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# The Permutation of the Terminal Subject towards indocility In the Colombian Health System.

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***ABSTRACT:*** *The production of the ethical subjectivity of terminal patients assigned to critical expression transformed into an unruly and reflexive perspective in the context of social reforms of Colombia describes a series of events that confronts the production of the subject of the government of others. The long-term purpose is the consolidation of a Care Policy as a dynamic and lasting strategy in the face of the health and legal demands learned during the experience of terminal illness in the context of health regulations in Colombia. The permutation of the terminal subject to indocility from the production of ethical subjectivity in the process of experimenting terminal disease, who, through an epistemological independence adopted a strategic element of resistance, managed to transform their relationship with institutions and the Government, has embodied indocility as an patient expert who contributes to the social construction of a Health Care System in Colombia.*

***KEYWORDS*** *-Colombia, patients, political movements, right to health, social reform*

## I. INTRODUCTION

The social security reform of the 1990s introduced an innovative model to Latin American Health Systems through Structured Pluralism[1] promoted by the Inter-American Development Bank in Colombia. The justification for the reform was based on the need to develop a relationship between the political and economic aspects of health in the epidemiological and demographic context of the country and, thus improve the efficiency of health services through the implementation of a technical-administrative complex made up of a system of economic incentives for the provision of health services, technological adaptation of institutions for greater competitiveness, standardization of clinical practice, and the implementation of financial mechanisms to promote rational use.

The regulated competition model ruled by Law 100 of 1993 transformed the health discourse into a set of market interactions on health care processes, according to the transcendent order of the economy that, would compromise the continuity of free provision of services. Basic services for the inhabitants of the national territory would enhance the private insurance axis through discourses of legal-administrative modulation of health services, privatization of social goods and weakening of public health institutions, which added effects to the health of patients with diseases such as cancer, HIV and terminal kidney disease, who experienced profound differences from the social perspective in terms of equity, particularly in minority communities.

Civil society expressed its disagreement with the reforms, the privatization of social and health security. This configured a set of interactions between different actors from social protest to the production of its own technology to address the deep social gaps of the health. During social mobilizations between1994 to 2010, the health issue was imperceptible due to the violence in the country, however, they transcended to the demand for the right to health.

Empirical information suggests—preliminarily—a change in the axes of mobilization during the period, expressed in the transit of more demands of a vindictive and union order - which in any case they do not disappear—towards configuration of others that name the health as a right, which is at the same time, a novelty and a paradox, because that name arises through the decrease in content and reach, precisely, of social rights.[2]

Research in Colombia has documented collective actions to demand the right to health after the reform of the Social Security System of 1993, the scope did not contemplate the production of subjects in the social struggles of health, in the words ofBorrero&Echeverry-López,2014:

...which is why research on collective action for health is incipient at the national level, the dominant theoretical approaches are structuralist, and there is still little research that approaches the study of the configuration processes of subaltern collective actors who dispute the field sanitary. [2]

The present research traces the configuration of ethical subjectivity in people who suffer from terminal illnesses in the context of the Colombian health system and its interaction in the social struggle for health. It is relevant to reveal the historical conformation of the control device through the analysis of government discourses to make visible the effects of power on the lives of patients through the incorporation of technologies of production, power and meaning, and their reach in the various aspects of life, for which the points of contact between the government of others and the government of oneself in the present problematization after the 1993 reform during the emergency as a possibility of resistance for health rights,as a demonstration of other modes of criticism and emancipation to consolidate purposes and efforts to improve the lives of people with terminal illnesses in Colombia and in the Latin American region.

It is relevant to mention works consonant with this research: Health-Illness as a social process by the Mexican author Asa Cristina Laurell[3]and Chronicle of renal disease, Voices that live and listen to the suffering of Francisco J. Mercado-Martínez Eduardo Hernández-Ibarra [4]. The first one describes in the Latin American context the process of health – illness as a social process from the perspective of Social Medicine and the compilation of patient narratives, the effects of regulations, and the experience of suffering from kidney disease that also questions medical knowledge.

The purpose of this work is to explore new ontological and epistemological possibilities in the social struggle for health, given the multiplicity of approaches and focuses to the social process of health-illness of patients and communities amid political, economic and health tensions. To propose a discontinuous perspective to reveal the meaning and intention of the speeches and the consequences on life is to reveal the biopolitical background of government at different times of the Colombian Health System from the reform of Law 100 of 1993 to the current ones.

