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OBJECTIVITY AND SUBJECTIVITY IN CLINICAL NURSING CARE: A REFLECTIVE DIALOGUE

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ABSTRACT

This reflection aims to assess the influence of objectivity and subjectivity in clinical nursing care. We sought to list which elements are necessary for an adequate definition of objectivity and subjectivity applied to clinical nursing care. When unveiling concepts and aspects inherent to care, the intertwining between care is observed based on subjective and objective dimensions. This reflection also allows for a better understanding of the power relations in the nurse's practice and visits the challenges found for the rupture of the current hegemonic model in search of clinical care aimed at the subject in respect to its various dimensions.

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INTRODUCTION

Nursing care includes elements of a scientific and technical nature, that is, imbued with a practical rationality, nursing needs to deal with the aspects that care, and the care action establish. Such strands are of an objective and subjective order. In nursing, care and clinic are intertwined, as there is no clinic without care and vice versa. The care not involved with the individual is a mere procedure. So, to perform care, it must be clinical, close, personal and individualized (MOREIRA, 2015). When interrelated, the clinic and the care enhance the nursing practice and a new signify their practice. Clinical care is the act of caring with responsibility, ethics and social commitment, provided by a qualified nursing professional, through technical-scientific knowledge and clinical eye, using attentive listening, touch, speech, in order to meet the real needs of being cared for, with respect to their uniqueness, life history and individuality (SILVEIRA *et al*, 2013). It is understood that nursing is technical, scientific and aesthetic, inserted in a social context, permeated by subjectivities. Despite having a practice that has historically been guided by modern scientific rationality, which is not subjective, Cartesian and became operationalized by the biomedical model (TEIXEIRA, 2004). Nursing has been transforming itself and stands out for the effort to make the relationship between objective and subjective doing more balanced, even though objectivity is necessary in its actions, nursing must never lose sight of the fact that care was born in subjectivity, in the emotional impulse, not caring and worrying (NODDINGS, 2003). Thus, the relationship between rationality and sensitivity is fundamental, considering that the sensitive reason guides the encounter with a possible internal reason. In view of the above, this article was built out of concerns arising from group discussions during the Critical Analysis discipline of the Doctoral Program in the Graduate Program in Clinical Care in

Nursing and Health at the State University of Ceará and aims to reflect on the influence of objectivity and subjectivity in clinical nursing care.

Objectivity in nursing practices: For many years, Nursing has used techniques as instruments of its knowledge and actions to the detriment of its essential functions: the care for human beings, the administration of the process of caring in Nursing and health education. In the twentieth century, with greater force from the 1950s, the development of nursing theories, with the objective of building a body of knowledge proper to the foundation of its practice, made the profession seek to overcome the limitations exercised by the influence of a traditional philosophy of science, which brought reflexes to Nursing practice and education (VALE; PAGLIUCA; QUIRINO, 2009). Thus, over the course of history, clinical nursing care has been developing in different settings and involving activities inherent to the profession itself, a consequence of technical and scientific competences, based on empirical, scientific, ethical, aesthetic, personal and political knowledge, with aimed at promoting, protecting and preserving health (SILVA; FERREIRA, 2013). Thus, care takes place in different settings and involves two distinct aspects: objectivity and subjectivity. Objectivity aims at precision and safety of care, characterized by the need for knowledge, control and development of techniques and procedures. It is related to compliance with the scientific method, where the legal responsibilities of the nurse's work are noted. The subjective character is centered on intuitive, sensitive and creative components. In this context, the nurse's praxis seeks to maintain a balance between these two focuses (SOUZA *et al*, 2005). Objectivity is found in the use of the same language, in the operationality of health practices, in which subjectivities are not allowed, as these do not present scientific basis, not even scientifically acceptable language. In the objectivity of caring for life, what one says, everyone understands (LIGUORI, 2007). In the structuring of this clinical nursing care centered on the character of objectivity, some objective characters stand out, such as care activities focused on the handling and control of machines, precautions in the analysis and mastery of the language of the devices and the monitoring in relation to possible effects undesirable substances that may be life-threatening. In order to preserve and restore health, it is often necessary to use devices that temporarily replace the vital functions of individuals under health care. Therefore, in addition to direct care, theoretical and practical knowledge for handling this machinery is essential in order to enable correct handling and interpretation of data, ensuring reliability of results and the conduct of care (SILVA; FERREIRA, 2011).

