



## Recognizing the subjective production of care

El reconocimiento de la producción subjetiva del cuidado

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**ABSTRACT** This article assumes that there is a subjective production implicit in health care and suggests that qualitative investigation in health should also take into account studies on this dimension of reality. The subjective production of health care manifests itself on three levels: the first, the rizomatic networks which are formed and act in flows of intensities within health services and connect the workers in their working environment through lines of integral care; the second, the desire which is formed in primary, unconscious processes and operates as a productive energy to propel the processes that construct reality; and the third, the "live work in action" which serves as a platform upon which the networks of health care are produced. There is a combined and synergic movement among the three dimensions. This tells us that workers construct their work processes according to a unique way of understanding the world and taking part in it, putting a limit on the normative frameworks that attempt to structure the practice of care into rigid protocols. It is within the work of caring for health that these personal singularities manifest themselves and for this reason is a diverse, varied expression of manifold subjectivities in action.

**KEY WORDS** Health Services; Work; Process Assessment (Health Care); Health System; Brazil.

**RESUMEN** Este artículo parte del supuesto de que hay una producción subjetiva del cuidado en salud por lo cual sugiere que la investigación cualitativa en salud debe contemplar también estudios sobre esta dimensión de la realidad. La producción subjetiva del cuidado en salud se manifiesta en tres planos: el primero, las redes rizomáticas que se forman y actúan en flujos de intensidades al interior de los servicios de salud y conectan a los trabajadores en el ambiente del trabajo a través de líneas de cuidado integral; el segundo, el deseo que se forma en los procesos primarios, inconscientes, y opera como una energía de producción propulsora de los procesos de construcción de la realidad; y tercero, el "trabajo vivo en acto" que actúa como una plataforma sobre la cual se producen las redes del cuidado. Es un movimiento combinado y sinérgico entre las tres dimensiones. Esto nos revela que los trabajadores construyen su proceso de trabajo de acuerdo con un modo singular de significar el mundo e intervenir en él, poniendo un límite a las directrices normativas que intentan encuadrar las prácticas del cuidado en fórmulas rígidamente protocolares. El plano del trabajo y del cuidado en salud es el lugar de manifestación de las singularidades y por ello es diverso, múltiple, como expresión de las subjetividades en acción.

**PALABRAS CLAVE** Servicios de Salud; Trabajo; Evaluación de Proceso (Atención de Salud); Sistema de Salud; Brasil.

## INTRODUCTION

This work seeks to collect evidence on the existence of a subjective production in health care, and based on this affirmation suggests that the processes of qualitative assessment of health services should incorporate subjectivity into the analytic framework as one of the dimensions of the mode of health production.

The underlying assumption is that workers within the same Family Health Team (FHT) act in a singular way in the production of health care, that is to say, each acts in a different manner even though all are subjected to the same normative framework. This difference demonstrates that the work process does not follow a pattern, as the care practices are conditioned by each worker's singularity. In this setting, the FHT regulations, which have the attribute of standardizing the workers' behavior according to rules formulated for the program's operation, influence the workers' activity within very restricted limits; when they are in a work situation with a user of health services, it is they who in that moment determine how the care should be provided. Therefore, the ability to exert influence at managerial levels upon the daily activity of each worker is limited and quite differentiated.

It is perceived that the mode of health care production would be effectively exposed in its micropolitical field were there a method capable of verifying the dynamic and complex mode of operation of each of the workers in their daily activity, including their subjective production in action, which produces health care and also produces the workers themselves as subjects in the world.

This text is based, initially, in the theoretical production that inscribes the subjectivity that acts in the construction of the socius, that is, the microcosm in which each worker is located and operates micropolitically. At the same time, it is demonstrated that a specialized, dynamic approach, which can be achieved through certain cartographical instruments, is necessary in order to identify this micropolitical action. These instruments have sensors highly sensitive to the study and

understanding of social reality, to the perception of surrounding phenomena, and especially to the everyday production of life based in the centrality of the subjects in action (1-5).

