



CONCEPTION OF SUBJECT AND ITS IMPLICATIONS IN CLINICAL PRACTICE OF NURSES IN HIV / AIDS CLINIC

CONCEPÇÃO DE SUJEITO E SUAS IMPLICAÇÕES NA PRÁTICA CLÍNICA DO ENFERMEIRO EM AMBULATÓRIO DE HIV/AIDS

CONCEPCIÓN DE SUJETO Y SUS IMPLICACIONES EN LA PRÁCTICA CLÍNICA DEL ENFERMERO EN AMBULATORIO DE VIH/SIDA

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ABSTRACT

Objective: to discuss the conception of the subject and its implications for clinical nursing practice in HIV / AIDS clinics. **Method:** study of theoretical reflection, in which we approach the concept of the subject from how it came about in the field of modern science, as the subject of knowledge and reason, to the dimension of the unconscious subject and the desire, considered in psychoanalysis. **Results:** we understand that to know the subject we must perceive them beyond their disease process, in their uniqueness, through a listening to their life story, so we can create conditions of appearance of the subject from the unconscious. **Conclusion:** we consider that the possibility of working with the unconscious allows redirecting the nursing care to a clinic of the subject. We believe that this dimension of the unconscious subject can innovate and renew the clinical practice in nursing. **Descriptors:** Nursing; Science; Psychoanalysis; Acquired Immunodeficiency Syndrome.

RESUMO

Objetivo: discutir a concepção de sujeito e suas implicações para a prática clínica do enfermeiro em ambulatório de HIV/AIDS. **Método:** estudo de reflexão teórica, no qual abordamos o conceito de *sujeito* a partir de como ele surgiu no campo da ciência moderna, como sujeito do conhecimento e da razão, até a dimensão do sujeito do inconsciente e do desejo, considerada na psicanálise. **Resultados:** compreendemos que para conhecê-lo temos de percebê-lo além do seu processo de adoecimento, em sua singularidade, por meio de uma escuta da sua história de vida, para que possamos criar condições de aparecimento do sujeito do inconsciente. **Conclusão:** consideramos que a possibilidade de trabalhar com o inconsciente permite um redirecionamento do cuidado de enfermagem para uma clínica do sujeito. Apostamos nessa dimensão do sujeito inconsciente para inovar e renovar a prática clínica na enfermagem. **Descritores:** Enfermagem; Ciência; Psicanálise; Síndrome de Imunodeficiência Adquirida.

RESUMEN

Objetivo: discutir la concepción de sujeto y sus implicaciones para la práctica clínica del enfermero en ambulatorio de VIH/SIDA. **Método:** estudio de reflexión teórica, en el cual enfocamos el concepto de *sujeto* a partir de cómo él surgió en el campo de la ciencia moderna, como sujeto del conocimiento y de la razón, hasta la dimensión del sujeto del inconsciente y del deseo, considerada en el psicoanálisis. **Resultados:** comprendemos que para conocerlo tenemos que percibirlo además de su proceso de enfermarse, en su singularidad, por medio de una escucha de su historia de vida, para que podamos crear condiciones de apareamiento del sujeto del inconsciente. **Conclusión:** consideramos que la posibilidad de trabajar con el inconsciente permite un re-direccionamiento del cuidado de enfermería para una clínica del sujeto. Apostamos en esa dimensión del sujeto inconsciente para innovar y renovar la práctica clínica en la enfermería. **Descriptores:** Enfermería; Ciencia; Psicoanálisis; Síndrome de Inmunodeficiencia Adquirida.

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INTRODUCTION

Patient? Client? User? Subject? There are several ways in which people treated in health services are called.

The term patient began to be used in the fourteenth century and is related to the person who has patience, calm, resigned. However, its use may suggest implicitly a passive position and hierarchically lower than the professional, since the origin of the term refers to the word suffering, derived from Latin: *patiens*, from *patior*, which means to suffer.¹

Before the concept of term *patient*, as the one who suffers passively, other terms have been sought to overcome this idea of passivity in the face of suffering, as customer, user and subject.

