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NEW PARADIGMS IN CLINICAL CARE RELATIONS

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This article discusses the changes in clinical-care relations and their causal factors, emphasizing the transformations suffered by the variables of knowledge, method and organization. Our paper contrasts this new paradigm shaped by the conception of neuronal man, disciplinary atomization, and idolatry management, with other modalities of the care link based on regular conversation with the patient and among professionals within the health care network. Finally, we note some key aspects in the clinical dialogue, such as trust in the symptom and in the subjective position as a guide for clinical intervention.
Key words: *Care relations, Scientism, Trust in the symptom, Network.*

El artículo aborda los cambios en la relación clínico-asistencial y sus factores causales, poniendo énfasis en las transformaciones que han sufrido las variables de saber, método y organización. El trabajo confronta este nuevo paradigma, marcado por la concepción del hombre neuronal, la atomización disciplinaria y la idolatría de la gestión a otras modalidades del vínculo asistencial basadas en la conversación regular con el paciente y entre los profesionales de la red asistencial. Finalmente, señala la importancia que toma, en este dialogo clínico, la confianza en el síntoma y en la posición subjetiva como brújula de la intervención clínica.
Palabras clave: *Paradigma asistencial, Cientificismo, Confianza síntoma, Trabajo en red.*

The current situation, marked by a strong crisis in the system, an economic crisis but above all a confidence crisis that encompasses all areas (political, financial, social relations), has exacerbated the emergence of new paradigms in healthcare relations. This is not new, the result of the current situation, since the transformation of the healthcare relations in different areas (clinical, social, educational) is age-old, but the current crisis has exposed it more starkly.

The model of modernity, in the field of health, based on the privileged relationship between the patient and the clinician defined as a healthcare specialist: the doctor, psychiatrist, or psychologist. It was a relationship based on the absolute authority of the professional regarding the treatment of the ailment, an authority that rested on an assumption of the patient regarding his learning. As a result of this assumption there was trust from one party and professional confidentiality from the other as an intrinsic part of this private and intimate dialogue.

Postmodernism exacerbates some of the contradictions and paradoxes already encompassed in the program illustrated. One of these derives from the consideration of the rights of the individual as a principal value, which undermines the previously absolute authority of the professional, who is no longer enough to deal exclusively with the treatment of the ailment. The professional's knowledge is relativized and placed in tension with other forms of knowledge that come into play: psychology first, but also education and social, and this is why the ideal of health is understood, from that moment onwards, on three registers: the biopsychosocial. It is an ideal that is more like a professional multiculturalism than a sufficiently substantiated approach (Gabbard & Kay, 2002).

A NEW PARADIGM IN THE HEALTHCARE RELATIONSHIP

Now the first decade of the twenty-first century is over, we can say that this "individualist" trend, together with the false promises of scientism, constitutes the bedrock of the new healthcare relationship, the characteristics and consequences of which can already be clearly discerned.

A first obvious characteristic is the distrust of the subject (patient, user, student) towards the professionals whom they increasingly assume to know less about what is happening to them (which is why the second opinion has been institutionalized) and who they increasingly fear will become an element of control rather than assistance. Current figures on manifestations of subjective protests against medical proposals, including therapeutic boycott (rejection of what is prescribed), lack of adherence to

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treatment or violence in health or social centers are a clear sign of this loss of confidence in the healthcare relationship (Serra, 2010). Not forgetting phenomena of fraud or deceit by a minority of patients, who oppose in this way, obtaining a secondary benefit, the imposition of control logics, an increasing trend in the healthcare relationship.

A second characteristic is found in the defensive position of the professionals themselves who increasingly use preventive procedures to avoid potential threats or complaints from their patients. Thus fear becomes a key force that conditions the healthcare practice, the consequences of which, as we shall see below, are not trivial.

The third characteristic shows one of these consequences: the loss of quality and quantity in the doctor-patient bond. The dialogue to which we referred earlier, based on listening to the uniqueness of each case, and requiring a face-to-face meeting with some consistency and regularity, has become an increasingly fleeting encounter, short-lived and always mediated by some technology (tests, computer, prescription). The "care" style that Berger describes, referring to the country doctor John Sasall (in a travel diary by the journalist, accompanying a country doctor in England after the war: "A lucky man" edited by Alfaguara in 2009), is already a relic when compared to the current visit protocol in primary care, where the doctor pays more attention to the requirements of computer applications than listening to the patient, at whom she hardly looks.

