Higher Education in Nursing: Between symbolic domination and political emancipation

ENTRE A DOMINAÇÃO SIMBÓLICA E A EMANCIPAÇÃO POLÍTICA NO ENSINO SUPERIOR EM ENFERMAGEM

ENTRE LA DOMINACIÓN SIMBÓLICA Y LA EMANCIPACIÓN POLÍTICA DE LA ENSEÑANZA SUPERIOR EN ENFERMERÍA

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ABSTRACT

In this reflection we problematize the action of caring and teaching how to care in nursing based on some of Pierre Bourdieu's concepts about domination and symbolic power. The basic tenet of this work was to think of education as something vital for our existence on Earth. In this article, we used Pedro Demo's ideas as a reference to talk about education, which is understood as a developer of political subjects and as something far beyond formal knowledge management. It is the very first base on which human autonomy is built, and it leads to a constant growth of opportunities to exercise citizenship, qualifying our everyday existence. In the academic context, where health, education and nursing are all gathered, the competent, critical and reflective teaching work can be highly institutive praxis.

DESCRIPTORS

Nursing
Education
Faculty
Education, nursing
Students, nursing

RESUMO

Nesta reflexão, problematizamos a atividade de cuidar e de ensinar a cuidar em enfermagem e, para tanto, vamos tomar por base alguns conceitos sobre a dominação e o poder simbólicos de Pierre Bourdieu. Nosso pressuposto foi pensar a saúde como um constituinte fundamental para a produção da nossa existência sobre a Terra. A educação, neste texto, é abordada, tendo por referência as ideias de Pedro Demo, entendidas como uma construtora de sujeitos políticos e bem mais amplas que o manejo do conhecimento formal. A educação é a base primeira sobre a qual se constrói a autonomia humana e, assim, permite a constante ampliação das oportunidades para o exercício da cidadania, qualificando a nossa existência cotidiana. No contexto acadêmico, no qual se cruzam a saúde, a educação e a enfermagem, o trabalho docente competente, crítico e, sobretudo, reflexivo, pode se tornar uma práxis altamente instituinte.

DESCRITORES

Enfermagem
Educação
Docentes
Educação em enfermagem
Estudantes de enfermagem

RESUMEN

En esta reflexión, analizamos la problemática de la actividad de cuidar y de enseñar a cuidar en enfermería, para lo que vamos a basarnos en algunos conceptos sobre dominación y poder simbólico de Pierre Bordieu. Nuestro presupuesto fue pensar a la salud como un elemento fundamental para la producción de nuestra existencia terrenal. La educación, en este texto, es abordada bajo la referencia de las ideas de Pedro Demo, entendida como una constructora de sujetos políticos y mucho más amplia que el manejo del conocimiento formal. La educación es la basa primaria sobre la cual se construye la autonomía humana, y así permite la constante ampliación de las oportunidades para ejercicio de la ciudadanía, calificando nuestra existencia cotidiana. En el contexto académico, donde se cruzan la salud, la educación y la enfermería, el trabajo docente competente, crítico y, sobre todo, reflexivo, puede tornarse una praxis altamente educativa.

DESCRIPTORES

Enfermería
Educación
Docentes
Educación en Enfermería
Estudiantes de enfermería

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INTRODUCTION

As faculty and nurses we live in two institutions that continuously interpenetrate and give each other feedback: health and education. Both are essential assets for human beings, the former is a *sine qua non* condition to produce life, and the latter is indispensible to add quality to our existence on Earth.

Health is something everyone wishes for; hence it as so many senses and meanings. Education, in this setting, has a character that implies more than managing formal knowledge; here it is the primary basis over which the autonomy and citizenship of each and every one of us is constructed.

As nurses and faculty in health and nursing, we are privileged individuals in producing *politicity*, which is defined as

> the human ability to think and intervene, in the sense of reaching growing levels of both individual and collective autonomy, which permits one to write a personal history and imagine innovations in the natural evolutionary process [...] in the politicity concept, however, the focus refers less to broadening the given limits than to having the ability to deal with imposed limits, or overcoming obstacles through the main path of self-surpassing[1].