The subjective production of the environment in which one lives and works is marked by a constant deconstruction and construction of existential territories, based in certain criteria of knowledge, but also and fundamentally guided by sensibilities in the perception of life and of oneself, in flows of continuous intensities among the subjects that participate in the construction of social reality. This perception, according to which the subjects in the work setting act with flows of connection among them, is inspired by the concept of "rhizome" used by Deleuze and Guattari in the introduction of the book *A Thousand Plateaus* (1); it expresses a flow with a movement both circular and horizontal at the same time, which connects the multiple, the heterogeneous, within the micropolitical dimension of the construction of a map that is always open, allowing various entryways, and which, whenever ruptured at any point, can recover by finding new flows that permit growth and new connections. The plateaus, therefore, appear as a dynamic, connected movement that operates among different levels of existence and intensities.

The challenge of qualitative assessment, according to the subjective dimension, is to deepen the understanding of the micropolitical dynamics of each worker so as to perceive how, in their singularity, they produce care every day, assuming that this subjective production of health care exists within the work process and at the same time in the production of their own selves as subjects of that work. These dynamics are produced as workers interact with users and health issues, through their production process.

## CARTOGRAPHICAL INSTRUMENTS APPLIED TO THE QUALITATIVE ASSESSMENT OF HEALTH WORK

To begin with, the cartographical instruments that will be discussed herein are based on three concepts that are considered

constituents of the method or that are essential components of cartography and provide cartography with conceptual identity. The elements in discussion are: the thesis of the rhizome, as flows of connected intensities that produce social reality (1), which appears to be the basic concept of the general idea of cartography; desire as a propelling force of the subjects' action, expressing the subjective production of the *socius*, as Deleuze and Guattari suggest in *Anti-Oedipus* (2); and finally, Emerson Merhy's theory of "live work in action" (6,7) as the axis of tension that produces cartographic lines. These three concepts, within the cartography sought to be produced, are each inherent to the others.

### The rhizome: cartography in action in the work process

The first important reference for thinking about cartography as a research method comes from Deleuze and Guattari, especially in the introduction of the book *A Thousand Plateaus: capitalism and schizophrenia*, in which the authors discuss the rhizome as a production mechanism of social reality, based on the action of subjects in connection with each other and with the world, through flows of intensities. There, they list several characteristics of a rhizome:

1 and 2. Principles of connection and heterogeneity: any point of a rhizome can be connected to anything other, and must be. [...] 3. Principle of multiplicity: only when the multiple is effectively treated as a substantive, "multiplicity," is that it ceases to have any relation to the One as subject or object, natural or spiritual reality, image and world. [...] 4. Principle of asignifying rupture: [...] A rhizome may be broken, shattered at a given spot, but it will start up again on one of its old lines, or new ones. [...] 5 and 6. Principle of cartography and decalcomania: a rhizome is not amenable to any structural or generative model. [...] Perhaps one of the most important characteristics of the rhizome is that it always has multiple entryways. (1 p.13-18)

The rhizome operates using the plateaus as high-intensity platforms of subjective production of the social environment connected to the levels on which reality manifests itself. Thus, the plateaus have great importance in cartography as a place of power in the production of the world and of life. According to the authors:

A plateau is always in the middle, never at the beginning or at the end. A rhizome is made of plateaus. Gregory Bateson uses the word "plateau" to designate something very special: a continuous, self-vibrating region of intensities whose development avoids any orientation toward a culmination point or external end. (1 p.26)

The plateau, within the microphysics of health work, is primarily a place of production and, as such, of confluences of intensities that affect the subjects who are in a situation of work and care; and the rhizome is its cartography in action. The multiple, heterogeneous nature of the rhizome, with its multiple entryways, also lends it porosity as it is crossed by diverse logics in the agencies that construct social reality. There is no room in this cartography for value judgments on the subjects' actions; rather, what is sought is an understanding of their operation within the action of desiring-production they undertake in the production of care. Within this logic there is no good or bad, beautiful or ugly, but rather subjectivities which are captured by a certain existential territory and express the world of life according to that territory. Therefore, those subjects act according to the planes of consistency formed in their relation with others, in their immediate otherness and always in action.

When the worker and the user meet, each has the capacity to affect the other, and this is possible due to the intensities that circulate among the relationships established between two bodies. Here we can understand bodies as the subjects in action as worker and user, or worker and worker, and also in relation to the rules, knowledge, and instruments that shape bodies within the health care setting. According to Espinosa, as quoted by Deleuze (8), affects may cause joy or sadness, respectively increasing or diminishing the power of the subjects to act in the world of life. Particularly, in the case of

health, the connections among the different work processes established between workers-workers and workers-users can create an invisible energy field that works in circulating flows that enfold health care in action and form "lines of life" or "lines of death," depending on whether the worker-user encounter produces comfort, connection, autonomy, satisfaction, or behaviors that are limited and bureaucratic, producing heteronomy and dissatisfaction. Depending on the existing situation, there will be an increase or decrease in the power to act.