The fourth characteristic, a correlate of the previous one, is the remarkable increase in bureaucracy in healthcare procedures. The number of reports, questionnaires and applications that a specialist psychologist must complete already exceeds the time spent on the healthcare relationship itself. All this occurs without the benefit of these procedures being insured, as we shall discuss below.

These characteristics constitute a new reality marked by a noticeable loss in the authority of the professional, derived from the substitution of his sole discretion (a key element in praxis) to the detriment of the monitored protocol, a reduction of the subject being cared for to an element without specific properties (homogeneous), and who reacts with the types of rejection mentioned above (boycotting and violence), as well as a number of diverse and serious effects on the professionals themselves: burn-out, recurrent depressive episodes, malpractice (Soares, 2010).

'Authority' here is to be understood based on its etymology (*auctoritas*), which derives from 'author', someone who is capable of invention, understanding and problem solving, not someone who bases his or her actions on the exercise of power (*potestas*).

KNOWLEDGE, METHOD AND ORGANIZATION

This new reality is the result of an extensive and illusory reductionist zeal that deals with the complexity of the reality we approach, by reasoning and simplified procedures. This translates into deep transformations on three levels: the epistemological assumption that defines a deterministic conception of knowledge and the human subject; the methodological assumption that implies a mode of interaction between the disciplines which aims to erase any differences and, finally, the organizational assumption that responds increasingly to operations of monitoring and control, disguised as resource optimization measures.

A paradigm operates and illuminates our understanding because it establishes the key concepts and the logical relationship that they have with each other. This orders the theoretical concepts in a way that is not always visible, and the scientific theories become indebted to the paradigm. A paradigm, therefore, generates a practical action, and is never innocuous. Below we will discuss some of these key signifiers and their interrelation, in order to better comprehend their consequences.

The neuronal man

Today we are witnessing the proliferation of research on human genetics, the biological foundations of our mental, emotional and relational processes. These investigations attempt to explain, based on our brain neurochemistry or our neuronal physiology, how it is possible that someone chooses a partner, decides on their share investments or joins a political party. All this is based on the idea of the neuronal man, a subject without consciousness, or at least with a scheduled consciousness and a functioning beyond his control, decided by mysterious synapses (Pérez-Alvarez, 2011). This theory extols the idea of an irresponsible individualism, since one's actions would be predetermined due to causes beyond oneself (brain chemistry, genetic makeup).

The logic of this new knowledge about man, reduced to its neuronal condition, constitutes a true construction of an asubjective loop that presupposes two operations. The first of these operations is aimed at producing algorithms of digitalized brain images, obtained by brain imaging techniques. The resulting algorithm is by definition

meaningless; these are significant formulas that are combined together according to mathematical logic.

How then can we give a value to these formulas? This requires a second operation that consists of extracting from the social discourse a second signifier which, linked to the first one, establishes a meaning and makes an assessment of the suitability or otherwise of the behavior or cognition. Take the example of a digitalized image of an individual, moments before making a stock market investment. The image obtained is connected with a thesis on the excitement produced by this decision and thus a "natural" correlation is established between the neuronal algorithm and the subjective decision. Or the case of a teenager with signs of aggression towards her parents, which is classified based on the correlation of the size of her amygdala, regarded as a fundamental brain structure in emotion, particularly in response to stimuli of negative content, with aggressive behaviors. From here the therapeutic measures are established based on a combination of psychotropics (brain substance) and psychoeducation (social and personal skills).

The trap of this logic is to take this second signifier as reality itself as if, instead of being part of the social discourse, it were the mental reality itself, when in fact it is pure metalanguage. This generates a set of tautologies based on the equivalency of a cerebral localization, a neurotransmitter, and an associated conduct or a correlative mental state (depression, anxiety, happiness, etc.).

This has a double impact, on the one hand it naturalizes and normalizes social matters and on the other it justifies the double exclusion of the subject, that produced by the "scientific" operation -which involves removing the subjectivity to carry out the measurement - and the subsequent one, clearly ideological. An abstract object becomes a supposedly real entity with a physical-neuronal substrate that enables its evaluation and comparability based on its status as a measurable object. Each measurement is assigned a unique figure that takes on a mystical, objective and irrefutable value. This then enables a classification on a scale from High to Low based on an idea of continuum and hierarchy of performance.

