PSICANÁLISE E HOSPITAL: QUESTÕES DISCURSIVAS A PARTIR DE TRÊS EXPERIÊNCIAS

PSYCHOANALYSIS AND HOSPITAL: DISCURSIVE ISSUES BASED ON THREE EXPERIENCES

PSICOANÁLISIS Y HOSPITAL: CUESTIONES DISCURSIVAS A PARTIR DE TRES EXPERIENCIAS

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ABSTRACT

This article is the result of work carried out by psychoanalysts in different health institutions. Our aim is to give a voice to the subjects who are affected by the most diverse traversals in their bodies - bodies which, as we understand it, are not just an organism. We found that often, by identifying them with a diagnosis or even a behavioral category, the possibility of giving credence to what patients say about themselves or the situation they are going through is emptied, which can produce another source of suffering. Contrary to this perspective, in the discourse of psychoanalysis, the person addresses the subject, allowing them to produce something by taking their place of speech. This is the foundation of our methodology, both in terms of working with patients and in terms of research, both of which have a Moebian relationship - a relationship that Elia (2023) approximated to that of a researcher. With the aim of verifying the place of the psychoanalyst in the institution and the effects of their work, we have gathered hospital and outpatient clinical experiences in three different devices belonging to the SUS network.

Keywords: Psychoanalysis. Hospital. Mental health.

RESUMO

O presente artigo é fruto do trabalho realizado por psicanalistas a partir de sua inserção em diferentes instituições de saúde. Nossa visada é dar voz aos sujeitos que ali estão acometidos pelos mais diversos atravessamentos em seus corpos – corpos que, como entendemos, não se resumem a um organismo. Verificamos que, muitas vezes, ao serem identificados a um diagnóstico ou mesmo a uma categoria comportamental, se esvazia a possibilidade de se dar crédito àquilo que os pacientes dizem a respeito de si mesmos ou sobre a situação pela qual estão passando, o que pode produzir uma outra fonte de

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sofrimento. Na contramão dessa perspectiva, no discurso da psicanálise o gente se dirige ao sujeito, permitindo a este produzir algo ao tomar seu lugar de fala. Eis o fundamento de nossa metodologia, tanto em sua vertente de trabalho com o paciente, como no de pesquisa, tendo ambos uma relação moebiana – relação esta que Elia (2023) aproximou à de *pesquisante.* Com o objetivo de verificarmos o lugar do psicanalista na instituição e os efeitos de seu trabalho, reunimos experiências clínicas hospitalares e ambulatoriais em três diferentes dispositivos pertencentes à rede SUS.

Palavras-chave: Psicanálise. Hospital. Saúde mental.

RESUMEN

Este artículo es el resultado de un trabajo realizado por psicoanalistas a partir de su intervención en diferentes instituciones sanitarias. Nuestro objetivo es dar voz a los sujetos que se ven afectados por las más diversas travesías en sus cuerpos - cuerpos que, tal como lo entendemos, no son sólo un organismo. Hemos comprobado que muchas veces, al identificarlos con un diagnóstico o incluso con una categoría conductual, se vacía la posibilidad de dar credibilidad a lo que los pacientes dicen de sí mismos o de la situación que atraviesan, lo que puede producir otra fuente de sufrimiento. Contrariamente a esta perspectiva, en el discurso del psicoanálisis, la persona se dirige al sujeto, permitiéndole producir algo al ocupar su lugar de palabra. Este es el fundamento de nuestra metodología, tanto en lo que se refiere al trabajo con el paciente como a la investigación, ambos con una relación moebiana, relación que Elia (2023) aproximó a la del investigador. Con el objetivo de verificar el lugar del psicoanalista en la institución y los efectos de su trabajo, hemos reunido experiencias clínicas hospitalarias y ambulatorias en tres organizaciones diferentes pertenecientes a la red SUS.

Palabras clave: Psicoanálisis. Hospital. Salud mental.

INTRODUCTION

The possibility of inserting psychoanalysis in public health institutions is the result of the incorporation of the psychosocial dimension in health, which, in the twentieth century, engendered a new model, alternative to the biomedical one, known as the biopsychosocial model (De Marco, 2006). In order for this model to operate in the different health institutions, it was necessary to include multiprofessional teams, composed of technicians from different fields of knowledge, including psychology – and it was in this wake that psychoanalysis had some opportunities to insert itself. From this insertion, we perceive the importance of giving voice to the subjects who are there, affected by the most diverse crossings in their bodies – bodies that, according to psychoanalysis, are not limited to an organism. On the other hand, the entry of the psychoanalyst also opened the door for him to intervene in multidisciplinary teams, whose demands for listening have been repressed for a long time (Miranda & Ferreira, 2024). In order to verify the place of the psychoanalyst in the institution and the effects of his work, we gathered, here, clinical experiences of psychoanalysts inserted in different fields of research and inserted in hospital and outpatient institutions in devices belonging to the SUS network.