The term *client* arises from the specific vocabulary of liberal market economy, implying the person who rushes to health services, to some extent, the consumer character, and the health, the characteristic of a commodity, not a social right. The term *user* is each of those who use or enjoy some collective thing, connected to a public or private service.¹

Thus, the term user may be understood as broader, but, in health services, we perceive the use of the three terms, which causes some confusion among health professionals about the best way to call those who seek them.

Although each term focus on a different way of perceiving those who seek health services, we understand that all seem to further strengthen the position assigned by the biomedical power throughout history, a restricted place, reductionist, objectifiable, focusing on disease.²

The term *subject*, on the other hand, arises from the subjection to the field of the Other, because we were not born subjects, but we constitute ourselves as such from the contact with the Other (the mother, even if she is not the generator).³ Although there is this subjection, we consider the term subject as the most appropriate to deal with someone who not only has a disease, but who has subjectivities and singularities that need to be understood from the life story of each subject.

In our view, the concept of this term does not seem clear, for though it is widely used in current health practices, we realize that the professional has not appropriated this concept and uses it, not to point a change in their practice, but to strengthen the model in which the subject is understood as an object of science.

This concept of object is depicted by the clinical pathological model, in which the subject is objectified in his ailing condition. In addition, the prime location of this clinic is the hospital and its main actor is the doctor, with the role of discovering the disease in the patient's body.⁴

Seeking this context in a specialized clinic in patients with Acquired Immunodeficiency Syndrome (AIDS), with regard to how nurses deal with patients seropositive for the Human Immunodeficiency Virus (HIV), we do not think different. According to empirical observations and research carried out in this clinic, we realize that the look directed to this patient is more focused on disease and treatment adherence and not on the subject.

We understand that patients with HIV seek not only a clinical follow-up of their disease, but professionals that welcome them and understand beyond the disease process, as subjects with their subjectivities and singularities, since much more than a pathological process, living with HIV / AIDS is part of a wide network of meanings.

It is extremely important to think about the notion of the subject we have and how it relates to us and to others, as this concept will guide and support the clinical practice of nurse.⁵ In this sense, we wonder: how the conception of the subject can help the nurse to conduct their clinical practice at a clinic for HIV / AIDS?

To answer this question, we will discuss the concept of the subject from how it came about in the field of modern science until the dimension of the subject in psychoanalysis. It is, therefore, a theoretical reflection study with the aim to discuss the concept of the subject and its implications for clinical nursing practice in an ambulatory for patients with AIDS.

METHOD

Study of theoretical reflection, in which we will address the concept of the subject from how it came about in the field of modern science, as the subject of knowledge and reason to the dimension of the subject of the unconscious and desire, considered in psychoanalysis.

RESULTS AND DISCUSSION

◆ **Conception of subject to science**

Modern science is constituted as praxis exactly by the exclusion of the subject, based on the assumptions of objectivity, universality and generalization. In the model of modern rationality, knowing means to quantify. The intrinsic qualities of the object are

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disqualified and instead the quantities in which eventually one can translate come to dominate. What is not quantifiable is scientifically irrelevant. This knowledge, of science itself, aspires to the formulation of laws in the light of observed regularities in order to predict the future behavior of phenomena.⁶

The thought that gave rise to this definition of modern science emerged from the seventeenth century with Descartes, who opened the first ideas on the concept of subject.

Descartes, in formulating that one can doubt everything, but cannot doubt that the one who doubts thinks, inaugurated the Cartesian *cogito*: I think, therefore I am; who came to affirm that what is true is what can be conceived clearly and distinctly solely by reason. He begins to doubt the existence of everything and refuses any outside authority, even divine, claiming the thought as a single point of certainty.⁷

The Cartesian *cogito* became the only truth that cannot be doubted. Descartes introduced a loss in the field of knowledge: the assurance of the voice of God as a single reference, and in linking the existence to the certain of thinking, he dissociates it from all that is not rational. Thus, he separates the existence and its possible attributes, which becomes an ideal for the modern science.⁸

Therefore, the notion of subject begins with Descartes and the Cartesian subject came to be characterized as that of conscience, of thought, who seeks the truth in the rationale of the facts. Since man is a being of thought, he can, through strict application of the method of doubt, reach the truth.