For Gadamer (2011), knowledge, as essential to the practice of doing and acting effectively, is confronted with the technique which favors the expansion of human skills with consequent changes in the objective reality. Therefore, considering the hermeneutic thinking of this philosopher in the implementation of clinical nursing care, presupposes to recognize that objectivity, intrinsic to any health action, should not be the object of purely instrumental knowledge, endowed with a scientific-technological complex by a professional or service that is used on a passive substrate, the patient or community. Objectivity must be developed in the meeting between the nurse, "being who cares", and the patient "being who is cared for", who seek adequate results, from the perspective of both, for prevention, improvement of quality of life and / or reduction of negative aspects of care (AYRES, 2007). Professionally, the action of caring for nurses includes elements of a scientific nature. Formally, they perform therapeutic acts and operations within the scope of health practices. Objectivity in the actions of caring for nurses is required to meet the demands of the health-disease process of the subjects under their care, as many therapies, whether medical or nursing, require interventions that require apparatus and technical procedures. Nevertheless, one cannot fail to recognize that nursing takes care of people, and in this process deals with human subjectivity and with the multiple ways in which these people experience suffering, pain, losses, gains, joys, happiness (FERREIRA, 2012). Therefore, in the construction of their science and in the practical application in care, in the technical-clinical-interactive field, nursing must bring together the specialized knowledge of the sciences, the social knowledge and the subjectivities involved in the care actions.

Subjectivity in clinical care and relations of power: Subjectivity can present itself in different ways that enhance human understanding, as it transcends the areas of knowledge with concepts in philosophy, psychology and social sciences. For Foucault (2004), subjectivity permeates the relationship with oneself and allows each one to perform for themselves "a certain number of operations in their body, in their soul, in their thoughts, in their conduct, in order to produce a modification, a transformation and to reach a certain state of perfection, happiness, purity and supernatural power". Guattari (2010), said that subjectivity can be expressed both in behavior, desire, attitudes, language and in the perception of the world of individuals. The transformations resulting from subjectivity work in their way of perceiving the world and articulating themselves, with work processes and with the social order. The construction of relations between individual and society is based on subjectivity. With the mediation of emotions, language, group formation, replacing reality. In this way, the dialectical unity between subjectivity and objectivity is mediated by a social subjectivity that, through affective and linguistic codes, guarantees the maintenance of its status quo (LANE, 2002). In view of this, the subject being both body and consciousness, the subject is objectivity, being a body, and subjectivity when being consciousness, thus, it cannot be reduced to either of these two dimensions. Because the subject's specificity is a product of the relations of the body and consciousness with the world, a consequence of the dialectical relationship between objectivity and subjectivity in the social context (MAHEIRIE, 2002).

In this sense, subjectivity emerges in nursing care, since the relationship that takes place in the clinical field is not restricted to the body, as in organ medicine, but to the subject who experiences health, illness and his own care. It is important, therefore, to know how to approach, to have sensitivity in perceiving, in the other, verbal aspects and body expressions and to have the ability to listen to favor a therapeutic relationship anchored in the sensitive dimension of care (TEIXEIRA, 2000). The components of the subjectivity of nursing professionals can often be compromised due to the incorporated meanings related to attitudes that prioritize routines, institutional needs, technical and administrative functions, to the detriment of nursing's own knowledge, often subjecting themselves to the wishes and institutional determinations, resulting from power relations (PIVOTO *et al*, 2017). Therefore, the dynamics of one side prevail over the other, revealing in the relations the idea that some rule and

many obey. The structuring of these relations is maintained at the expense of a majority, since the principals are interested in neutralizing the mandates, by reducing these the mass of maneuver in the service of their privileges (DEMO, 2002). Power relations have a strong influence on the production of subjectivity and on the decision making of nurses. In labor relations, perceived as production relations, they give rise to the discipline's micropolitics. This aims at the domination of the other in the sense of modeling and standardization and aims to control the individual so that his decisions and behaviors are defined based on the norms, techniques and determinations emanating from institutional organizations (BUSANELLO; LUNARDI; KERBER, 2013). In this perspective, it is observed that there is an establishment of the singularization of subjectivity and, still, it seems not to be desirable in organizations, as they exalt standardized individuals, following so-called collective value systems, so that they maintain the production of a social subjectivity and guarantee the preservation of organizations (GATTARI, 2011). Subjectivity, based on the culture of submission reproduced and incorporated into behavioral patterns, has contributed to keeping nursing at a crossroads, between determinations external to their knowledge and practices, and also to the possibilities for transforming clinical care (BAGGIO; ERDMANN, 2010; FIGUEIREDO *et al*, 2014). Therefore, in this moment of transformation, subjectivity in clinical nursing care and the exercise of organizational power should be disconnected through greater resistance from nurses in the face of impositions, thus acting as a holder of intellectual, physical, emotional support to interpret human responses, plan, implement and evaluate nursing interventions in order to ensure comprehensive care.