### **Desire: the force that propels the productive action of healthcare work**

The second important reference to the use of cartographical instruments refers to the concept of desire which lies within the foundational thought of schizoanalysis.

In the book *Anti-Oedipus: capitalism and schizophrenia*, Deleuze and Guattari (2) establish up a conceptual fight, in the style of the great epics, to reaffirm the idea that the desire formed in the unconscious is productive energy and is therefore what drives the subject's construction of social reality. As Deleuze and Guattari state:

...the first evidence points to the fact that desire does not take persons or things as its object, but the entire surroundings that it traverses, the vibrations and flows of every sort to which it is joined, introducing therein breaks and captures, an always nomadic and migrant desire, characterized primarily by its "gigantism": no one has shown this more clearly than Charles Fourier. In a word, the social as well as biological surroundings are the object of unconscious investments that are necessarily are desiring or libidinal, in contrast to preconscious investments of need or interest. (2 p.302)

According to the authors, desire, just like production, has the energy of the invention of social reality, of the creation of a new unfolding of the world of life: it is revolutionary. Desire is agency, that is to say, it is always active, producing what is "socially real" in every dimension of life. This idea is related to another

which holds that the production of the world occurs through desiring subjectivities that, by operating in flows in connection with many fields of intensity, form new worlds that are constructed in the process.

The driving force of construction of society is desire, which is formed at an unconscious level and is constitutive of subjectivities, and in the social plane transforms the subjects into protagonists par excellence of processes of change. These same subjects work in the construction and deconstruction of worlds, a process in which existentialist territories are modified. "The order of desire is the order of production; all production is at once desiring production and social production" (2 p.306).

An "always nomadic and migrant" desire, according to the authors, that enacts agency in the formation and also in the deconstruction of worlds. This process is discussed in detail by Rolnik (3) when she explains the processes of territorialization, deterritorialization and reterritorialization — understood here as existentialist territories — and the way certain events engender changes in subjectivity. In this case individuals or collectivities of subjects are deterritorialized expressing structural changes in the way of signifying and interacting with the world of life. This happens because of the power of desire, that is to say, the driving force of the production of society, of new ways of acting in the world, and of the production of new subjects.

This is the way cartographies are produced. So far, we have perceived that the rhizome as continuous flows and desire as a productive force together form an idea of the cartographical formation of health care production processes. Up to this point, we have been looking for references to a method of analysis of the production of care that reveals the productive action of the subjects, in terms of their uniqueness, as well as their agencies in the construction of the social reality of the field of action of the world of health care. The method seeks to chart the visible and invisible plane of the production processes, with the subjects in action, propelled by desiring energy. To complete the composition of the method suggested, we will bring to the discussion the concept of "live work in action."

In his 1997 text, *"Em busca do tempo perdido: a micropolítica do trabalho vivo em saúde,"* Merhy reclaims for the field of collective health the concept and power of live work, characterized as a process spurred by the agency of subjects that entails freedom, creation, and inventiveness. Naturally, the production process of health is contradictory and live work may be captured by the instrumental logic of health care production: dead work. But the importance of this concept applied to the work process of health care demonstrates the possibility that workers have to carry out their work with a high level of freedom, exercising, in a manner of speaking, a reasonable self-rule over their productive activity.

In the micropolitics of the work process, the concept of impotence has no place; if the work process is always open to the presence of live work in action, it is because it can always be "crossed" by different logics involved in live work. An example of this is the permanent creativity of the worker in action within the public and collective dimension, which can be "exploited" to invent new work processes, and even extended to previously unthinkable directions. (7 p.44)

As expressed by the author, the work process of health care is always relational, and this relation has the characteristic of the *intercessor*, that is to say:

...what is produced in the relations between "subjects," in the place of their intersections, is a product that exists for the "two" in action and does not exist without the moment of connection, a moment in which the inter establishes the search for new processes, always one in relation to the other. (7 p.37)

This relational process is propelled by the freedom inherent to "live work in action," and generates relations in high intensity flows in the interior of the work process. These flows create a connection between workers, users, people and things that find each other in the plane of the health care production process and are constitutive parts of that process. The network produced in the daily informality of a health unit

or team is like the rhizome: it has neither beginning nor end and it connects at any point.