In this sense, we realize the dependence of existence toward thinking, for it is through the process of thinking that a subject arises, the subject of thought. Thus, the Cartesian *cogito* founds the modern science and inaugurates the concept of the subject. But if it establishes the conditions of real appearance of the subject, as stated above, it does not take him into account, it does not work with him nor about him. The subject is supposed by science to, in the same act, be excluded from it, or, more precisely, be excluded from the field of operation of science.³

As science does not operate with the subject, another field of knowledge arises, that resumes this concept of subject, operating it on him, the psychoanalysis. Psychoanalysis, although it has not been restricted to the discursive field of science,

comes from this, providing a break from the dominant paradigm and proposing a subversion of the concept of subject to create the conditions to operate with him.

♦ Conception of subject for psychoanalysis

Psychoanalysis will operate on this same subject of Science. This is the thesis of Lacan, without the advent of the subject with Descartes, psychoanalysis could not have come to light.⁷ This means that there is a subject of science that is the same on which psychoanalysis operates, but what will be of interest to psychoanalysis is precisely that which is not considered by science, which escapes rationality and that cannot be represented in the conscious.

Sigmund Freud, the father of psychoanalysis, by giving voice to his hysterical patients, found that their speech revealed something of another order that, even unknown to the speaker, carried a meaning of the truth of the subject. He found something that determined the speech of these women and that flew to the rules of rationality. Then, the concept of unconscious arouse.

Freud thus subverted the concept of the subject of science and innovated by saying that the subject was not confined to the plane of consciousness, but he was determined by an unconscious content, by a knowledge not known and that, although not known, carried something of the history of this subject.

Despite being a not known knowledge, Freud realized that it would not stop interfering in the lives of his patients, because when he let them speak freely, something emerged from a slip, a mistake, even though they did not know what they were speaking.

Thus, Freud found that the unconscious finds ways to express itself, which he called formations of the unconscious: slips, lapses, dreams, symptoms and jokes.³ So, the speech reveals the subject, who will emerged in the failure of the conscious, coherent discourse, producing emergency conditions the subject of the unconscious.

For the Cartesian philosophy, the subject is One, unified, identifiable, whereas for the psychoanalysis he is not identifiable, but subject to identification and, far from being unified, it is divided in relation to sex and castration. Castration, which denotes the subjective division, is the truth of the subject banned by the discourse of science.⁷

By breaking with the speech of totality and indivisibility of the subject, Freud inaugurates a new knowledge about it: that the subject is divided between the conscious and the

unconscious. This unconscious determines the actions of the subject and that marks him.

The Freudian procedure to reach the unconscious was analogous to that of Descartes to reach the *cogito*, as it was from the doubt he inaugurated the *cogito*, for psychoanalysis, it was from the doubt that the presence of a formation of the unconscious was signaled. And it is in that place of doubt that the subject manifests, in the field of unconscious as missing thought.⁷

For Lacan, the psychoanalytic discourse renewed the question of knowledge posed by Descartes, because the unconscious emerges as a knowledge that is not known, that escapes the speaking being. Thus, contrasting the Cartesian *cogito*: I think, therefore I am; he says: I am where I do not think.⁷

Unlike science, for which the thought defines the being, substantifying the subject, for psychoanalysis, he has no substance and his being is out of thought. The subject is an empty, constitutive lack of desire to be. He is one made from its lack; it is not, therefore, a complete and indivisible whole, as stated by science.⁷

Science does not know the subjective division by which the subject sustains the desire, as psychoanalysis does not dissociate the advent of the subject from the advent of the wish that generated it. It is where something is missing that the subject is, this signifier that is lacking, this void of representation that expresses the wish.⁷

Freud's discovery of the unconscious is that it has certain laws of operation and includes the desire, on which the subject does not always wants to know. The unconscious desire is forbidden, prohibited, incestuous and therefore unbearable for the self, for the conscious subject. However, the fact that we do not want to know does not make it go away. There is something there wanting to be held, pushing. Sometimes, this pressure is huge and escapes in the form of distress, through the unconscious formations that aim to satisfy somehow this desire.⁶

In addition, one must consider that the human subject is, above all, a language being. This, in its inability to symbolize everything, throw him in a hopelessly subjective division and marks man's ignorance of his own suffering condition.⁹ So, we recognize the dimension of desire and what it means to work together with the Other.¹⁰

♦ Implications of the conception of the subject in clinical nursing practice in HIV / AIDS clinic

From the foregoing, in relation to the concepts of subject for science and

psychoanalysis, we propose a reflection of the concept of subject that permeates the clinical nursing practice in HIV / AIDS clinic. This reflection will be done from empirical observations of the researchers and from some research carried out in this clinic.