Epistemological independence based on criticism and indocility sustain resistance during health crises and propose structural changes that transform health policies through the confrontation of other modes of existence in extreme situations of illness or death, which from now on will influence the political: self-care as a strategy to confront government techniques, ethical subjectivity as a liberating practice against the neoliberal capture of life and health, and the art of indocility as an aesthetic component in the fight for health. Therefore, the following question arises: ¿How could an ethical subjectivity "reflexive indocility" serve as political resistance of the terminally ill patient in the social struggle for health in Colombia.

## II. Development

The terminal patient establishes a time and space as an individualmatter to understand his or her history, recognizes how the effects of the regimes of truth have lodged in his or her body that the terminal patient materializes, the rupture establishes his or her uniqueness in the attempt to preserve the essence of the human being and the existential that makes us unique and different as mentioned by Vasilachis de Gialdano[5].The set of practices grants an ontological perspective nourished by critical and reflective elements which reconstruct the

subject to distance itself from everything that has historically limited it despite the worn-out body, which, unlike the docile ones, finds its strength in physical exhaustion to reconfigure disruptive strategic elements.
Life is the space for the exercise of biopower and discipline operated by a government system based on the physical and emotional internalization of those who suffer from terminal illnesses, with the consequent validation by government devices and discourses in everyday life, leveling the individual where contact is produced between the objectification of the system and subjectivity. In this way, the initial approach to discourses that assign the signifiers in each phase of the process occurs to give continuity to the totalizing capture of the subject, through the multiplicity of interconnected strategies that they cover the essential aspects of the demographic and epidemiological context. It configures a conductive exercise that, unlike the pastoral modality of power as described by Foucault, confronts individuality through obedience to laws and knowledge which sediment the institutional bases of government and, in turn, it reflects in the social structure itself the production of subjects and subjectivities that support the System : It prescribes to each their place, to each their body, their illness and death, to each their good, by the effect of an omnipresent and omniscient power that subdivides itself in a regular and uninterrupted manner until determination end of the individual, of what characterizes then, of what belongs to them, of what happens to them.[6]

It is possible that ethical reflection breaks through desire, establishes appropriate techniques for self-care that allow one to reconfigure one's existence, and poses how to resolve the problem about the relationships between government, individuality, and desire during illness. The critical expression of communities and patients allows us to glimpse the restrictive effects on life and the imminent risks in the complexity of government impositions here, the fundamental thing is the exercise of criticism that leads to questioning the rationalization of power, the effects on physiology through exclusive or restrictive ways of life according to the requirements of the economy, that is, the interaction of technologies that governs individuals continuously and permanently incarnated in the body.

The body acts as a permeable membrane, communicating with the inside and outside. What do bodies communicate? Bodies communicate the conditions of our existence, the actions of the State, they express what people are silent about due to physical limitations, because they are prohibited or because they choose not to do so [7]. It displays narrative possibilities that allow us to read how life has been impregnated in us from the moment we are born until we die, capturing the path taken by possibilities, capacities, frustrations, pains, and desires that are drawn in the skin, skeleton, muscle mass, nervous system, digestive system, in the senses, in the psyche. It is a compendium of experiences in the world that transcends biology, everything leaves a mark. ¿Could resistance produce another possibility of experimentation embodied in the body of terminal patients?It gives rise to the production of an insurrectionary and visible body to continue living outside the government management schemes, so as not to fall into the fallacy of care in the neoliberal context and transcend self-care as an ethical-political proposal.

The self-care subject is the result of the immersion of subjects in the business management of the biological and the social during the suffering, blurring their individuality and autonomy; unruly subjects produce other forms of knowledge from the construction of discursive series based on ways of disengagement from the management of life. This new relationship establishes a new attitude by questioning the knowledge and rationality of government discourses, this subject moves between epistemological and ontological production by detaching itself from the regimes of truth, in Butler's words:

Who can I become in a world where the meanings and limits of the subject have been established for me in advance? By what norms am I coerced when I begin to ask who I could become? And what happens when I begin to become that for which there is no place within the given regime of truth? Isn't that precisely what is meant by "the disengagement of the subject in the game of politics of TRUE"? [8]

The subject internalizes a new practice to take on the challenges, adopts a political strategy to prevent the effects of discourses such as self-care, an *ethos* oriented to the construction of a social dialogue to reconcile the possibilities of emerging knowledge for the construction of possibilities different from government schemes, distant from the fallacy of care in the context of neoliberal subjectivity. It is pertinent to review the different perspectives that are part of the process of detachment from the production of the subject, recognizing the value and contribution to the event that begins with the antagonistic, reflective, and ultimately indocile perspective, which are described below without order of causality.