Challenges for potentializing clinical nursing care: After seeking the influence of objectivity and subjectivity for the exercise of clinical nursing care, it is necessary to realize that both are essential, since for the nursing science that has been presenting itself as an objective, one must consider the subjective conditions of those who exercise it and whoever receives it. The objective and subjective knowledge of clinical nursing care must be combined to provide assistance that includes all dimensions of the subject, in addition to the disease and the body. Thus, we have to situate the care of man also in the understanding of the implications that, perhaps, a certain disease has on the sociability of man among his peers, for example, work. Providing an environment of multiple possibilities that is welcoming to the multifaceted demands of the individual, depending on the subjectivity and needs of the patient, is urgent in our contemporary society. It is considered that through the predominant use of objectivity, man can fail to clarify who he is, excluding his internal understanding and with this knowledge, science does not have access to the human way of being and acting, and man can be subjugated by its products, considered scientific (VIDOR, 2013). In this context, Demo (2002) conceives as the primary reason for knowledge the promotion of autonomy, where the individual from the condition of mere receiver, becomes the author of his own choices. Thus, it is relevant to develop modes of nursing care based on defined theoretical-philosophical references and derived from individual and collective reflections that contemplate the evaluative understanding of this care in the socio-political scenario in which it is inserted (SOUZA *et al*., 2005). In view of the above, politicity as a human capacity to be able to think and interfere, in order to achieve high standards of individual and collective autonomy, favors the conduct of its own history, as well as the idealization of changes in its evolutionary process (DEMO, 2002). Such an attribute comes as a possibility to enhance care, in order to be emancipatory and deconstructing the very structures that subjugate it. It suggests a dialectical movement, in which the relationship of dependency happens more to build the autonomy of the actors involved than to maintain itself, as a self-centered exercise of power. Care as a management of aid-power has as its central focus the dynamics, both of historical processes and nature, assuming here a social, ecological and epistemological approach to care (PIRES, 2005). Thus, it is essential to use subjectivity as a value of creative power, a power to create new, innovative devices, an intricate and dialectic (social - individual) production of meanings. It is the movement of affects, movement or circulation of affected bodies, which is what is understood as the movement of the care relationship. (MACHADO, 2009).

At this juncture, Mori and Rey (2012) affirm that to assist a patient, one must start from a notion of health that is constituted by the social, as well as by the different needs and individual processes that are organized in this experience, and, in the same way , illness is also demarcated by the social, not just an individual process. In this sense, the appropriation and use of subjectivity favors a vision that integrates social and individual aspects, as well as recovering the person as a subject in the processes of health and illness. Therefore, the complexity of Nursing science was perceived in order to break with the historical conceptions of reductionist health practices so that one can effectively understand the complex organization of the care process in objective and subjective terms, and, then, seek to strengthen the profession as science. The great challenge that Nursing has today is to effectively provide care with a view to comprehensiveness, directing its actions beyond the technique, the objectivity. Furthermore, health work for Nursing brings as a point of discussion the creation of new health practices that broaden the view on the specificities of each social being, understanding it as unique. According to Carbogim *et al*. (2015), nursing actions should not be based on merely vertical activities, but primarily on dialogical and problematizing processes that value the individual's history and culture and favor the acquisition of adequate health conditions. Adding your practice to actions that value the subjectivity of care guarantees individualized assistance. It is essential to break with the positivist paradigm, expanding to a territory where it is possible to make an exchange between rationality and dialogicity for each being, without losing sight of the necessary sensitivity in conducting the health processes that must be thought about. for each individual distinctly. Given the above, clinical nursing care aims to expand the clinical view beyond the disease and the body. It seeks to combine scientific knowledge with the values of the subjects to be cared for, in a construction of a work process that aims at prevention, cure and rehabilitation.

Conclusion

The study of the objective and subjective implications in clinical nursing care constituted a valuable opportunity to reflect the practice of nursing care, as well as the perspectives of its advancement as a science. Although modern, non-subjective and dualistic scientific rationality divides the client's perception into two approaches - objective and subjective, it is up to nursing to face the residues of the old health models that act on the thoughts and emotions of professionals and in the organization of

institutions. It is believed that it is possible, through the use of intertwined and implicated knowledge and techniques, to build liberating, supportive, emancipatory nursing care, in a way of interaction that contemplates human beings who care and human beings who are cared for, in a harmony that meets needs and brings about the intertwining of knowledge and practices, in which care converges into science. Thus, it is emphasized that it is necessary that the nursing of the future combines feeling and reflection with technology. Therefore, there is an urgent need to build postmodern nursing, a nursing mediator between machine and heart, which looks at the other human being and sees a living body, which desires and pulsates, where the biological is not excluded, but understood in a perspective psychosomatic and relational.