The convergent point of these experiences is the bet that psychoanalytic listening has the power to rotate the discourses rooted in the institution and, mainly, to question the hegemonic discourse of contemporary science. The latter has been joining the discourse of the capitalist, who has capital itself as its agent and as its target, although it considers itself to be neutral, without ideological, political, and economic interests (Beer, 2017; Dunker & Iannini, 2023; Elia, 2023). In fact, the result of this is the promotion of an economy of subjectivities in favor of capital, which makes them objectified (Alberti et al., 2022). The psychoanalytic method implies that the psychoanalyst, as the agent of his discourse, addresses the subject in such a way that he begins to speak, because it is as a speaker that he articulates and invests in his desire, even in the face of the adversities imposed by life.

The hospital environment, in addition to being the place where many adversities are put on the scene, is a territory in which there is a prevalence of medical discourse, which often promotes the identification of the patient with his disease, reducing him to his diagnosis – as is quite visible in the case of the care of children with a syndromic diagnosis, as will be presented.

METHODOLOGY

The present work arises from the experience of psychoanalytic researchers who have a direct practice in hospital institutions. Silva & Macedo (2016) highlight the importance of the researcher remaining actively involved in the clinical process, so that the emergence of the material to be interpreted through the psychoanalytic method is possible. Let us see why this articulation between *praxis* and research in psychoanalysis is essential in the methodological field of psychoanalysis based on the book *The Science of Psychoanalysis,* by Luciano Elia (2023). Elia addresses the specificities of the science of psychoanalysis, warning that, in this field, methodology is not "the mere list of operational and technical procedures that the researcher performs" (*Idem*, p.217). Our method, therefore, moves away from the "classic methodological discussions in research in the human and social areas, which are subdivided into the quali*/quanti binomial*"; nor does it coincide with "the methods and techniques of research used in psychology" (*Ibidem*).

The only method to be used in the field of psychoanalysis is "the psychoanalytic method, the same one used in the device of psychoanalytic experience" (Elia, p.218). In order for the particularity of this method to be sustained, Elia indicates that, although the researcher is not in the position of analyst, neither does he occupy the place of experimental researcher. He is a "very peculiar, specific analysand, who alternates his moments as a scientist and researcher with those of analyst" (Elia, p. 224). In order to finally designate this place of researcher who occupies the place of analysand, Elia proposes the term *researcher* (Idem, p.226).

The examples presented here could be gleaned from this position of researchers in public health services, including the effects of an ethical position that takes into account singularity, of course. These effects can be observed in patients, but also among other health professionals, who may have a greater or lesser reception in relation to what is directed to them from clinical listening – depending on the level of openness that these professionals present in relation to the psychoanalytic discourse.

We will see that, if, on the one hand, an articulation between psychoanalysis and medicine is possible and beneficial, we would even say necessary, on the other hand, we verify a tension produced by the interaction between these two fields, considering that, for the medical discourse, it is precisely subjectivity, so dear to psychoanalysis, that can sometimes end up being subtracted in its approach to the patient. Hence the importance of the psychoanalyst, whose mere presence in a team signals the presence of the "man" in his own disease, taking into account the equation brought by Clavreul: "sick = man + disease" (Clavreul, 1983, p. 99-100).

CLINICAL CLIPPINGS

AN ARTICULATION OF ACADEMIC RESEARCH GUIDED BY PSYCHOANALYSIS AND THE INTERNSHIP IN THE PSYCHIATRY SECTOR OF A UNIVERSITY HOSPITAL.

From the systematic monitoring of the possible articulations between practice and investigation, we report to what extent the insertion of this specific practice contributes to the teams in which psychoanalysis is inserted. We ask what is transmitted, in psychoanalysis, in such a way that it can be verified that, from his insertion in a team, something effectively contributed? We have encountered different teams over the years, including a psychiatry service at a University Hospital. In recent years, the team has welcomed psychologists who have passed public examinations who effectively contribute to the insertion of a practice that is also supported by psychoanalysis.

This is demonstrated by the work with Artur, who arrived at the hospital at a very young age, and today is already 12 years old. We could distinguish three times in the insertion of a psychoanalytic approach with the clinic with children in this service: 1) at first, the service had a specific Sector for the permanence of children who need psychiatric follow-up, supported by a psychiatrist who also had psychoanalytic training; 2) with her retirement, this Sector was closed, and the follow-up of children and adolescents in the service was restricted to medication, sometimes with a dialogue with teams of psychology interns from the university itself, who accompanied one or another of these patients; 3) today, with the inclusion of some psychologists who also have psychoanalytic training, a true dialogue has been opened with specialized students and residents in psychiatry, since it is part of their curricula to dialogue with these psychologists, without, as a result, the exchange with teams of those interns in psychology, or even with research professors from graduate programs at the Institute of Psychology who also have an orientation Psychoanalytic. In principle, we could say, the current scenario is very propitious to advance a transmission of psychoanalysis in the psychiatry sector of the aforementioned hospital, and particularly for work with children and adolescents. With practice, the question that increasingly questions us is: what is the extent of this scenario? To what extent can we effectively count on the presence of a psychoanalytic orientation within a psychiatry sector of a University Hospital, in this third decade of the twenty-first century, in the face of the whole scientistic thrust that intends to guide medical practice? To answer this question, we will try to summarize the Artur case, which has already been deepened on another occasion.