The constitutive freedom of "live work in action," related to the agencies of desire immanent to the productive activity of each worker, produces the social reality inscribed in the world of care. The work of health care is carried out restricted to a certain existentialist territory that operates under an ethical-political reference that the workers adopt as a "plane of consistency" between them and the users. This plane of consistency refers to the flows circulating in the relation established between the worker and the user, and is also related to the invisible field of health care, to the affects that give meaning to the worker-user relationship, and to the care that is provided.

## CARTOGRAPHY: SUBJECTIVE PRODUCTION OF THE MICROPOLITICS

According to Kastrup (5):

Cartography is a method proposed by G. Deleuze and F. Guattari (1995) whose aim is to accompany a process and not to represent an object. In general, it deals with researching a production process. Above all, the idea of developing the cartographic method to be used in field research in the study of subjectivity is removed from the objective of defining a set of abstract rules to be applied. Its purpose is not to establish a lineal path to reach an endpoint. Cartography is always an *ad hoc* method. (5 p.15) (a)

It is important to reaffirm that the production mentioned by the author refers to the subjective production of social reality propelled by desire. However, by producing the world, one is always in association with the *socius*, which means also and simultaneously bringing about the production of oneself. And that production of subjectivity occurs by means of "affectivation factors," that is to say, events that impact the microcosm and in some way reach the subject and impact his or her manner of understanding the world. In this context there is a process of subjective formation of the social environment and of oneself.

Within the field of health assessment, we presume that the work of analysis extracts a type of knowledge from the world that may return to the same social environment in the form of an intervention in that reality, and in the form of changes produced within the environment of interaction of the subjects that are being analyzed along with the health services. As they modify the social environment, the assessors are also affected by their object; thus, a process of subjectivation takes place, in this case a production of self. As a research method, cartography provokes both analysis and intervention, as it acknowledges the process of production of the self and of the world as something simultaneous, legitimate and inexorable.

Rolnik (3) uses cartography to analyze the Brazil of the 1980s. In the first part of book in which she details this work, the author defines the theoretical field in which she carries out her study; in the second part, she presents the cartography of the Brazilian context. In the text, the author defines cartography as follows:

To geographers, cartography — unlike the maps, which are representations of a static whole — is a drawing that accompanies, and is created in accompanying, the movements of transformation of the landscape.

Psychosocial landscapes can also be cartographed. Cartography, in this case, accompanies and is created accompanying the collapse of certain worlds — their loss of meaning — and the formation of others: worlds that are created to express contemporary affects, with relation to those worlds that the current universes have made obsolete.

As it is the task of the cartographer to give voice to the affects demanding entry, it is basically expected of him that he be immersed in the intensities of his time and that, attentive to the languages he encounters, he devour those elements that seem useful for the composition of necessary cartographies. The cartographer is first and foremost a cannibal. (3 p.23)

The author mentions the processes of formation and deconstruction of territories, understanding them as "existentialist territories," that is, that which everyone has inside and which

defines one's way of signifying and interacting with the world. This way of acting in life is unique, that is to say, characteristic of each individual, and for that reason it is multiple, because there will always exist as many worlds as there are people on the planet. If we bring this concept into the discussion of the production of health care, we can imagine that the work processes themselves contain the singularity of the existentialist territories in which workers are located; these existentialist territories may, for example, express values such as warmth, relationship and caring care, or they may express the opposite. And this is what will determine the type of care provided. The fact that the existentialist territory dwells in the subject means that wherever he works, be it in primary care, in the hospital, in specialized care, in home care, etc, he will provide the type of care harbored in his universe as an ethic — a way of being in the world — to be constructed. Therefore, what determines the type of care is not the physical space in which it is provided, but rather the existentialist territory in which the worker inserts himself as an ethical-political subject and that accompanies him wherever he may carry out his work process.

This process is intense, dynamic and strained by successive and continuous processes of change. The subjective production of social reality is manifested by movements of deterritorialization and reterritorialization of the subjects that operate daily: social functioning. And in that process the subjects bring about each movement with different intensities, as they are able to deterritorialize themselves, breaking with their place of origin and, consequently, adopting new existentialist territories, ethically and politically identified with the production of a new social reality. On the other hand, they may not complete the movement of deterritorialization but rather may return to their place of origin without producing any social change, thus perpetuating a conservative status of social functioning. Deterritorialization can take place because of different "coefficients," obeying a certain graduation of meanings according to the ruptures to be performed. Finally, in the course of her cartography the author reveals the dynamic of subjective production of reality that exposes the meanings, the multiplicity, the complexity of

human action in the micropolitical field, its expression and social construction.