REFERENCES

Ayres JRCM. 2007. Uma concepção hermenêutica de saúde. PHYSIS: Rev. Saúde Coletiva, 17(1):43-62.

Baggio MA., Erdmann AL. 2010. The (in) visibility of caring and of the profession of nursing in the relations space. *Acta paul. Enferm.,* 23 (6): 745-750..

Busanello J., Lunardi Filho WD., Kerber NPC. 2013. Produção da subjetividade do enfermeiro e a tomada de decisão no processo de cuidar. Rev Gaúcha Enferm., 34(2): 140-147.

Carbogim FC., *et al*. 2015. Sentidos da Integralidade no Contexto do Cuidado em Saúde. Investigação qualitativa em Saúde, 1:23-26.

Demo P 2002. Politicidade: Razão humana. Campinas: Papirus.

Ferreira MA 2012. Sobre a solidariedade e a solicitude no cuidado de enfermagem. *Rev Enferm UFSM,* 2(1).

Figueiredo PP *et al*. 2014. The non-implementation of the nursing process: reflection based on Deleuze's and Guattari's concepts. *Texto contexto –enferm.,* 23 (4):1136-1144.

Foucault M. 2004. O uso dos prazeres e as técnicas de si. In: MOTTA, M.B.Ética, sexualidade, política. Rio de Janeiro: Forense Universitária.

Gadamer HG. 2011. O caráter oculto da saúde. 2ª ed. Petrópolis: Vozes.

Guattari F 2011. As três ecologias. 21ª ed. Campinas: Papirus.

Guattari F,Rolnik S (2010). Micropolítica cartografias do desejo. Petrópolis: Vozes.

Lane STM *et al*. (2002). Por uma epistemologia da subjetividade: Um debate entre a teoria sócio-histórica e a teoria das representações sociais. São Paulo: Casa do Psicólogo.

Liguori G (2007). Roteiros para Gramsci. Rio de Janeiro: UFRJ.

Machado AL *et al*. (2009). Subjetividade e pós-modernidade na enfermagem. Rev. Eletr. Enf., 11 (4):1031-1036.

Maheirie K (2002). Constituição do sujeito, subjetividade e identidade. Interações, 7(13).

Moreira TMM *et al*. (2015). O cuidado clínico de enfermagem. Fortaleza: EdUECE.

Mori VD, Rey FG (2012). A saúde como processo subjetivo: uma reflexão necessária. Psicologia: teoria e prática, 14(3): 140-152.

NoddingsN (2003). O cuidado: uma abordagem feminina à ética e à educação moral. São Leopoldo: Unisinos.

Oliveira DC *et al*. (2009). O processo de Trabalho e a Clínica na Enfermagem: pensando novas possibilidades. Rev. Enferm. UERJ, 17(4):521-526.

Oliveira TR, Simões SMF (2013). A comunicação enfermeira-cliente no cuidado em unidade de pronto atendimento 24h (upa 24h): uma interpretação em Travelbee. Enfermería Global, 30:91-105.

Pires MRGM 2005. Politicidade do cuidado e processo de trabalho em saúde: conhecer para cuidar melhor, cuidar para confrontar, cuidar para emancipar. Ciênc. saúde coletiva, 10(4):1025-1035.

Pivoto FL. *et al*., 2017. Organização do trabalho e a produção de subjetividade da enfermeira relacionada ao processo de enfermagem. Esc. Anna Nery, 21(1).

Silva RC., Ferreira MA. 2011. A dimensão da ação nas representações sociais da tecnologia no cuidado de enfermagem. Esc. Anna Nery,15(1):140-148.

Silva RC., Ferreira MA. 2013. Clínica do cuidado de enfermagem na terapia intensiva: aliança entgre técnica, tecnologia e humanização. RevEscEnferm USP, 47(6):1325-1332.

Silveira LC *et al*. 2013. Cuidado clínico em enfermagem: desenvolvimento de um conceito na perspectiva de reconstrução da prática profissional. Esc. Anna Nery, 17(3):548-554.

Souza ML *et al*. 2005. O Cuidado em Enfermagem: uma aproximação teórica. TextoContextoEnferm, 14(2):266-270.

Teixeira ER. 2000. Subjectivity in nursing: the discourse of the subject in care. Revista brasileira de enfermagem, 53(2):233-239.

Teixeira ER. 2004. A crítica e a sensibilidade no processo de cuidar na enfermagem. Esc. Anna Nery, 8(3): 361-369.

Vale EG., Pagliuca LMF., Quirino RHR. 2009. Saberes e práxis em Enfermagem. Esc. Anna Nery, 13(1):174-180.

Vidor A. 2013. A objetividade da subjetividade. Revista Saber Humano, 3:68-75.

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