We noticed, as stated earlier, that the role of the nurse before the patient with HIV / AIDS is more focused on the disease and drug therapy. We know that adherence to treatment is very important, but we wonder: who is this patient beyond HIV? Do the nurses realize this subject? Where is directed the look of the nurse to? To the subject or to the disease?

Reflecting on these questions, we can understand that, although it seems clear that the look of nursing is on the subject, in practice, we see nursing care focused on guidelines aimed at indoctrination of the patient, that is, the non-adoption of risk behaviors, adherence to treatment, clinical monitoring and conducting periodic examinations, among others.

We perceive that these guidelines are more present at the counseling time, when there is prioritization of educational actions and risk assessment and, although there is an emotional support that is offered with the intention of taming the patient, so that he follows the professional's guidelines and adhere to treatment.

We understand that counseling may be the most opportune time to meet this subject, as it is the time when nurses have more contact with this patient, to understand him better, which allows listening the subject and the performance of a more specific care.

Faced with this, we wonder: is this look really on the subject or on the disease? We think it is on the disease, and this brings us to the influence of the biomedical model, centered on the role of the professional, which is to discover the disease in the patient, and the clinic is not an instrument for uncovering the truth, still unknown, of the patient, but a way of having the truth already acquired and to present it as a fully structured knowledge.⁴

The professional already has the entire body of knowledge needed to care for the patient and in that context, we identified that the knowledge of the professional is based on guidelines established by the advisory manual on HIV / AIDS, proposed by the Ministry of Health and that, although it address the emotional support as one of its components, the nursing care acquires a predominantly informative face, based on scientific knowledge.

What often appears in the routine of health services is a subjection of those who seek assistance to the knowledge of those already ready, where the professional knows in advance what one should or should not do to achieve a cure. The scientific knowledge is the truth about the subject, and these are not in possession of any knowledge. Reducing the subjective experience to pathological issues is to ignore that the subject, despite inhabiting a body, cannot be reduced to it.⁶

Thus, in this intervention model, the subject is not the patient, but the health professional, as this has the knowledge, and the patient becomes object, since he has to follow the conduct established by the professional. To this concept of subject of knowledge we associate the concept of the subject proposed by the Cartesian method, because the subject is a thinking being, a being of knowledge, reason and truth.

We believe that the concept of subject that permeates the clinical nursing practice in HIV / AIDS ambulatory is based on the subject of science, in its conscious dimension. We understand that for the clinic to be understood as a true knowledge it is necessary that the nurse renounce any position of totalizer knowledge and throw himself in the untimely of each meeting, each intervention.⁹ Thus, when considering the subject and the relations established with the health service as a starting point for the production of care, it can be produced horizontal therapeutic relationships.¹¹

To know the subject we must receive him in his uniqueness through a focused listening not in his illness, but in his life story, so we can create the conditions of appearance of the subject of the unconscious. In this sense, listening allows considering what is being said by the subject aware that this subject is exactly in what he says, not knowing what he is saying.¹²

Taking into account only the apparent subject, the subject of consciousness, implies denying the Other that exists in this subject, who is imposed on what cannot be said, but who insists in manifest through the formations of the unconscious.⁶

We are not proposing to turn the counseling or a nursing care in an analysis, but to bring another look beyond the medical clinic, whose objective is not only in the biological treatment, but that allows the emergence of other issues concerning the life history of the subject. However, to cope with the dimension of the unconscious of the other, the nurse needs to contact their own unconscious in a review process, as this implies a moment of

estrangement, of dealing with something unbearable to consciousness, and this professional cannot do it before dealing with their own issues.