Broadly speaking, cartography is a method, but at the same time it is an anti-method because its purpose is not to uncover the truth; it does not hold itself up as an example to be followed, and for this very reason it upholds the idea that there is a method for each object, that is: cartography is an "ad hoc" method. The base assumption is that it is extremely complex for an assessment of health services to reveal the processes of the production of subjectivities, making use of the observation of the agencies of desire, the affectivation factors, and the collective mechanisms of social production, on the grounds that there exists a subjective production of social reality. In that way, subjectivation produces new existentialist territories and allows for the invention of new worlds in a simultaneous process of invention of oneself (5). It is interpreted that the cartographical instruments are sensitive enough to grasp the reality of care production in the form closest to what is real, nearest to chaos, in the encounters in which the flows of intensities, the production of affects, the technologies that expose the organized side of knowledge applied to care production are produced. In synthesis, cartography makes it possible to enter into the complex, singular and yet multiple world of health care. But, on the other hand, social reality may manifest itself in the reproduction instead of in the production, in processes of subjective capturing of the subjects, in which the ethics of care is restricted by the norms of life and work, by the repetition of meanings, the distortion of signs, therefore provoking a blurring in the field of vision of the "vibrant eye." This is what cartography must analyze, not only in the plane of intensities of life production, but also in the plane of holistic capturing of existence.

### **CARTOGRAPHING THE PRODUCTION OF CARE ALONG THE LINES OF "LIVE WORK IN ACTION"**

The creation of the Unified Health System (SUS, from the Portuguese *Sistema Único*

*de Saúde*) greatly impacted the concept of health and the right to health care by imprinting the idea of citizenship in the daily life of health care services. It introduced new ways of working in health and, above all, the understanding that the setting in which health care is provided is multiprofessional and that care is always constructed in relation to another, be they a worker or a user.

The SUS therefore made a major impact; it was an event capable of triggering processes of subjectivation, in other words, the collective production of new subjectivities. Subjectivity is socially and historically constructed, and is created through the events, encounters, multiple life experiences that the subject undergoes in his or her social interactions and experimentations. What we mean to say here is that the encounter between an individual worker or a collective and an event — like the creation of the SUS — may trigger in the worker the production of a new subjectivity, that is, a new way of understanding care and interacting with its social construction, an "affectivation factor" (b), something that affects those present in the setting impacted by the SUS and in this way produces new subjectivities based in that encounter.

The SUS was developed as a theoretical, practical, and subjective production born of the field of health surveillance. This reference, instrumentalized by epidemiology, generated a wide framework that encompassed experiences and shaped health care services which became well known in Brazil, such as the Local Health Systems (9), Health Districts (10), Healthy Cities (11), all of them related to the field of health surveillance and all containing a significant component of Health Promotion (12). Every setting for the production of this new health system in Brazil, the SUS — its creation, its networks of services, the research and publication in the field — all of these elements were generated through that particular territory of knowledge and practices, upon which the foundations of the health system were laid.

However, in the multiple areas that make up the health field, another referential territory was constituted that influences the subjective production in the health care: the "anatomical-clinical" model of structuring health

knowledge and practices, whose basis is the Flexner Report (c). This report was the main device for reorganizing training references of the medical field as well as various other healthcare professions in the 20th century. Given the technological advances and the tension caused by the medical-industrial complex in its organization of services based on the high consumption of inputs, the healthcare model that originates from this trend took on the hegemonic characteristic of a type of care oriented toward the "production of procedures" (15).

Surveillance and clinical medicine as fields of knowledge and practices coexisted in the creation of the SUS, however not cooperatively, but rather as opposed fields. This opposition is not natural; it was created imaginarily by those who conceived the health reform. In other words, the subjects that formulated the healthcare field produced a symbolic and discursive division between the initial "preventive" model of the health surveillance field and the "clinical" model centered in "curative" practices. Obviously, this specific case is a representation associated with Flexnerian medicine. However, we insist that this is not the only interpretation of the medical profession; clinical medicine can be made up of various connotations and practices, and may even constitute different fields. Nevertheless, this dichotomy arose mainly because clinical medicine, in the case of the health reform, was associated with the biomedical model.