A thesis that is extremely simple in its clinical application: the set of symptoms identified is named as a disorder whose definition is arbitrary and included as a new taxonomy, which soon turns into a "natural" entity. The supposed etiology has an organic nature linked to functional deficits (imbalance in various neurotransmitter systems). At the root of all this we assume a genetic cause, which although indemonstrable (autism, schizophrenia, etc.) appears as the ultimate guarantee, scientific evidence of the entire discourse (Tizón, 2009). The information that we have about the future DSM V only confirms this idea (Frances, 2010).

These "neuronal" theses also reach the area of social intervention, although with less intensity than in other areas such as health or education. People already speak of the "Wall Street neuron" to explain human behavior with the paradigm of economic liberalism, as if we were acting isomorphically to the capitalist system (Pérez-Alvarez, 2011). The aim of this is to find the neurological basis of social practices at a time when we are witnessing a clear decline in the humanities and social sciences (Llovet, 2011).

This pseudoscience is presented as liberation from the ancient *religare*. It relies on the power of science, exorcizing the ties and contaminations of the old procedures that involved a "confusion" between subject and object. The paradox is that this abusive science, or scientism, ends up producing a new religion due to its holistic character.

Evidence that is not so evident

The second great transformation of the new realities of healthcare refers to its procedures and the technology it uses. The privilege granted to some techniques, such as those mentioned above for brain imaging is based on the axiom of scientific evidence. Today there is not a single healthcare assistance program that does not proclaim the requirement of "scientific evidence" for the treatment techniques permitted. In fact the expression "scientific evidence" has become a sort of password, necessary for financing the healthcare project but whose proof is often dispensable. It seems more a practice of consensus and adherence (there would be the camp of "scientific evidence" and that of "others") than verification of a requirement truly derived from the scientific method (Ubieto, 2010).

As Pérez-Alvarez reminded us, in the abovementioned article, the magnetism of the images traps us in these pseudoscientific explanations without us realizing they are a sophisticated charlatanism whose most important conclusion is that ultimately our will is dispensable; it is the brain that creates and decides for us and that "after major investment of time and money, the findings of neuroscience do not represent progress in psychological knowledge" (Pérez Álvarez, 2011).

We will not dwell on the criticism of the abuse of the

concept of "scientific evidence" (the first paradox is found in the term "evidence" itself, a "false" interpretation of the English word that could be more precisely translated as "proof") but it is worth questioning its success (Ubieto, 2010). Unquestionably there is a combination of factors that show how the (mis-)use that some of these techniques have made of the paradigm of modern scientific medicine, founded by Claude Bernard (1976), protects them from any criticism of charlatanism or pseudoscience, when it is in fact an exercise of power, dressed as scientism, in various areas: the academic, professional and institutional.

Today we see how most of psychiatry, a part of psychology and, of course, much of neuroscience, aspire to be defined as behavioral sciences, excluding the subject itself from its object. This operation requires an absolute encryption of the procedures, diagnostic tests, therapeutic effects, and the results of the programs. It is an encryption that we may consider necessary and appropriate in some medical practices, in all that is related to treatment, since they constitute its very essence, but it is fallacious and ridiculous when it comes to taking the exact measurement of that part of the subject that is by no means, nor can it be, encryptable, although it is not ineffable either (Broggi, 2003). It is what the biochemist Javier Peteiro (2010) has called, and demonstrated successfully, scientific authoritarianism, typical of post-humanist society (today all indications are that current trends in science lead to "soft" concepts: uncertainty and undecidability based on the contributions of Heisenberg regarding the uncertainty principle, which states that the accuracy with which one can simultaneously measure the position and velocity of a material element is necessarily below a certain threshold. Or that of Godel himself, who states that all theory, no matter how rich in axiom it may be, necessarily leads to "undecidable" propositions: it is not possible to demonstrate that they are true or false. The same thing occurs in serious research into genetics and neuroscience.

Furthermore, the method corresponding to this new healthcare reality configures an interaction between the disciplines (psychiatry, psychology, medicine, social sciences, education) of a multidisciplinary kind, where each one adds to the previous one in terms of addition, rather than interaction. There is no dialogue possible between them, only summation of data or hypotheses. The ambition is a professional multiculturalism where everyone acts without being accountable to the other, and concealing that there will always be a discipline of higher rank that ultimately orders the whole set. In this case it is the neurosciences, those that are acritical, that provide the final cause.