The term *politicity* relates to a type of knowledge that involves disruptive ability, i.e., one that permits us to not be an object of the pressure from outside or others; rather it leads us towards the constant construction of our own history and, thus, to assuming our condition of political subjects and citizens. Being political

> is knowing how to make plans and plan oneself, to create and become an opportunity, become a subject and permanently reconstruct oneself across life, conceiving ends and adjusting the means to reach those ends, exercise one's freedom and, most of all, fight against whoever wishes to limit that freedom, manage oneself as a citizen capable of having a personal history, and learn in a reconstructive-political way[1].

Health and education, in this setting, are seen as two institutions holding a great potential to manage political beings, and, in our everyday practice, they occur by means of the actions and practices involved in teaching about care and providing care to others. Therefore, they are activities that can be reviewed considering their potential of generating politicity.

As a staring point, we assume that health care, just as the educational process, if performed with pleasure and competence, brings people closer together and encourages them to want more health and a better quality of life.

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We are deeply hermeneutic beings, and because we work with human beings who need care and with those learning how to provide care, we stand in a working place that is essentially political, i.e., a place where emerges the wish that permits us to ponder on active utopias, which in our practice translates into an act that permits us to provide human care. Legitimate care involves deep interaction between people, and this live and interested act can generate inspiring knowledge of prudent and multiple ethics that are capable of favoring the multicultural coexistence of human beings[2].

Our main focus is to reflect upon the construction of citizenship and political subjects in the process of teaching health care, based on the educational process. This reflection involves both the macro-structural and micro-structural areas present in the worlds of health and education. In these macro and micro areas, encounters occur between subjects and institutions, wishes and submissions, all of which we want to understand in terms of their power to generate politicity inside a universe that approximates and interweaves nursing and health with education and the development of citizens. We start by explaining the origins of our thoughts regarding the object that is the fulcrum of our studies, the ways to encourage the construction of citizenship in the multiple relationships that occur in our everyday practice as health and education workers.

A first approach on the theme was during my masters program, through studies on gender and nursing. I made a deeper approach in my doctorate, through studies on the phenomenon of symbolic domination that occurs between workers and users of public health services. The look that was developed about symbolic domination revealed the world of symbolic violence and power[3]; a perspective that encouraged me to seek theoretical foundations that would help to develop problematizations to reach a better understanding and find new ways to minimize the asymmetries we found in the areas where health care is delivered as well as in places where nursing care is taught.

The referred asymmetries have a straight relationship with the various aspects associated with how communication is established between the different subjects involved in these processes: students, nursing faculty, health service users, who are in constant interaction, but with specific levels of interference in the processes of either giving, teaching, or receiving care, or learning to provide care. Hence there is intentional or unintentional manipulation in the communication between these different subjects, which reoccur in the phenomena of mystification, disqualification and objectification present in the different ways of establishing the interrelation between subjects in

this specific universe of providing care and treatment in health and nursing.

All these phenomena are somehow linked to the symbolic domination that is generated from the desire of dominating the suppression of subjectivity of some over others, always with more structured knowledge and, apparently for that reason, more legitimate. In order to achieve the alienation or submission of some over others, we must understand two movements that occur simultaneously: the mystification of the knowledge of some and the disqualification of the knowledge of others, who will begin believing they have heterogeneous processes of living, falling ill, and learning. They will become subjects that believe that this knowledge goes much beyond their understanding of the world, and, thus, will require the intervention and knowledge of those in order to live and survive, which occurs in a very candent manner in the health area[4].

As any highly structured knowledge the Bourdieusian theory on symbolic domination showed us a reality molded on dominant and dominated individuals, on types of knowledge and practice that, because of their complex structure, would self-perpetuate through symbolic power. While this power legitimates its holders, it also places those without power in a subaltern position, and they are, perversely, disqualified; this also occurs with their knowledge about themselves.