Son of a very young couple, when Artur turned two years old he experienced the separation of his parents and began to see his father very sporadically. She lived with her

maternal grandparents until the age of ten when she joined her mother who was already pregnant with Artur's current stepfather. Even so, the grandmother continued to take care of the boy a lot, and she was even the one who brought him to the first interview. She recalled at the time that Artur had become very aggressive when, at the age of six, he was totally abandoned by his father. Aggressiveness is, in fact, one of the complaints that return with some frequency, not only from the grandmother, but also from the mother. She emphasizes a significant increase in aggressiveness on the occasion of the move to the new house, where she began to live with her and her stepfather, shortly before her half-sister was born. But he also notes that Artur only has aggressive behaviors with female figures, and that he respects his stepfather a lot with whom he has developed a very good relationship.

Artur was followed, in addition to Psychiatry, by Genetics, General Practice and Neuropediatrics when he arrived at the University Hospital at the age of four, remaining there until the following years – precisely in the second period of the Service, the one in which attention had been reduced to medication monitoring. In all those clinics, the significant "deficit" marked Artur, as he had a so-called fragile X syndrome, identified by Genetics. It is associated with certain behaviors of the boy called inconvenient, in addition to convulsive disorders and bodily manifestations such as prominent ears. For the medical discourse, this will justify the myriad of diagnoses that the boy brings in his medical record, from autism, to ADHD, language deficit, among others. All these diagnoses led to a family discourse, but also from the school, according to which Artur is a child who would not be able to learn. Thus, when he arrived at the first appointment for a follow-up based on psychoanalysis, at the age of 12, the young man could neither read nor write. And compared to his sister ten and a half years younger, he is always said to be the one in deficit, with an inopportune behavior.

The first interview with Artur introduced a problem that remained the main subject for many months that followed: the separation from his paternal aunt and grandmother. The fact that they had more recently cut off contact with Artur – probably because he called them all the time, without limit and without truce – led him to request that we get their phone number, so that he could call from his cell phone. Evidently, we did not know them and even less did we have these numbers, but their insistent demand led us to conclude that Artur supposed that his therapist knew everything, even what, in reality, he could not even have known. As a result, we were able to raise a diagnostic hypothesis based on the Lacanian psychoanalytic theory, of an unbarred Other, a hypothesis, therefore, that occurred in transference, indicating a structure without the inscription of the Name-of-the-Father. Other statements by Artur corroborated this hypothesis: Artur made no distinction between time –

he and the therapist were the same age in certain sessions – nor place – at the same time, his aunt and grandmother could be in the United States and/or in a shopping mall in Rio de Janeiro –, some neologisms also appeared in his speech. But precisely for this very reason, and for the fact that he has become so attached to these two relatives on his father's side who left him – such as his father, by the way –, for the fact that he communicates correctly with the therapist, and even despairs with a "I don't know what else to do" (sic), the hypothesis of autism can be definitively discarded, allowing work from the diagnosis of psychosis. We then hypothesized that Artur had developed a psychotic structure as a result of his first experiences with the Other, for this reason, a treatment that articulated medication monitoring with psychoanalytic listening, and family monitoring, initiated the possibilities of improvement. And although Artur had consequences due to the genetic disorder – such as the shape of the ears – the psychoanalytic diagnosis made it possible to reorient the therapeutic project itself, to the extent that, before, the reading of the genetic diagnosis only identified a "deficit" of Artur's, as if it were an impossible problem to solve and that would prevent the boy from even learning. This, then, is our hypothesis that points to the possible iatrogenic intrinsic to a child's diagnosis. Only at the age of 12 did Artur have the chance to be heard, until then he was only treated with exams and medications – both clinical and genetic, as well as psychiatry.

As the sessions progressed, Artur began to address some demands to the therapist herself, in the same way as he had done with his aunt and grandmother until then. This was not without a negative transference, as for example the day he shouted to the therapist: you don't want to take me – a phrase he had originally referred to his aunt. It is likely that the term "aunt" itself has contributed, to the extent that in the children's speech, their therapists are usually called aunts... But it was this immediate transfer that allowed a new orientation to the treatment because, clarifying that she was not his aunt, the therapist suggested that together they write a message to the aunt. At the same time, it was proposed to him to return once more that week, which was very well received by Arthur. A disappearance – from the session, from the therapist, from himself in the session – began to emerge a return, a possibility of reunion in the same week.