Too much management kills the clinic

The third transformation refers to the organizational models of care practice, currently dominated by what is known as NPM (New Public Management). This managerialist model is based on a new legitimacy: customer (user/consumer) satisfaction. It aims to integrate the services and subscribe them into the local networks under the perspective of shared responsibility with the population and with suppliers to increase the availability and quality of services. The concerns about the efficiency of the organization on behalf of the public administrators and politicians responsible often overlook the real concerns of the citizens.

Thus, quality is presented as a renewed and consensual form of control, based on the traceability of practices to great detail. It is even presented as a voluntary servitude disguised as the ultimate liberation from old beliefs and outdated procedures that constrained individual freedom (De La Boétie, 2008). It reconciles trade and morality and appears when the quantity (Welfare State) is in short supply and it replaces this lack. Quality always existed in association with professional qualifications but it now seems to be an objectifiable attribute, outside of the care relationship and it imposes on the idea of (social) utility reifying the social relationship with the aim of customer satisfaction. Quality is connected with immediacy, consumption, enjoyment and instantaneousness.

NPM transforms citizens into users/clients and the task is measured in terms of efficacy (excellence) understood as the efficiency and monitoring of professional acts, which is contradictory, at times, to the criteria of quality and ethics. It is known that the continuity of the professionals and the ongoing adjustment to the requirements, the keys to a good care relationship, sometimes come into conflict with the demands (and times) of productivity and the rigidity of the protocols. We emphasize some of the basic principles of this new social reengineering:

- Hierarchical classification of services: a centralized planning model is opted for, where the hospital becomes the reference unit (hospital-centrism).
- Standardization of practices and processes: imposition of "one best way" as the only way to do things, exemplified in the imposition of guidelines, protocols and the (acritical) idealization of "good practices". To date there appears to be little agreement on the nature of these "best practices" because for some they are stan-

dards to transport, once they have been formalized, and for others they are experiences that are only verifiable in their implementation and therefore they are not generalizable, only methods of observation and reflection.

In fact, the idea of Good or Best Practice (BP) as the only protocol is questionable for several reasons:

- ✔ This idea gives reason to believe that a practice without evidence indicates a lack of value.
- ✔ It underestimates the specific cultural data of populations (Anglocentrism)
- ✔ It belittles the judgment of the professionals and removes them from the act, overriding their judgment and guidance.
- ✔ It is based upon research with internal validity (coherence of data interpretation) but without a guarantee of external validity (generalization of results). How does one validate a BP if does not exist independently of its implementation? By protocolizing it, a misstep has already been taken.

- Methods imported directly from the field of public health: the use of sequenced programs verified in preventing illness and imported to the field of psychology in the logic of sanitizing the mental and social issues.
- Idolatry of the act, as a synthetic index of management measurement, is key. There is no philosophy of action, but of economic acts. The act is taken as a benchmark, quantified in monetary terms, and intended as a small, homogeneous and instant picture of the exchanges in order to compare them and control them financially (Chauviere, 2007).

It is a new way of doing things that undoubtedly involves a change in the relationships between professionals and patients, based on a conception of professional services reduced to a sequential series of technical acts that can be rationally managed. This is where dysfunctions are justified and not in the lack of resources or the living conditions of the populations affected. These "customers" are subject to standardized care but they are not collective or individual stakeholders in the change.

At the same time, generalized assessment plants suspicion as a new social bond (paranoia) among managers and technicians and between these and users. Thus we pass from trust to suspicion. In an era in which time and space were basic, fundamental coordinates with little variability, nobody was ashamed or hid the fact that the professional formed part of the case, since he was part of the problem and the solution. The close bond ensured that what was defined as the problem varied in shape as the relationship subsisted, simply because it had been opened to the intervention of the other, an external but very close professional. Feelings of shame, guilt, deception, gratitude, sometimes hostility, were included in that bond. The role of the professional was to deal with all of the subjective "pollution"; the transfer could never leave him indifferent and would sometimes surprise him at unexpected times and in places far from the office.