This pattern of powers and knowledge appeared to be to little auspicious to advance and reflect upon the construction of free and autonomous subjects, but through it we can take hold of many elements to understand the many complex aspects of power and symbolic domination. Based on these first theoretical considerations, we will begin our theoretical digression about the possibilities of building citizenship in the practice of care and of teaching health care and nursing.

KNOWING TO DECONSTRUCT – BETWEEN *HABITUS* AND DESIRE

We therefore have different subjects that meet each other in the acts involving therapeutic care and the educational process: faculty, students, users, all of whom are molded on different references of life and work, but share the same human fragileness and finitude when they fall ill and need to be cared by others. I might be cared by a former student, who in turn could be cared by a former classmate, who might need to be cared by the nursing aide or technician who supervised him or her during his or her internship, or who was a former student in the technical course. We are nothing but vulnerable human beings with just a few different levels of dependency on that other person who offers us care and comfort.

The context of care and the educational process can work as the *loci* of consensus or divergence, of producing autonomy or heteronomy, depending on the desire potentials of the many participating subjects. Several events occur in these places, caused by the constant experiences of coping and impacts that at some times feed the subjects' transformation, and, at others feed their accommodation. Each subject reacts to each event in his or her own particular way. There are no serial reactions; some subjects react proactively, others withdrawal and remain silent, while others reflect and prepare themselves to either escape or cope with the event in a tempestuous way.

The bases of this theory were written by Pierre Bourdieu and Jean-Claude Passeron in the book *La Reproduction, éléments por une théorie du système d'enseignement*, published in France in 1970 and in Brazil in 1975. The concepts regarding domination and symbolic power were addressed in the book *A economia das trocas simbólicas*, published in Brazil in 1974.

Because Pierre Bourdieu developed the general concepts of his theory for the education area, we had to appropriate some of his concepts to apply them to the health area, as it was our first object of knowledge and intervention, and, along with education, is part of the subjects' world in the referred context.

Bourdieu criticized objectivist knowledge by considering social action as the meaning nucleus of the world, and, in this movement, replaced subjects as the center of a society that works mainly based on intersubjective relationships. In theses relationships, *communication* occurs as an intersubjective, socially structured interaction, i.e., agents of speech communicate within a filed in which social positions have already been structured objectively. Hence, they face each other in a relationship of power that reproduces the unequal distribution of powers assigned to the level of society as a whole[5].

The Bourdieusian theory responds to the criteria defined by experts as a true theory: it is structured and coherent with its concepts and arguments towards a conclusion[5]. In terms of its symbolic power concept, it underlies the idea of dominant and dominated individuals, hence it works as a unique element in the structuring of their view of symbolic domination. Bourdieu states that, due to the load of dissimulation and transfiguration carried by the symbolic power, it is a

> subordinate power, a transformed version, i.e., unrecognizable, transfigured and legitimated, of the other forms of power [...] that guarantees a true transubstantiation of the power relationships implying to ignore-acknowledge the violence that they objectively comprise, thus transforming them into symbolic power, capable of producing real effects without an apparent use of energy[3].

This type of power is almost magical, because through it one can obtain the equivalent to what is obtained with force, without, however, using it. The author recalls that one should find symbolic power where it is less visible, where even its existence is ignored, because it excludes

submissions and can only be exerted by suppressing the other's possibilities without becoming an autonomous subject. The ideal setting for symbolic domination to emerge is one of heteronomy and arbitrariness, in a subtle way that is not noticeable by the subjugate individual[3].

The Bourdieusian conception for symbolic power is that of a crude reality and we see it taking form every day in the relationship between professionals and health care users. However, theoretically it keeps us from thinking about the process of building autonomy and hinders the appearance of subjects of desire, empowered and who develop based on the constant coping and exercise of limits and possibilities imposed every minute.