Faced with the fact that he does not know how to read or write, in one of the sessions that followed that one, he surprises the therapist with the question: "Did I think, auntie?", which evidently provoked the question on the other side: "Has anyone ever told you that you don't think?", reassuring him: "I think you think all the time!". In response, Artur, a year and a half after starting the treatment, replies: "yes, auntie. I'm smart, right. Thank you, aunt." By thinking and being intelligent, thus debunking the many deficit diagnoses that

were imposed on him from a very early age, he wants to learn to read and write. The many a priori deficits caused by the diagnosis of fragile X that effectively brings with it so many others as effects of it, allowed us to raise the hypothesis that the deficits were, in reality, an investment in the subject Artur and, instead of the diagnosis of the syndrome having promoted a redoubled care with the child's literacy and schooling, led to a crystallization of such effects. In turn, we think that such crystallization is certainly also a consequence of the lack of care and syndromic assumptions, since we think that they have not been anodyne in relation to the way in which the child's relationship with the Other was established and, therefore, to the very psychic structuring of psychosis. Of course, family composition and the lack of greater assistance to one's own family may have been the most determining factor. In any case, autism and schizophrenia are articulated (Alberti, 1999), but they are not the same thing. It is not a question of developing this whole issue, as the literature in psychoanalysis on it is vast and complex (Pozzato & Vorcaro, 2014). The question we raise refers to the fact that autism is assumed to be applied to every child with fragile X syndrome, resulting from the identification of autism as an exclusively organically determined syndrome – disregarding all the vast literature that examines, for example from the point of view of psychoanalysis, the possible multiple determinations for autism or schizophrenia. On the other hand, in our view, such a position is absolutely iatrogenic, as it prevents a bet on the subjectivation of the schizophrenic child, in order to dialectize his relationship with the consistent Other.

Presenting the preliminary results of Artur's follow-up at the heart of a psychiatric service, and especially him being in a University Hospital with medical students and psychiatry residents, is, in addition to the possible advances of the case, one of the contributions that psychoanalysis inserted in the hospital can offer. A bit like what we were able to verify also in the context of a pediatric sector that has a specific outpatient clinic for children with Down syndrome.

CONSEQUENCES OF A CLINICAL ACTIVITY IN A PEDIATRIC OUTPATIENT CLINIC FOR CHILDREN WITH DOWN SYNDROME

Before starting the discussion, we emphasize that Down syndrome (sD), or trisomy of chromosome 21, is characterized by medicine as a genetic condition that presents specific phenotypic characteristics, delay in neuropsychomotor development and intellectual deficit (Brasil, 2015). However, in addition to the genetic factors that necessarily make up sD, we highlight that the syndrome is expressed in each person in a unique way, considering the influence that other factors exert, such as cellular interactions,

environmental factors, as well as the time and place where cells divide, among others (Moreira; El-Hani; Gusmão, 2000).

Thus, due to the clinical health issues that may be associated with this genetic condition, such as congenital heart disease, hypotonia, neurological and ophthalmological alterations, etc., children with DS need care from various specialties. In the state of Rio de Janeiro, we have a University Hospital as a reference that, combining the specific care that this genetic condition requires, offers multidisciplinary care to children with DS in the range of zero to three years of age.

In order to discuss DS at the interface between psychoanalysis and medicine, highlighting how the medical discourse operates and the place that children with DS occupy in the hospital context, we bet on psychoanalytic listening.

We consider here by medical discourse the methodological imperative based on objectivity and scientificity, requirements imposed on physicians, in an attempt to demarcate, for example, that the medical record be filled out based on the same categorizations and clinical observations, regardless of which physician does it and, above all, regardless of the characteristics of the case by case. As a result of this protocol logic, singularity is excluded from the scene in the same way that the subject is reduced to the phenomena he presents, being placed in previously established diagnostic categories (Clavreul, 1983).

From this perspective, for medicine, DS is a genetic condition that necessarily leads to an intellectual disability, which ends up fixing these children in the place of "incapable". As a secondary effect of these low expectations regarding the child's capacities, we found in our experience that his subjectivities are hardly taken into account. We hypothesize that this is due to the fact that these children have been crystallized in discourses that take them as an object, whether of care, diagnoses or interventions. These discourses affect them not only through social life, but also in the very heart of their homes and even in certain medical and pedagogical contexts. We cite as an example the statement of a mother who expressed well this de-subjectivizing view of the child with DS: "I don't know if in his case it is possible to see a psychologist". Faced with such a question, we ask ourselves: "why wouldn't it be?". Because she was so stigmatized due to what was interpreted as her disability, the mother herself did not consider the possibility of this child having the capacity for psychological care.