This false polarity between surveillance and clinical medicine is transmitted through the different mechanisms that create the SUS: training, health education, regulation of the system, service protocols, etc. That is how, in the setting of health care production, a subjectivity is created that operates collectively in the production of services deeply involved in health promotion and prevention, but not truly committed to a clinical practice of care that, when occurring, operates under the bureaucratic logic of health programming.

In the management of health services, a logic determined by reason and established knowledge can be observed, as well as another logic that operates through subjectivities produced within the context of the creation of the

SUS. If this second logic were easy to organize by means of protocols and health education, it would be possible to standardize procedures. However, health care in action is provided through the affects (d) that surround the workers and users' meetings. These encounters are determined principally by singularities, therefore, there may be as many models in operation as there are subjects present. It is in this setting marked by chaos that care is really produced, and the agency to create new practices and unlock the workers' creativity is unfurled.

The development of the SUS generated certain paradoxes that serve as analyzers of the technological, attention-based model that was created. One problem-analyzer is related to the universality of access; although this ideal was established as the main principle of the SUS, the services still grapple with long waits, lines, and, in the majority of services, with rationing mechanisms, such as the selection of users to access services, appointments for procedures, etc. One can also observe work processes that are fragmented, despite the existence of a discourse emphasizing group work; technical knowledge that, although supposedly omnipotent, is not effective enough to meet the users' needs; and hierarchical relations within healthcare teams. In synthesis, these contradictions reveal strong tensions in health care networks.

The search to overcome the health situation in Brazil was produced over time. It began with several authors of the collective health field questioning how the territories of capture in the field had been formed. An example of this is the medicalization of society, that is, the creation in the social realm of a line of thought centered on the biological model and the construction of large-scale medical services, with the objective of expanding the medical job market, taking place especially after the advent of community medicine in the USA in the 50s and 60s. It is important to mention the construction of this hegemony within Brazilian institutions, described by Luz (17 p.50-51) as the production of a hegemonic medical rationality in the State and in society.

The development of the SUS is made up of multiple theoretical formulations, and clinical medicine began to be valued in the arena of



health reform, along with the general idea of investing in the micropolitics of work processes to consolidate processes of change in health. These formulations, developed principally during the 90s by Gonçalves (18), Cecilio (19), Campos (20) and Merhy (6), opened a new field of research on and intervention in the settings of production of the SUS as technical-political project and the subjective construction of a particular ethics of care.

The SUS takes its shape based on a multiplicity of knowledge, actions, techniques and policies, constituting a diverse setting that at the same time abounds in references that favor the formation of a certain technological, attention-based model. These efforts are mainly the expression of the collective desires of workers, policymakers and users, formed in the wake of the movement for health reform and in the heated debates about the structural changes experienced in Brazil, particularly in health, in the 80s and 90s.

This text posits that desire is the core that propels the social production of collective and individual subjects, and creates the subjectivities that express singularities, that is, the unique way of perceiving and acting in the world in a given time and place. Therefore, this process can be modified all the time, and a single subject can express various singularities depending on the space-time in which he is located and on the affectivation factors to which he exposes himself. The expression of the social environment is perceived as absolutely complex, dynamic and identified with multiplicities. The SUS is therefore the expression of the various formations that gave it meaning: territories marked by the tradition of prevention and health promotion, by a clinical practice centered on biological research, by work processes centered on prescriptive and not very relational actions, by caring health care, by the bonds formed among workers and between them and the users. In short, there are infinite agencies that make up the complex setting of production, but at the same time they are the manifestation of the real world, its clearest expression, seen by the lenses usually established by the interpretations of reality, which very often disguise reality or modify its image.

According to Rolnik (3), the existential territory is a reference that forms meanings and identities in the subject, that is to say, singularities that operate in the world of life in general. In the case of health we can say that the production of health care is always generated through an individual or collective worker that brings about the work process using as a reference his existential territories. The movement for change in health assumes a process of deterritorialization — that is, a rupture with the old territory — and movements of reterritorialization, looking for new existential identities that will demand new care practices. The deterritorialization assumes agencies, that is, processes of change that are conflictive, painful, imbued with comings and goings in which the subject is constantly in confrontation with himself and with the territory in the making; it is something like "the floor falling out," a death of oneself, in search of another ground to stand on based in new references of life and production.