Despite understanding the limitations imposed by symbolic power, we believe that it should be problematized, because, objectively speaking, there is, in the context of the process of caring and education, on one end, dissubjected subjects, with their submitted subjectivity, and, on the other end, citizen subjects, bearing free subjectivity. Dissubjected subjects can be understood as those caught in the invisible web of symbolic domination, most of whom did not yet reach the condition of self-development and assume the leading role in their own lives. They are essentially reproductive subjects with poor autonomy and a weak power of decision. However, on the other end we have subjects with strong desires who are proactive, elaborate, re-elaborate, and exercise their rights and their citizenship, i.e., they are emancipated, productive subjects who assume the leading role in their lives.

We believe there are always remnants of autonomy, even in the most extreme situations of liberty deprivation and, to associate this statement, we infer that there are subjects *situated* in several locations of the imaginary line that separates dissubjected from the more autonomous subjects in the context of the care and education processes. There are also subjects who are tutored and caught in the subtle traps of symbolic domination, submitted to the knowledge and object of others' practices, and there are also the freer and citizen subjects, who use their knowledge and practices actively and creatively to increase their levels of participation and citizenship of all those in and beyond their environment.

We should keep in mind that these active and creative subjects, interested in collectiveness, are always a minority. It is much more common to see subjects who, once reaching specific knowledge use it to submit others and hence also end up being captured in the *subtle trap* of symbolic domination, because they reproduce practices and attitudes that not only downgrade others, but also reduce the quality of life of everyone, including their own. This is the portrait of societies that are highly hierarchical but have a weak democracy.

This *capture*, caused by the subjection of others, increases social insecurity, violence, and deteriorates collective spaces and the environment. It makes life precarious for the number of people who do not experience wealth, and it steals their dignity. There are many 'marginal' contingents, who live at the margins of a consuming society, survive from what is left over from others. The macro social outcome of these processes of capturing subjectivities and desire is the constant fear to which we are exposed in the places we live and wherever we have to walkabout, and there, with no exceptions, we are potential victims of the inequality we helped to create.

The phenomenon of symbolic domination, therefore, should be clearly understood by those interested in qualifying existence in their context of practice and set as their basis the encouragement towards autonomy and the construction of citizenship. Furthermore, they understand the latter as a collective, dynamic, and ethical process that requires abandoning the idea of kindness and compassion for others, to assume more symmetrical attachments, founded on the sharing of knowledge, equity and solidarity in actions and attitudes[6].

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Despite the fact that there are extremely dissubjected subjects in our place of practice, we reiterate that we are in a privileged place to consider the possible paths to build citizenship, because as faculty and nurses, we work to develop the people who will work in health care.

Health and care can both be improved in the context of teaching and practice, as elements that, besides adding meanings, put people in continuous interrelationships, and can thus been seen as constructors of more symmetrical relationships between these different human beings. However, this can only occur if we think of them from the perspective of an emancipatory education model.

In this perspective we see human beings dynamically interacting, building and rebuilding practices and relationships that may or may not be redundant in the qualification of their existence. To reconstruct practices and relationships that could add quality to life, there is a need to understand and explain the dominant patterns of the actions of the interacting social subjects, so that from this understanding it is possible to deconstruct the logic that perpetuates domination.

Demo says we only understand things based on our perception of the world, hence it is deducted that the subordination of that *other* will always be understood from our self-referent logic[7]. Accepting the decentralization and dissolution of the I that implies to change this logic and consider the other as a subject with the possibility of assuming multiple leading roles, holder of autonomy and knowledge, is one of the greatest challenges of human liv-

ing. However, it is one of the few paths that, are presented to us to, based on our practice, reconstruct human living on more favorable bases the emergence of citizenship, the qualification of existence and permanence of democracy.

Based on the multiple relationships established throughout our life we all have a unique history with resources just as unique to cope with our limitations. Many of those limitations and resources are embedded in the symbolic dimension of our existence, which needs to be made more visible, understood and reconstructed in the areas we live in.

Bourdieu dived into the symbolic world to understand the submission of some to others and for understanding the symbolic is essentially relational and only occurs based on shared experiences.