In the hospital context, we found that the interface between psychoanalysis and medicine produces a tension that unveils the way in which subjectivities are often silenced by medical discourse. According to psychoanalysis, understanding that the subject is

always from the unconscious, we bet on the advent of the subject in all his singularity, regardless of whether or not he presents any syndrome. Thus, we verify that the work that is required at the beginning of the clinic guided by psychoanalysis is that of dialectizing these so-called stigmatizers.

It is important to note that the objective imperative position of the medical discourse is justified by the need for the physician to apply his technique in the best possible way. However, the professional does not seem to realize that, by excluding his own subjectivity and that of the patients from the scene in favor of his exercise, they are present and produce effects, especially in cases of communication of difficult diagnoses/news. How? In the daily life of the hospital, health teams are often crossed by numerous embarrassments arising from the malaise that some cases cause, either due to the complexity and social vulnerability they present, or because of the idealization of maternity by some professionals, or even as an effect of the stigmatization historically constructed about Down syndrome. This malaise does not fail to influence the ways in which the doctors and the health team themselves relate to patients and their families, as we will see in the fragment of Nilma's case.

From the context of a private maternity hospital in the city of Rio de Janeiro, we highlight the statement of a doctor to Nilma, Zoe's mother, who is a 16-year-old girl: "you will have to abandon your life to take care of her. People with this condition need a lot of care for the rest of their lives".

Upon hearing this commandment, the mother, deeply shaken by the doctor's speech in the postpartum period, reported that it was only a few years later that she was able to come to the conclusion that she did not reject her daughter or her diagnosis, but rather the certainty prophesied by her doctor that she would have to give up her life to take care of a baby who, supposedly, it would depend totally on her due to Down syndrome. This situation illustrates the power of medical discourse that can contribute to the crystallization of the patient's future. Thus, although the medical discourse aims at neutrality, objectivity and scientificity, Nilma's case denounces how difficult it can be for doctors to remain objective and neutral at all times.

In addition, we highlight the frequent reports of mothers seen at the outpatient clinic about how the moment of the news of the diagnosis occurred and how, many times, the information was given at the time of birth in a careless and insensitive way, as we can see below: "They [in the maternity ward] looked at my baby as if he were a monster"; "They said she had something wrong and sent us to the geneticist"; "Nobody explained to us what the syndrome is, they just told us to look for a geneticist and sent us away"; "Hearing that

diagnosis [at the time of birth], in front of everyone, broke me. It was as if a hole had opened in the ground and I fell there."

In view of these statements, we found that receiving the diagnosis of SD from a child requires an important work of psychic elaboration of the mother, father and family members, whether during pregnancy or after birth. In addition to this moment that potentially generates anguish, we emphasize that the lack of preparation of these professionals to communicate the diagnosis can cause important effects on the relationship between the mother and her baby in these first moments of life. That said, we pose the following question: would such difficulties be due to the lack of technical preparation of health professionals and/or the difficulty that physicians face when subjectivities emerge on the scene?

We observed that the difficulties experienced by team members seemed to have more to do with aspects of their own stories. Here we highlight the importance and urgency of the psychology professional who works in the hospital context to also take care of listening to the professionals who are part of the health teams, since they are also subjects with fears, embarrassments, anguish, expectations and frustrations. After all, how can the child with Down syndrome be welcomed by the mother if she is not welcomed by the teams, in her difficulties, anguish and even rejection regarding motherhood or the diagnosis of Down syndrome?

We aim to privilege the interface of psychoanalysis with the teams and the effects of psychoanalytic listening in front of these professionals who operate from the discourse of medicine, ratifying the importance of the place of the psychology professional in the hospital context. And to observe that, based on the effects of our interventions, even in the smallness and difficulties, it was possible to sustain psychoanalytic listening in dialogue with medicine.

ISSUES THAT AROSE FROM THE CARE OF CARDIAC PATIENTS IN A STATE HOSPITAL.

The questions that will be raised below originate from a work in the public network, in a backup hospital aimed at patients with cardiac alterations, many of whom are waiting for surgical procedures to be performed in other hospital units in the state.

The cardiology clinic has some specificities, related, notably, to the fact that it is focused on an organ that, for the popular imagination, represents life. Therefore, it is not only with the idea of finitude that the subject is faced when he falls ill, but also with affective aspects of his existence (Borges, Oliveira & Vasconcelos, 2020).

Although heart disease affects the physical dimension, which can be evidenced through clinical, laboratory and imaging exams, we found that the patients at this hospital demanded psychological care because they were distressed, wanting to talk about other issues that afflicted them. Curiously, they minimized the severity of his cardiac condition and, not being able to wait for the surgical procedure to be performed, they often asked to leave the hospital. This position bothered the medical staff, to the extent that patients placed their demands as subjects ahead of the care necessary for the disease. It is worth remembering that, as Clavreul (1983) pointed out, the medical discourse is directed precisely to the disease. For the author, the patient is only taken into account by the doctor to the extent that it enables the information of data about the illness that afflicts him; but, as far as its subjectivity is concerned, it is all the better that it be silenced so that the disease can be isolated.

