. The home visit reported below is the result of a cartography performed at a home meeting between health professionals and a user, described in Hubner[11].

Results and discussion

We bring to the scene the report of a home visit by health professionals to a home, whose objective was to actively search for 'rebel patients', who, for many reasons, did not adhere to the team's prescriptions for their own health. Mistress 'Tarsila' (not her real name) was one of those cases, who despite being hypertensive and presenting some of her well-altered exams, drank alcohol daily. These team members suggested that the supporter accompany them on this visit so that they could think together 'what to do' with this 'patient'[11].

They come to the door of Mrs. Tarsila's house, clapping hands, calling for her. She, sitting at the kitchen table, recognizes the familiar voice of the professionals and authorizes them to enter. Medical and nursing technician enter observing the interior of the house. They greet and hug each other. Tarsila invites them to sit down and starts the conversation by saying that it's hot. It was a carioca summer day with thermal sensation above 40 degrees, and no water at home. She offers cold water and a smile on her face. She also says that she will not offer the beer she is drinking, because she knows that the doctor is against it and is in working hours. The supporter is introduced to Mrs. Tarsila. He addresses her, shakes her hand and compliments the appearance of the very cold beer, and claims that he also likes beer a lot. She admires and offers it to him, who refuses it because he is on business hours, but he claims that at another time he would share the beer with her with pleasure. The doctor frowns and behaves in an unfriendly way, with dissatisfaction.

Every single body in the encounter has the power to affect and be affected, and in this moment of intensities, compose or not compose among themselves, generating effects on these same bodies. When these effects are of joy, increases the power to act, and of sadness, generates the reverse effect, reduces the potential[12]. Therefore, the way in which the meeting between the health professional and the user takes place, also has therapeutic effects, because a good meeting will increase the vital energy, with positive effects on the therapeutic project.

Observing the scene, from the outside, the cartographer's vibrating body perceives no fluidity in this encounter, but a tensioning. The expression of ease and joy of our user seems to contrast with the expressions of our doctor. She opens up her medical suitcase and asks the nursing technician to measure her blood pressure (which is high), and shows her last exams (quite altered). In her eyes, there

is a noticeable discomfort, discontent with that image in front of her – Mrs. Tarsila and the nearly empty beer bottle. She presents herself at this moment with the almost usual self-image of 'angry doctor' stamped there, he automatically triggers his whole protocol for hypertensive and diabetic people: not eating salt, sugar, let alone drinking. The attentive cartographer watches, and with his vibrating body tries to devour the sensations of our 'patient'. He realizes that her mask of expression that conveyed joy, affection, intimacy, shatters, and immediately another one is put in place. It is more serious, harder, but safer, absolutely connected to that situation. Mask of disappointment, but very clear in terms of expression, of who knows where she is stepping in, what she wants, without any exception. The intensities experienced by them were disparate, distant. So far, there was no plan of consistency, of agreement, in which their affections could meet. The doctor, with her eye retina only, does not understand Mrs. Tarsila's posture and looks questioningly at the cartographer and asks,

So, what do I do with such a woman?

I suggest listening to our Tarsila, knowing from her what does she think about this situation? Do you want to talk about this, Mistress Tarsila?

She, from the age of 78, speaks, already smiling again, a little about her life.

I raised five children on my own, helped each of them build their own placer, their home. I was an ironing lady, cleaning lady, lunch lady, I 'did my best' to survive and raise my boys, doctor. I was widowed at 42 and never had a partner to share dreams, expenses, dating. Today, if I need anything, I have my retirement and my daughter who lives upstairs with her mate who can help me. My pleasure in this life doctor, says Mrs. Tarsila smiling, it is drinking, drinking beer, teasing those who pass on the street, play. But when I think I'm crossing the line I go to bed, and laugh alone, watching everything spinning. So I'll tell you something: Taking beer from me is almost killing me. It is my joy, my will to live, to wake up. My life was very hard, Doctor, I've lived a lot, 'I'm on velvet', and if I die tomorrow, be calm, I won't blame you. So, I ask you, stop telling me to stop drinking, or I'll be very upset with you.

The cartographer observes our doctor and notices her mask of expression upset, but even contradicted says, "*What can we do, you're the one who knows*". And with her displeased doctor-expression mask, she turns to the cartographer who, until then, has only observed, and questions. What to do? I don't know how I can help anymore. He shuts up. She says goodbye by handing her paper recipe sheets, which our smiling Tarsila picks up and asks her daughter to keep. The cartographer observes our doctor and her cleavage, demerged expression, somewhat contradicted, without clarity of sensation. It seems that our doctor is now touched by the double capacity of her sense organs. With her eye retina she feels embarrassed, upset, but her vibrating body (which she apparently does not know), somehow manifests, and blandly says goodbye, is frustrated. After leaving the house, the cartographer does not resist and says:

you should come more often to visit Mrs. Tarsila, and if you want after work, who knows you may have a beer with her, because in this exchange I think you can help each other a lot.

She, reflective, may not yet realize that in this meeting with Mrs. Tarsila, doctor of life, an expression of joy, of willingness to live life on her own, independently; our doctor had just 'consulted' herself. Life is made of choices, and our Tarsila seems to know very well what she wants and autonomously chose how she wants to live and dream. After 'all life is worth living', and we, health professionals, can only ask: can I help you? But not impose, dictate. Our Tarsila seemed happier than many of us in her way of living, caring. Let us move on

with our lives, Mrs. Tarsila, and, if you need me, I will be there in the unit to welcome you and take care of you, which is what I consider the only course to be taken by our professional in her interest to help.

In other meetings, the professional reports to the cartographer that she and our Tarsila have become good friends, sometimes meeting just to talk. On Tarsila's birthday, she was invited to have a beer with her, and they spent a lot of time talking about life, about love, about the sea.