We propose, instead of limitation, the wideness; in place of the reductionist model, the complexity, knowing that the knowledge about the subject is not available to everyone and will not be available to anyone, except for the reintroduction of a questioning on the subject, his life story, his significant.⁶

In the case of a patient with HIV / AIDS, the nurse cannot be limited to the disease process and adherence to drug treatment, but should, above all, ask himself who that subject is and what his life story is, and consider the dimension of the desire that composes him.

FINAL CONSIDERATIONS

This discussion on the concepts of the subject, bringing the possibility of working with the unconscious, allows nursing care to redirect to a clinic of the subject, in which this may put other issues that go beyond their disease process, but that concern his uniqueness and his constitution as a subject.

The conception of the unconscious of the subject may contribute to the ability to think in a new clinic for nursing, more singular, that is not guided only in the biomedical model, but involving the care to the subject in his multiple dimensions. We believe that this dimension of the unconscious subject will reinvent the care and thus innovate and renew the clinical practice in nursing.

REFERENCES

1. Saito DYT, Zoboli ELCP, Schweitzer MC, Maeda ST. Usuário, cliente ou paciente? Qual o termo mais utilizado pelos estudantes de enfermagem? Texto & contexto enferm [Internet]. 2013 [cited 2014 May 22];22(1):175-83. Available from: http://www.scielo.br/pdf/tce/v22n1/pt_21.pdf
2. Paiva Filho F. Contribuições da psicanálise para a clínica de enfermagem em drogadição: do drogadito aos ditos dos drogados [dissertação de mestrado]. Fortaleza (CE): Curso de Mestrado Acadêmico em Cuidados Clínicos em Saúde da Universidade Estadual do Ceará. 2011 [cited 2014 May 22]. Available from: http://www.uece.br/cmaccilis/dmdocuments/francisco_paiva_filho.pdf
3. Elia L. O conceito de sujeito. Rio de Janeiro: Jorge Zahar Ed.; 2010.
4. Foucault M. O nascimento da clínica. Rio de Janeiro: Forense Universitária; 2004.

Sousa PKR de, Miranda KCL.

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5. Sousa PKR, Miranda KCL, Franco AC. Vulnerabilidade: análise do conceito na prática clínica do enfermeiro em ambulatório de HIV/AIDS. Rev Bras Enferm [Internet]. 2011 [cited 2014 June 23];64(2):381-4. Available from:

<http://www.scielo.br/pdf/reben/v64n2/a26v64n2.pdf>

6. Aguiar DT, Silveira LC, Dourado SMN. Mother in psychic suffering: object of science 1. or subject of the clinic? Esc Anna Nery Rev Enferm [Internet]. 2011 [cited 2014 July 9];15(3):622-8. Available from:

http://www.scielo.br/scielo.php?pid=S1414-81452011000300026&script=sci_arttext

7. Quinet A. A descoberta do inconsciente: do desejo ao sintoma. Rio de Janeiro: Jorge Zahar Ed.; 2011.

8. Lopes RG. Quem é o sujeito da psicanálise? Tempo psicanal [Internet]. 2008 [cited 2014 July 1];40(2):249-72. Available from:

<http://www.spid.com.br/revistas/r40.2/03%20TP40.2%20-%20Rosa%20Guedes%20Lopes.pdf>

9. Oliveira DC, Vidal CRPM, Silveira LC, Silva LMS. O processo de trabalho e a clínica na enfermagem: pensando novas possibilidades. Rev enferm UERJ [Internet]. 2009 [cited 2014 July 9];17(4):521-6. Available from:

<http://www.facenf.uerj.br/v17n4/v17n4a12.pdf>

10. Fink B. O sujeito lacaniano: entre a linguagem e o gozo. Rio de Janeiro: Jorge Zahar Ed.; 1998.

11. Vieira AN, Silveira LC, Silva LMS, Rodrigues DP, Martins IC. Reflection about the contributions of psychoanalysis for the care and nursing clinic. J Nurs UFPE on line [Internet]. 2014 [cited 2014 Dec 12];8(2):450-6. Available from:

http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/5843/pdf_4614

12. Lima DWC, Silveira LC, Vieira AN. Listening in the treatment of psychological stress: an

2. integrative review. J Nurs UFPE on line [Internet]. 2012 [cited 2014 Dec 12];6(9):2273-80. Available from:

<http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/2632>

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