For Clavreul, the patient is the result of the equation "man + disease", and diagnosis is the act that makes him enter the medical discourse: "in this way, the doctor shows that what the patient suffers from has its place in the system of signifiers that constitutes the medical discourse" (Clavreul, 1983, p.52).

We will present here some examples of situations that marked the division between man and disease in a hospital that is very fond of the biomedical model. We do not intend to generalize the situations experienced there, but only to present them in order to demonstrate that the medical-centered model can remain hegemonic, even when concealed by psychosocial veneers – which may include the presence of multidisciplinary teams and a *round* with different professionals. We will demonstrate that, in these situations, the psychoanalytic approach can have important effects, and it is not up to us to go back in the face of the possibilities of intervention.

AN ILL-MANNERED DOCTOR

The following fragment involves the case of a patient, Manoel, who had suffered a heart attack and, even presenting a serious condition, with an indication for heart surgery, demanded to leave the hospital without continuing the treatment. This, in fact, is why we were called to attend to him.

We started the service avoiding keeping ourselves in a position to convince him to stay in the hospital, prioritizing inviting him to speak in free association. He said that he was very distressed, and that this situation was being intensified by the insistence of the other professionals in presenting various reasons for him to stay. Manoel talked about how difficult it was to stay hospitalized and that he would like to be at home with his family. We

asked what had happened before the heart attack occurred. Although it is a physical involvement, related to a series of cardiovascular alterations, we have noticed in our practice that it is not uncommon for infarction episodes to occur subsequent to traumatic events. When questioned, the patient said that his son had been brutally murdered due to his involvement with illicit drugs, correlating the heart attack to this terrible event when he said: "my heart couldn't take it". She blamed herself for her son's death, and, by asking for discharge in absentia, she put her life at risk as a way of doing penance for not having been able to avoid her son's involvement with the crime.

The patient was crying profusely when talking about this son when he was interrupted by the sudden appearance of a doctor. Caressing Manoel's arm, she asked "why are you crying? Oh, don't cry." The patient himself was astonished by the interruption.

After the doctor's departure, Manoel was indignant: "but how rude! This doctor doesn't respect your work, right?" The patient was talking about the brutality of an act carried out against his son, when he was violently removed from the position of subject. Fortunately, he rejected the doctor's consolation, which placed him again in a place of object: before he was prevented from expressing the desire to leave; Now she did not want him to cry, without even knowing the justified reason that led him to this manifestation of sadness. In any case, even without us touching on the issue of his discharge request, he ended up deciding to wait for the referral for surgery.

IS IT POSSIBLE TO HEAR WITHOUT GIVING VOICE?

Mário was a black patient, without teeth in his mouth, living in a community in Rio de Janeiro, approximately 70 years old. He was a very large man, who moved with difficulty and had a serious cardiac condition, which required surgical intervention. The way Mário expressed himself was that of a typical carioca, mixing spontaneity, a certain irritation and irony. He was crossed by the culture of samba and had, in his community, a certain prestige.

Some staff at the hospital, including nurses and physiotherapists, complained a lot about this patient, saying that he addressed them in a rude manner. Once a nurse identified a certain "evil" in her speech when she asked him to bathe her. On another occasion, Mário would have presented "diarrhea", and warned the nursing team that he had soiled a toilet. Some time later, they found feces on the lid of a toilet. He was asked if he had evacuated that day, to which he replied in the affirmative. Because of this answer, they understood that he was the one who, purposely or not, had soiled the toilet lid, although he denied that he had done so.

During the meeting in *the round*, the medical team was informed about "Mário's bad behavior" and the aforementioned suspicion, unquestioned. To our surprise, the team began to discuss possible ways to "expel" Mário from the hospital: "we can, yes, send him away for misconduct" – even though there was no medical indication for him to be discharged at that moment. One of the doctors then said he would have a "serious conversation" with him. He considered himself a "physician-psychologist" because he believed in the precise power of his interventions with patients about whom a member of the team complained. That same day, the "doctor-psychologist" called the patient's daughter and said, harshly, that if he did not change his behavior he would be "thrown out" of the hospital.

The content of this conversation was reported to us by a nurse, adding that, after the doctor's visit, Mario was very sad. He slept all afternoon and seemed depressed. We waited for him to wake up to find out how he was: "I'm sad, very sad. The doctor called my daughter to give me one of those 'pito'. He said that I treat the nurses badly and that I would have 'shit' on the toilet lid."