Today, time and space have been virtualized, they are mutable and instant references, every act being measurable and quantified in monetary terms. The aim is to deconstruct every act, sequence by sequence, and to allocate values to performance and to decontaminate it from any subjective interference. The purpose is to clean all waste, any leftovers that do not add any value to the resulting goods. The famous Lean method, which brought success to the Japanese car industry and then was imported to the U.S. and now serves as a basis for improving public management, aims to create flexible, agile production systems that are able to respond to customer demand (Kamata, 1993). It consists of eliminating any waste, all those activities that do not add value and whose origin is threefold: wastefulness, instability and variability of procedures.

The impact of this NPM on the participants is notable because, although there will always be some discomfort regarding the task itself, this model emphasizes the distance between the point of view of the direction and the actors: conflicting values, overload and dissatisfaction with teamwork (Soares, 2010). Added to this is a lack of job security, with ill-defined tasks and a real impossibility to develop expertize due to a lack of recognition. The elimination of shared cultural references leads to a kind of industrialization of the clinic.

There is no doubt that this new organizational model has led to some positive effects, such as facilitating a number of integrated care networks or the use of new technologies, but it is clear that as a whole it represents a significant increase in management structures and an accentuation of the means of control as well as a constant pursuit of efficiency, without clear benefits.

In the same way that neuroimaging and its techniques fascinate us, idolatry of management can also make us forget that it implies an idea of the subject and of social relations. Excess, in psychoanalysis, is always the index of an added enjoyment, a satisfaction that is veiled in the demanding of evidence and which is nothing more than a desire to control and tame this impossible and not at all

clear reality, which always appears to us as disconcerting and disturbing.

This dimension of impulsive enjoyment is what scientistic ambition wants to erase with its "programming" of the subject and the current techniques of "case management" firmly based on digital idolatry. The paradox, as noted before, is that that which is repressed returns as waste, useless excess and ultimately enjoyment. A recent example is offered by the article published by the prestigious British journal PLoS (Black, Car, Pagliari, Anandan, Cresswell, Bokun, et al., 2011) that dismantles in one stroke the belief that the application of electronic technologies to health (eHealth), concretized in the computerization of medical dossiers, provides some benefit to improving the health of patients, despite the millions invested, or the financial health of the institutions that use them. The conclusions leave no room for doubt: there is no evidence to support these resources and instead there are proven risks (data insecurity, confusion of diagnoses, prescription errors, decreased patient-clinician contact, a substantial increase in bureaucratic tasks and administrative expenses, etc.).

TRUST IN THE SYMPTOM

This new healthcare reality, inspired by the guidelines of NPM, is not the only way to address mental and social ailments. In fact it coexists with other modalities of the transference link that seek to avoid renouncing to subjectivity, as the specific element of the human subject, that which makes each of us somewhat unclassifiable.

A wide range of theoretical approaches and current psychological practices share basic issues in this paradigm of subjectivity, understood as the undeniable fact that the subject is not measurable as such (even though some of its performances or vital signs may be measurable), since the subject does not meet one of the key requirements of evaluation: it is not clear or transparent.

Some of these practices are based on psychoanalysis and others on various approaches such as the phenomenological-existential approach or others included in the "contextual model" (González Pardo & Pérez Álvarez, 2008). We will focus our approach based on the clinic and the teachings learnt from Lacanian psychoanalysis and our institutional practice.

We argue that the subject is not measurable because it houses inside it an element of opacity that is something intimate, pointing to the most real of each individual and is therefore unrecognizable to the subject, meaningless. The existence of such extimacy nevertheless is manifest to the subject himself under paradoxical, contradictory ways, as in the effect of subjective division, which many patients convey to us and can be seen in some movie characters who seek themselves desperately: "I would like to go back to being myself. "

That subjective division, which Freud founded in his hypothesis of the unconscious, we recognize in everyday life and in the clinic in the form of the various configurations of the unconscious (lapses, dreams, Freudian slips). "Man thinks using words. It is in the encounter between these words and his body where something takes shape"(Lacan, 1988). There, in what Lacan calls "moterialism" (the materialism of words), resides the grip of the unconscious, where each individual sustains their symptom.

Trusting the symptom is a good guideline for clinical practice, to remind us that the subject we serve is not programmed or determined by his genetic or neurological conditions. He is still, with all that baggage, a responsible citizen, able to answer for his actions, and our partner in the therapeutic dialogue. His symptom tells us about the locked, suppressed and hidden meanings, but also of his drive to satisfaction, that which motivates him without having a clear meaning a priori.