In the health field, the stage is set for a hegemonic capitalistic (e) becoming of health care production, marked by a technological, attention-based model centered in high-cost procedures. The construction of a cooperative becoming for the SUS assumes the existence of mechanisms capable of producing agency in the construction of new knowledge and practices that resignify work in health, and above all, health care. The agency of desires capable of operating in the construction of a new SUS assumes a confrontation with the territories already structuring the health services and, above all, a rupture with their capitalist and capitalistic becoming.

There are constantly different territories at play in the SUS. The subjective agencies, in their movement of producing the world, promote the deconstruction and at the same time the formulation of new territories in the micropolitics of the work process. This is only possible because the work in health is dependent on live work in action (6,21) which enables, given the freedom of action in health, many back and forth movements, territorializations and desterritorializations, the composition and decomposition of worlds. It is a continuous movement of discoveries that stem from the everyday movement of production of the

SUS. It is important to emphasize that as the individual and collective worker produces the world of health care, he is also produced by that same world, by the circulating affects in the relations established with himself and with others. The health worker is both the producer and the product of certain techno-attention models. "Every one of us passes through the most varied micropolitics and every one of them changes our way of thinking, feeling, perceiving, acting: they change everything" (3 p.55).

Changing the mode of production of health care assumes, from our point of view, in addition to a change in work processes, a process of deterritorialization of the workers and users of the SUS, using as a reference the fact that workers operate according to their existential territories. This territorial existence is not physical, but rather is found within each worker, organized according to his or her subjectivity. For this reason, a change in the work processes of a structural, lasting character requires the production of a new worker subjectivity. This process is difficult, complex, and painful, as it means breaking with the established modes of work and production; the worker will see the world as it is: chaotic but powerful due to the singularities that form and find synergy to produce health care. The change in the production of health care is marked by new subjectivities active in the production of care, that come from a way of working in health that centers on the relational field; it means making each encounter with users open to speaking and listening, exchanging glances and gestures that have meaning for both the worker and the user and that form the center of the work process. The processes of change until now have always been partial and have not been able to produce a deterritorialization of the hegemonic medical model, which produces care based in a logic of

the production of procedures. The productive restructuring

...is that which results from a change in the way of producing care, generated through innovations in the production systems of health, that have an impact in the way of creating its products, and in the way of attending to and caring for people and population groups. (23)

Although representative of a period of change in the way of producing health care, the restructuring takes place within the limits of the current model; that is, the capitalistic agencies that operate in health production remain active in the present subjectivities, even after a change in the work process.

In order to bring about a "technological transition" it would be necessary for the productive restructuring to continue to break with the current structures of the biomedical model, with its production process centered in the act of prescription, organizing instead more relational work processes. If a restructuring process does not reach this level it will no longer be innovative and will establish itself as a fixed territory that carries out a production different from the current mode of health care production, but that finally does not break with its foundations, such as the high consumption of hard technologies and the secondary consideration of the relational dimension of health care and the intersubjectivities that operate in the subjective production of health care. This process would then deepen, immobilize and harden the structures that comprise the work process, impeding agencies of desire to manifest themselves and become active in the construction of new territories of health care practices.

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## END NOTES

a. Certain quotes that appear in the original document in Spanish are free translations from texts published in Portuguese. These quotes were subsequently translated into English for this version.

b. Regarding the "affectivation factor," please see Rolnik (3).

c. The Flexnerian model refers to the medical education model introduced under the Flexner Report (13), which suggested training whose core was the "need to link education to research in the biomedical sciences," and that resulted in a model of medical practice centered on the anatomical-physiological body, with the hospital as the main reference (14 p.92-93).

d. "Affects" has, in this text, the meaning assigned by Espinoza, and refers to the capacity of affecting and being affected in an encounter. The affection that provides positiveness ("joy") produces more power of action in the world and the one that provides negativeness ("sadness") produces less power. Quoted in Deleuze (8).

e. In contrast with *capitalist*, which refers to an economic system, *capitalistic* means a way of life, work, and existence, subjectively centered on references subjectively oriented by the social organization of consumption. In the production of care in the health field, capitalistic is associated with a work process with a high consumption of procedures, to the detriment of more relational processes, that is, a process centered on existentialist territories with logics typical of capitalistic subjectivity. Please see Guattari and Rolnik (22).

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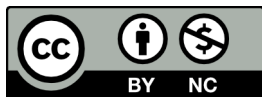
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