Hearing him talk about this accusation, our intervention was a laugh. How can doctors in a deadly environment like a hospital bother to pursue a supposed toilet "lid"? When he saw that we laughed at the situation, Mario also laughed, and began to narrate the situation in an increasingly comical way: "I saw the poop and went to another bathroom. Do you think that if I did a 'shit' like that, I wouldn't get a dirty ass? Wouldn't he have to take a shower afterwards? The real 'shit' is out there". And he repeated: "can you believe that the doctor called my daughter to say: your father left feces on the toilet lid?!". By quoting the doctor's speech with different intonations, in an increasingly funny way, he distanced himself more from that accusation that had been made against him, stopping to justify himself in order to convince us that he was not the "author of the work".

We told him that we were not there to do investigations and that we were concerned about his state of health. At the end of the service, after so many laughs, he was no longer sad.

During the next day's round, in which we participated, the other doctors talked about the improvement in Mário's behavior. They addressed the "doctor-psychologist" who had admonished him by saying "Doctor, your therapy was a success!" – "therapy" because he used to say that he did "therapy" with patients who behaved "badly". This "therapy" consisted of speaking harshly to patients, threatening them to expel them if they did not behave. Little did they know that the success of this procedure was due to the fact that patients, after being threatened, sought psychological care. This was the case with at least

three patients we treated. One of them had told us: "After the doctor came here, I feel like a boy. He said that if I didn't calm down, he would make a paper to send me away. Does he have this power?!". The patient calmed down only when we were able to relativize this doctor's speech, saying that he was just bluffing.

During the *round*, the interventions of the "doctor-psychologist" were gradually exalted, while our interventions, which in fact appeased the patients, had their visibility increasingly repressed. As well as the subjective expression of patients (identified as rude when they manifest themselves with the particularities of a population placed on the margins of what is considered polite polite), we, in psychology, were also excluded when we brought up the position of those people, thus breaking with the hospital-centered discourse.

Our denunciation in different spaces regarding the conduct of the technicians led to making our permanence in the service unsustainable. We can thus say that the result of our work led to two invitations: one to leave the hospital (we ended up being dismissed), and the other, made by the patient himself (Mário), to visit him in his community after the surgery.

This duplicity of invitations, one to the outside and the other to the inside, brings up important questions about the ethics of an analyst, and demonstrates well how psychoanalysis is not aseptic, as some of its critics put it. Giving voice to the subject objectified by the medical discourse is not an easy task. And sustaining this voice can be as difficult as our permanence in some spaces.

CONCLUSION

We present here some fragments of care provided in health institutions. Despite the particularities of each device, we demonstrate how much the interventions carried out, based on a psychoanalytic approach, had important effects for patients, often placed as objects of medical discourse.

We retrieve a text that distinguishes teams according to their greater or lesser acceptance of a psychoanalytic intervention. It is a text that takes up a metaphor from Lacan (1975, p.18), according to which psychoanalysis would be the last flower of medicine. The fact is that, in the first two teams briefly addressed here, both inserted in the university context, it was possible to find those who were interested in our interventions. In the hospital that had no connection with the university, these interventions ended up being rejected – just like ourselves. These differences in the possibilities of the analyst's action confirm the hypothesis that "the University Discourse, having somehow subverted the Master's Discourse in the university hospital, introduced a dialectization in the medical

order, opening paths for the analyst's action" (Alberti, 2000, p. 50). Even if this also opened the doors, as the author continues, to the injunction of the Discourse of the Capitalist – whose effects were developed and exemplified by Moreira & Araujo (2023) –, "for the simple fact that it is articulated with the University Discourse", such subversion welcomed the exercise of clinical care linked to academic research regardless of the content of this exercise, because in the University Discourse one knowledge is equivalent to the other. There are differences, therefore, between the work carried out in a place "in which the adjunct professor of the Institute of Psychology receives the same salary as an adjunct professor of the Faculty of Medicine and in a hospital in which the doctor has a higher salary than the psychologist, for the simple fact of being a doctor" (Alberti, 2000, p. 50).

With the experience of many years in the articulation between psychoanalysis and hospital practice, the marriage of the discourse of science with that of the capitalist becomes increasingly evident there, in the way the author develops it in this text. What can be observed regarding the psychoanalyst's discourse in the daily practice is that it requires the psychoanalyst's permanence in it, because, as much as there are receptions of its effects in everyday life, and as much as Lacan (1993) has observed that the only discourse that can confront that of the capitalist is that of the psychoanalyst, There is no psychoanalysis that can be sustained without the presence of the analyst.

Our interventions, both during patient care, during rounds or with other professionals, are in tune with what Lacan called "psychoanalysis in extension". They are directed to the institutional field of a hospital unit, based on what is developed didactically, through "psychoanalysis in intention" (Lacan, 2003, p. 251). In it, even if the developments cannot be verified immediately, it is believed that the "original experience" of psychoanalysis leads to an effect of time *a posteriori*, a condition that Lacan considers radical to psychoanalysis (Ibidem).