These experiences can break or aggregate different social groups, making some submissive to others in certain relationships, which is particularly clear in the context of health relationships and also in education. In order to manage knowledge to benefit social relationships that are more symmetric and citizen, we must understand some aspects of the symbolic dimension in which we are immersed, with the presupposition that knowing means finding means to reinvent it.

Symbolic dimension is inherent to human beings and to the idea of humanity itself, as it is through it that the meanings that will produce symbols are constructed. This is how humans are different *in* and *from* the animal world: humans symbolize, interpret and represent their own existence in many different ways, depending on the environment to which they belong and on the groups with which they relate. Hence, the many specificities of human beings are defined, meet and are included in the broad concept of culture, and it is in this context that, from the objective knowledge perspective, symbols, values, myths, and rituals are included, i.e., the ceremonies by which groups are defined and differentiated[8].

By introducing the importance of symbols in the structure of human beings, I think of two things that interest us in the construction of this essay: on one hand the body and health, as places where meanings are produced, and, on the other, the health services and universities, as privileged and legitimated placed for intervening in the body, develop health professionals and produce new knowledge.

If symbolic power is subordinate, unrecognizable, and modified from other forms of power and impels us to ignore or even recognize the violence they comprise, this only occurs because of the imposition of *habitus*, which ensures the perpetuation of this type of power without any apparent loss of energy. *Habitus* was a concept that Bourdieu worked extensively as it is through it that the dominant view is reinterpreted and subordinated by other subjects.

This author recalls that *habitus* refers to the class status of some and others and to the cultural context that differentiates them, and may be understood as

> a system of the socially developed dispositions, which as structuring and structured structures, comprise the generating and unifying principle of the body of practices and ideologies characteristic of a group of agents[9].

The Bourdieusian concept of *habitus* may refer to the idea of habit, but they are different in their essence. The word *habit* is a noun of Latin origin that means frequent repetition of an action, use, or custom, thus having a much more modest delimitation, when compared to the sociologically developed concept.

By stating that *habitus* is a system of durable dispositions, the authors recalls that the already structures social structures are what *induce* their own reproduction. Therefore, he syas, they work as structuring structures; in other words,

> as the principle that generates and structures the practices and representations that can be objectively *regulated* and *regular* without being the product of obedience to rules, i.e., do not presuppose a conscious intention of the ends, because they are not a product of the organized, intentional or conscious action of the group that constituted them[10] .

The author of the symbolic exchange economy theory states that *habitus* ensures the interorization of exeriority and assigns the agents' action to their social position, and based on *habitus* practices are reproduced as their agents interiorize them as structured structures that appear coherent to those producing them. By analogy, the acts of teaching and caring are also unfolded due to *habitus,* because as a generating principle, it will define the structures, behaviors, and the forms of organization in the areas where these practices occur, that is, through laws, norms, rules, habits, customs, and routines that are determined and reproduced by peers within health and education organizations[10].

This picture from the institutional analysis point of view can be understood as the side that is more instituted, more settled, repetitive and reproductive of the processes and will always occur based on the view of the dominant. It is a phenomenon that will take place so as to distinguish/differentiate faculty, students, health professionals and users, placing them in their specific places within organizations and thus receiving treatment that is also specific. The more structured practice and knowledge that circulate within these fields tend to be imposed as symbolic reference of veracity for the others.

These practices and knowledge, by means of the efficacy of the symbolic power, will comprise *truths*, constructed in a way that both agents and others who submit to them, will reproduce them and believe in them without major questions or any criticism. This reproduction of a claimed legitimacy in constructing hierarchies and establish asymmetries, takes place in health and education practices alike and configures the phenomenon of symbolic domination, a type of domination based on symbolic changes that require *objective* – but also pre-reflexive-*complicity* –of the dominated.

Symbolic dominations in the Bourdieusian theory transports, carries, and becomes legitimate through symbolic power, and with it one obtains 'the equivalent of what is obtained by force, without, however, using it'[3]. Therefore, when pondering about the relationships that occur in the processes of caring and teaching, we must discover the symbolic power where it is less visible and how we use it in our practice and everyday interactions.