The hyperactivity observed in some subjects has no more meaning than itself as an impulsive activity, satisfaction of the body that each individual inhabits. Small wonder that we live in an addictive society where everyone persists in that instinctual repetition in various forms (toxic substances, work, food, gambling). This idea of the body, developed by Lacan and others such as Miller (2004), is not reduced to its imaginary representation, or to the ideals that make it up, much less to its representation in the brain. It is a pleasurable substance articulated in language.

Thus the method that suits this care relationship is not the one described above, but another radically different one. Without renouncing the contributions of neuroscience and other disciplines, we must remember that the clinical method is not reducible or equivalent to the experimental method. Here, the main technique is still the conversation we have with the subject, about their ailment. It is a conversation that follows its rules (Ubieto, 2009) and promotes an interdisciplinarity that is not reduced to the sum of knowledge, as it commits the professionals to address the symptom in a cooperative manner, provided that it is possible and desirable. Morin (1992) already warned of the risk of the hyperspecialization of the researcher and what he called the "commodification" of

the object of study where there is a risk of forgetting that this object is always drawn or constructed.

The treatment of cases, based on this regular conversation, involves an experienced community that represents a social link between the services of social care, education and health, based on common ground and a shared reality of work (children at risk, domestic violence, mental illness). Its advantages are obvious and range from a better view of the case (global and individual) to the avoiding of certain episodes in the professional activity, limited by supervision spaces and the analysis of cases. In this model it is taken very seriously that it is always the subject who makes the first case construction, who prescribes the symptom to be treated, in its initial application, and who shows us how there is always a "plurality" of solutions rather than "The Solution", and his decision is critical in each of the solutions (Ubieto, in press).

This method requires commitment and therefore involves risks; the first is you have to be there in person because the therapeutic relationship is not possible without subjective involvement (Di Ciaccia, 2001). The psychologist, unlike the experimenter in her laboratory, is not an external character since he belongs fully to the experience. Subjective "pollution" is assured because the transference link established with the people he serves is not sterile or neutral; it is a bond of commitment in which he puts his theoretical knowledge, skills and legal obligations but mostly his personal involvement as a key element in generating trust and his professional authority.

The establishment of this bond is not without difficulties and is not guaranteed in all cases. The new healthcare reality imposes some changes for legal reasons. One is the prior and clear explanation of the rules of the game, either through protocolized procedures of informed consent or under the ethical guidelines of each profession, explicitly specifying the agreements, limits and responsibilities of each party. Moreover, in times of scarcity and change, the professional cannot avoid adjusting the objectives, priorities and procedures (tempo). This adjustment would be insufficient without being complemented by the other key procedure, which is inventing new ways of doing things, invention of the kind that generates *auctoritas*.

The use of protocols in clinical practice must respond to a justification beyond the purely administrative. A protocol may be a useful tool if it contributes to the creation of therapeutic effects in patients and/or training effects for the clinicians themselves and other professionals involved. Without such a benefit, the protocol becomes an end in itself and is therefore sterile in clinical praxis.

Finally, the organization that best fits this proposed healthcare relationship transcends the old figure of paternalism and hierarchy as an index of the power of the master and moves away from the current forms of disciplinary atomization that mask the new figures of the master, more acephalous (without a clear personalized reference) but with an equally clear desire to dominate.

The failure of the logic of the "one best way" presented, especially on the part of the Departments of Public Health, as "The Solution", is increasingly evident. Therefore we should think about the promotion of diversity in a mosaic of services tailored to the heterogeneity of situations and demands, as opposed to the homogenizing hospital-centrist model and the proposals of one single treatment, based on fallacious pseudo-scientific arguments.

Creating professional networks, flexible in their connections but firm in their orientation, favors the genesis of professional exchanges and the co-responsibility and participation of the various actors. Today we have ongoing experience that has made important progress to support the possibilities of this form of healthcare relationship (Leal, 2006).

In conclusion, and as a summary, we highlight the three key concepts of our proposal: adjustment, respect and invention. Adjustment linked to good use of the existing resources where the time variable should play an important role as an element of relationship management and the beneficial effects that it has in terms of precipitating the time of completion for professionals and the subjects attended (Lacan, 1998). Respect as an ethical principle that entails taking into consideration the mental and social ailment in its various forms, an index of a subject of whom we ask participation and co-responsibility. Finally, invention as an improvement strategy and especially in terms of not renouncing to remain, as professionals, the authors of -and responsible for- our own actions.

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