Our doctor, in her usual way of acting – the same protocol for certain health problems – considers that she has the technical knowledge and competence to intervene on the other's body, prescribing 'correct ways' of leading life, living, guiding to a biosubjectivity captured by medical knowledge, body control and submission to prescription on lifestyles. This would be translated as 'produce health' and bears the name 'care'; in an asymmetrical relationship, in which the worker commands the other, dictating to him/her how to act, how to behave. What our doctor may not even realize is that her living, free and creative work is being driven by dead work, machinery and protocols, instrumentalizing the care that remains contained in her technological universe (programmatic actions in health). All this does not consider the way in which the needs of this or any other user are socially and affectively constructed. It is not a matter of judging her or reproaching her for her way of acting. This is how she, an excellent professional, learned to take care.

Ayres[4] tells us about an active and current movement of health professionals and services to turn to the other's presence in the care space, optimizing and diversifying the forms and quality of this self-interaction and, from there, understanding the relationships that are established daily in these services, in the micropolitics of the work process, alive and in action.

Rolnik[12] considers that the production care field is that of the deterritorialization of the professions, and it occurs in micropolitics, which is the place of the issues that involve the processes of subjectivation in their relationship with the other, at the moment of the meeting, affecting and can affect this other, without protocols, without strings attached, without *a priori* definitions of what the other may need. Talking about caution, therefore, leads us to the invention of strategies for the construction of new territories, other spaces of life and affection, a search for 'exit' from territories that seem to have no way out. After all, Health is happiness, and in our meetings there must always be the question: can I help you?

The clinic is an instrument of care, and this perception is fundamental to analyze it, as it gives it power and, at the same time, limits, avoiding any attempt to reify clinical knowledge in relation to health care. It is just another piece that makes up the 'toolbox' of a healthcare professional who proposes to care.

It is mandatory, when we take care, to understand that conception of life guides the existential projects of the subjects to whom we provide assistance. How it appears there, in that meeting of subjects in and by the act of caring, the projects of happiness of those we want to care for.

The expansion of the 'toolbox' of professionals incorporating more lightweight, relational technologies in the production of care can be a bet so that we can agree dialogic therapeutic processes with those we propose to take care of. Health is happiness, let us always remember, so that we can help those who seek us, without interdicting.

Final considerations

This study reveals the paradoxical clinical practice in the field of health care, especially in primary care. Why do we deal with a paradox? Because at the same time as it is intended to be cared for, the clinic

is restricted because it simplifies the idea of body to anatomical and physiological structures and functions and consequently structures knowledge and practice that cannot act in the fullness of the body. In this sense, it remains imprisoned at its birth in the eighteenth century, when Foucault[2] describes the clinic as originating from the act of looking at the body, centered on the anatomical and physiological body. We recognize the insufficiency of this 'clinic', because it does not consider the affective body as existence, guided by reality and capable of managing the action on the world[16]. In this sense, the authors will propose the 'clinic of affections' as a clinical practice, complementary to the conventional clinic, and which recognizes the affective body as capable of responding to the care process, being active and proud in the pursuit of its rehabilitation and recovery. More than that, affect is a power generator and can activate energies in the desire field that can act as a driving force and set this body in motion in the sense of self-care, which is activated as a coefficient improvement factor of care production in general.

Furthermore, it is precisely in the 'affective body' that many issues will be revealed, related to the existence of the user, and which go unnoticed in clinical practices, when they are centered on the dysfunction or injury of the anatomical and physiological body. We can state that studies related to subjectivity and subjectivation processes will demonstrate how much these aspects matter for the therapeutic process, and for health care.

These questions lead us to the theme of 'clinical decision': where this decision goes, and where the user is in this process. What do they think, feel from the therapeutic projects that we health professionals define for them? In our example, Mrs. Tarsila, in her unique way of living, does not seem to agree with her therapeutic project. After all, all life is worth living.

Our user also has an idea of health, and practices a 'therapeutic project', which in its own way, leads life as it thinks it should. It is important to recognize the protagonism of every user in their care process. Every therapeutic project should be agreed between professional and users, as a way to better consider the multiple factors of the person's life in the act of caring.

The organism is formed by a 'body with organs', and a 'body without organs', which is the affective body. Care must necessarily contemplate these bodies in all their components. Affection lacks recognition as a device capable of activating desire, and internal forces that place the body in the sense of producing life in itself, and in its environment. Therefore, this study broadens the visibility of these aspects of clinical practice, and draws attention to the process of addressing the real 'health needs'[17] of those who seek us in and through caring.

Merhy[6] tells us that, in technological medicine, there is an impoverishment of the valise of light technologies, shifting the axis of care to an articulation between the valises of light-hard and hard technologies. This practice expresses certain well-defined procedures, reduced to mere punctual procedures, subspecialized in terms of professional competence, with which professionals establish their true bonds, and through which they capture users and their world.

Health care networks are full of situations like the one analyzed in this text. We urgently believe that a more appropriate approach, which considers the complexity of individuals seeking health services, should already be addressed within the scope of vocational training. More dialogical practices that recognize the health needs of each user and their way of being in the world.

After all, as Ayres tells us, we need to be clear that not everything that is important to well-being can be immediately translated and operated as technical knowledge. We

have to think that we are building mediations, choosing within certain possibilities what we should want, be and do those we watch – and ourselves.

> Nothing, nor anyone, can subtract from this same individual, as an aspirant for well-being, the last word about his needs[4].

Collaborators

Franco TB (0000-0001-7372-5262)* and Hubner LCM (0000-0001-7073-9888)* also contributed to the drafting of the manuscript. ■

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