Differently when it comes to the insertion of the psychoanalyst in the hospital, because if it is possible to verify this effect from time to time in the case by case of an intervention – whether with a patient, a family member, or even a member of the hospital team –, experience shows that the daily work of the psychoanalyst requires his presence in a persevering way, otherwise, the other discourses that circulate there take advantage of its absence to foreclose, on the one hand, the subjects, on the other, the lack, the failure, which limps.

Although the entry of psychoanalysis into health institutions was an important achievement, it is not at all easy to sustain its discourse, especially in institutions more

attuned to a totalizing medical discourse, which seeks to silence both subjective manifestations and those who seek to welcome it.

On the other hand, it is worth noting that, despite the fact that there are lines of psychological approach that are quite in agreement with the medical discourse, psychoanalysts continue to remain inserted in the different devices of the SUS network. This work lent itself to bringing examples that illustrate how much psychoanalysis persists and resists the totalizing discourse, as do the patients, who do not remain docile to the "bad education" of those who insist on silencing them.

REFERENCES

1. Alberti, S. (1999). *Autism and schizophrenia in the clinic of schize*. Rio de Janeiro: Rios Ambitious.

2. Alberti, S. (2000). Psychoanalysis: The last flower of medicine. In S. Alberti & L. Elia (Eds.), *Clinic and research in psychoanalysis* (pp. 37–56). Rio de Janeiro: Rios Ambitious.

3. Alberti, S., Silva, H. F., Diniz, A. P., Moraes, L. F., Soares, L. C., & Dantas, P. M. M. (2022). Objectification in the hospital and the times of Covid: A psychoanalytic elaboration of experiences. *Psicologia e Saúde*, *14*(2), 205–216. https://doi.org/10.20435/pssa.v14i2.1546

4. Beer, P. (2017). *Psychoanalysis and science: A necessary debate*. São Paulo: Edgard Blücher.

5. Borges Junior, D. P., Oliveira, G. K. C., & Vasconcelos, A. C. P. (2020). Contributions of psychoanalysis to the performance in the cardiology clinic. *Changes – Health Psychology*, *28*(2), 27–31.

6. Brazil. (2015). *Law No. 13,146, of July 6, 2015. Establishes the Brazilian Law for the Inclusion of Persons with Disabilities (Statute of Persons with Disabilities)*. Federal Official Gazette, Brasília, DF, July 7.

7. Clavreul, J. (1983). *The medical order: Power and impotence of medical discourse*. São Paulo: Brasiliense.

8. De Marco, M. A. (2006). From the biomedical model to the biopsychosocial model: A project of permanent education. *Revista Brasileira de Educação Médica*, *30*(1), 60–72.

9. Dunker, C., & Iannini, G. (2023). *Ciência pouca é bobagem: Por que psicanálise não é pseudociência*. São Paulo: Ubu Editora.

10. Elia, L. (2023). *The science of psychoanalysis: Methodology and principles*. São Paulo: Edições 70.

11. Freud, S. (2006). 16th conference: Psychoanalysis and psychiatry. In *Complete works* (Vol. 16, pp. 223–234). Buenos Aires: Amorrortu. (Original work published 1916–1917)

12. Kobori, E. T. (2013). Some considerations on the term applied psychoanalysis and the psychoanalytic method in the analysis of culture. *Journal of Psychology of UNESP*, *12*(2), 73–81.

13. Lacan, J. (2003). Proposition of October 9, 1967. In *Other writings* (pp. 248–264). Rio de Janeiro: Zahar. (Original work published 1967)

14. Lacan, J. (1993). *Television*. Rio de Janeiro: Zahar. (Original work published 1974)

15. Lacan, J. (1975). Conférences et entretiens dans des universités nord-américaines. *Scilicet*, (6/7), 7–31.

16. Miranda, B. A., & Ferreira, C. B. (2024). Experiences and practices of hospital psychologists during the Covid-19 pandemic. *Interaction in Psychology*, *28*(1), 25–34. https://dx.doi.org/10.5380/riep.v28i1.86079

17. Moreira, L., El-Hani, C., & Gusmão, F. (2000). Down syndrome and its pathogenesis: Considerations on genetic determinism. *Revista Brasileira de Psiquiatria*, *22*(2), 9–96. https://doi.org/10.1590/S1516-44462000000200011

18. Moreira, J. O., & Araujo, R. S. (2023). A subject, a policy and psychoanalytic listening: A reflection on the action of the psychoanalyst in the hospital ombudsman. *Psychoanalytic Time*, *55*, 610–634.

19. Pozzato, V. G., & Vorcaro, A. M. R. (2014). Approximations and distinctions between autisms and psychoses in children: Conditions of alienation to language. *Analytica*, *3*(5), 137–156.

20. Silva, C. M. D., & Macedo, M. M. K. (2016). The psychoanalytic method of research and the potentiality of clinical facts. *Psychology: Science and Profession*, *36*, 520–533.