As we practically ignore its existence, we may be developing vertical, asymmetrical and hierarchical actions and practices, which suppress the other of the relationship outro as a subject of him/herself and we change him/her into the object. Therefore, in an almost pre-conscious act, we are subtracting from them their possibility of holding the leading role of their own life based on their references and needs.

Hence, we transit as health and education professionals in a terrain that may be, with our contribution, heteronomous and arbitrary, in such a subtle way that we do not even realize ourselves as agents of practices and knowledge infected of symbolic domain and violence. Bourdieu points out that communication occurs

> socially structured interaction, i.e., the agents of 'speech' begin communication in a field where social positions have already been established. The listener is not the 'you' that listens to the 'other' as a complementary element of interaction, but confronts the other in a relationship of power that reproduces the unequal distribution of powers that are carried out at the level of global society[5].

This is the principle that rules the difference that originates symbolic violence: the difference between groups becomes asymmetry, because it stems from a classification scheme. The latter, on its turn, is a product of the incorporation of objectively structured structures, already present in the social environment in which agents exist. In this field it is also established that *the dominated arts of living are almost always recognized, even by those practicing them, from a point of view of destruction and reducing the dominant esthetics*[11].

By detaining the power of building knowledge and making practices be structured according to their interests, we, health and education professionals, reveal out position within the field where we work. As faculty and professionals holding knowledge about health care, we nurses stand as a dominant pole in relation to both our students and health service users. However, we have medical practice on our side, which is more firmly structured than ours and we end up reproducing it or trying to surpass it, hence we enter another power field. This configuration of powers lays on a field where we are both dominant and dominated, producers and reproducers of actions and knowledge.

We nurses help in the processes of maintaining health and life, but we also crystallize hierarchies that, at the same time, reiterate the exclusion and heteronomy of those of those who are subject to our practices as defined by our class *status*.

If *habitus* reports on a classification system that is symbolically constructed within the different social groups, a prerogative specifically architected within each social class defining it and differentiating it in relation to the other classes, the notion of class *status* is entwined to that of *habitus*, and both are a product of the social relations that engender them. *Habitus* tends to conform and guide subjects' actions, whereas class *status* defines the subject in terms of the group to which he or she belongs while also differentiating them from the other social groups.

Therefore, this definition of class differs from that of Marx, as it incorporates the symbolic aspects of the social relations that operate differentiate and distance the different social groups. One class can never be defined only by its status or position in the social structure. It has specificities of a social class based on the fact its members become deliberately or objectively involved in symbolic relations with individuals from other classes and, thus, express differences regarding status and positions according to a systematic logic, tending to transmute them in significant distinctions[9].

To understand the extent of the symbolic dimension entwined in certain social relations, when we look based on the Bourdieusian theory it is necessary to first understand the specific functioning of the bureaucratic microcosm of the locations where these relations take place[11]. On one hand we have the university and the educational process, where we include ourselves as faculty, and on the other, health care services, where we act as both health and education professionals. In the context where this study takes place, we have faculty and students who may also be health care service users and workers. There is a continuous and even simultaneous exchange between the roles that we assume in our daily work activities. At some times we are professors at others we are nurses, and student or users. In every role we live, fall ill and thus learn we have the need to be cared for by another person who, at some moment, was my student, colleague, colleague or professor, hence I use the area and knowledge that I once helped to build.

In this conjunction of human beings who at times care and at others teach or are cared for, we have different ways of exerting our potentials of autonomy and co-responsibility. At this point, other elements interest us, which point at the need to search for alternative dynamics to construct the other subject; one that is more autonomous, solidary and ethical, i.e., one that shares responsibilities, as it continuously reflects, in a deep, critical and vindicating way about the areas and relationships in which it is immersed[2]. This subject, always unquiet, acting and imperfect, is part and, above all, wants to qualify their existence and the areas and relationships in which they are involved.

If the chances for a continuous improvement are open only to the imperfect being, we observe that the *opening* of this individual make emerge uncountable possibilities of exercising new knowledge and methodologies for that other subject to appear, who is solidary and ethical, and no longer one that was a prisoner to the imponderability of symbolic domination[2].

We know that, due to the human diversity in which we are immersed, the phenomenon of domination will always exist to a greater or lesser extent in the relationships between people and groups, as many of its mechanisms are pre-reflexive. However, though having this pre-reflexive characteristic, the domination is a phenomenon that can be understood and dealt with, as long as we remember the Lukács Effect, described by the Institutional Analysis, which states that the more

> formal, rigorous and quantified a science is and the more it loses sight of the social conditions of its origin and development (i.e., the deeper its epistemological cut), the more it meets the scientific demands and contributes to the lack of knowledge regarding a social group about their own existence [...] the "lack of knowledge of a society about itself is the consequence of the progress of science[12].

What permits us to remember that life is much greater than any science is that human beings, as beings of possibility and promptness, can amaze and reinvent themselves.

Although the extract below has been thought in the context of management, we can perfectly use it in education and for the activity of teaching, once the attitude of the faculty in relation to their work makes the whole difference in the development process. Hence, we reaffirm that

> The nurse's behavioral commitment is characterized by identification and involvement with service, demonstrating dedication and enthusiasm, which indicate deep bonds between the professional and her work. Because she feels motivated, she invests her human capital and enjoys working in the organization because she values her interests and goals[13].

Faculty can been seen as the manager of the process of organizing and evaluating the teaching that he or she delivers. He or she must be responsible for the student's learning and to do this he or she must work with dedication and enthusiasm, and be involved in a way that establishes quality attachments with colleagues, students and also the local personnel to improve their relational and emotional competence in the concreteness and immediateness of the teaching process.

CONSIDERATIONS ABOUT A THOUGHT UNDER CONSTRUCTION

Our areas/zones of practice present uncountable possibilities for constructing and expanding the levels of leading roles and reinventing and stimulating the instituting potential, which are essential for the construction of citizenship in the contexts in which we work. The purpose of health and nursing practices in a more utopic view, either in the process of health care or education, must be thought of as constructors of autonomy and may point at the possible forms of constituting more symmetrical interrelations between human beings/subjects, in either the process of care or teaching.

Exercising citizenship implies on the existence of autonomous, but solidary, subjects, for the dialectic of help recalls that no one can emancipate without help, but the desired aim is to know how to live without help. The major presuppositions guiding our practice and experiences as faculty and citizens can be the valuing of and stimulus towards assuming a leading role in emancipation and citizenship. To do this it is essential that to see each human being with whom we will be in pedagogical contact as a being with desires, potentialities, will and promptness to become an emancipated subject of many possibilities.

In the reality of health and education in which we work as developer subjects, we see human beings exposed to many different adverse situations in life, health, and work. Such people include some of our students, but most are clients/users of the health care service where we work, teaching and caring. Those adverse conditions we know to exist in public health services impose many limitations to our students and also to workers and users of the health services.

On the other hand, however, if we think about what is real, in the world of action that is reaffirmed and where the political subject is constituted, we know that adversity implies in itself the possibilities to overcome it. In the health and education convergence, where we stand as faculty teaching how to care, we can make emerge the political subject that we desire in the process of nursing education. The emergence of that subject with formal, ethical and political competencies depends mostly on the promptness and competencies with which we, educators, deal with at our duty of teaching and the care we have towards our continuous development as faculty.

We, nurse-faculty professionals, must create, invent, and construct conditions for the instituting, the organizing, the new, unique, and revolutionary to break out and change the (asymmetrical) relationships that today are imposed in the process of both teaching and educating in health. Though distributed differently, amongst us there is sensitivity, compromise, and desire to do so among many professionals of the broad areas that are health and education. We believe that having desire as our guide, many of those subjects are in nursing, a category that has in its frame many subjects that endeavor and are committed and sensitive to what is new, unique, in either health or education. That group is still a minority, but it is responsible for levering the processes of change.

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