Under this context, health and illness are understood as a social process affected by the incorporation of new institutional, political, and economic structures in the reforms, it contemplates other axiological initiatives between knowledge and the subject, an antagonistic technique of knowledge against regimes truly to understand reality based on complementary knowledge. It includes an epistemological component that allows us to explore the paths of resistance and re-existence of life, confront historical processes, their inherence in daily life that evades the limitations imposed by race, gender, social class or illness, the key word is antagonist from the greek*antagonistis* formed from anti (opposite or contrary), the word *agon* in Greek means fight, combat or match, here the antagonist exercise is based on the configuration of critical thinking based on the cohesion of patients and scientific societies (subject and knowledge) from the epistemological conjunction lacking hegemonic validation.

This relationship between subject and knowledge strengthens the antagonism towards the System, based on the lessons learned in the vindication of the right to health and medical autonomy in the years following the 1993 reform, different perspectives, but not contrary, thus confront the deprivations of the model for more than two decades, consolidated synergistic processes to account for the multiplicity of the reality of patients, in the past and current epidemiological challenges added to a context of profound social inequalities in Colombia. The reflective proposal in resistance is the result of physical pain and systematic exclusion that elevates critical exercise to the spiritual stage, to redefine the possibilities they redefine their subjectivity, body and propose another way of seeing resistance through emancipation, it is the available alternative for others. The work of self, free, conscious, autonomous, and own exercise involves methods and strategies that make visible the techniques and effects of devices with the capacity to give antagonistic meaning to actions – force against government discourses.

The human and non-human elements [9]also reorganize tactics consistent with self-care, unlike other social mobilizations, this one establishes its own well-being dialogue with patients and scientists, assigning another meaning to the proposals under the leadership of a renewed subject with the analytical and purposeful capacity to understand the phenomena of subjection and overcome the imposed controls in their own way.This implies the exploration of events beyond particular experimentation, this moment is the initiation and development of own techniques to identify the problems of the System, but it is to account for the facts from its own history and narrative through the rigor of the analysis of the context using their own tools that take them to scenarios other than the governmental one, such as Latin American networks of patients, national and international media, academic events, in short, they resist from an independent epistemological point of view.

The body also poses another mode of existence that translucents the signifier into an antagonist, reluctant to generalization and objectification through the strategies of self-care, where the body and the spirit merge, so the connection contemplates the axis of the fights by incorporating reflective guidelines beyond the complications of the disease itself. It is no longer about the docile body that tolerates exclusion even in the current circumstances of the System; it is transformed into the indocile device of re-existence.

Directing patients and communities to alternatives in the biopolitical context is the intractable proposal, once the effects of power relations in people's lives have been identified; ¿Is it possible to dissociate discursive and non-

discursive government practices? What is proposed is dissociation of government discourses establishing a disconnection between the effects of the devices and the subject, is delimiting a margin of safety that establishes a space of action for liberation from fear and pain to confront its power, thus ratifying a prudent distance from to government practices and delve into the analytical experience that shifts towards the agency of life.

This new position in the totalizing structure leads to tactics that objectify the effects of the System, in Foucault's words, the device of strategies of relations of forces supporting certain types of knowledge, and supported by them (interview in July 1977) in this scenario the strategies the relations of force are supported by the emerging epistemology. Therefore, the device also acquires another approach in the management of resistance, different from the market model resulting from the conjugation of the reflective subject, emerging epistemology and the dissociation of discourses to transform bio politics and see it as a purposeful alternative to interaction with life. The alternative biopolitics in the indocile status embodies the challenge of self-care, the staggering of the action of resistance at the political level, understood as an individual and collective decision that seeks to care for the disease and its avoidable by linking the multiplicity of knowledge – emerging and re-emerging to contain the effects of the manipulation of the System, from a coherent and sensible proposal according to the needs of the people from the principle of distributive justice, individuality and autonomy.

The contextualization of the exercise of permutation of the terminal patient into an unruly subject facilitates the interpretation of the event that is the production of ethical subjectivity, based on its immersion in the totalizing matrix that generates points of contact between the government of others and the government of oneself to answer the question ¿ What are the points of contact between the relations of power - knowledge and the constitutive inflections of subjectivity during the experience of illness? The intention of this document is not to establish a causal relation, in words of Foucault: How are these fundamental experiences of madness, suffering, death, crime, desire, individuality related? I am convinced that I will never find the answer, but this does not mean that we should give up asking the question.[10]

The narrative reveals the adversity during the suffering, especially in the midst of the transformations of the System, but at the same time they propose discursive and non-discursive practices that guide efforts to maintain their individuality in the face of the generalization of the System as an action of resistance, maintaining it during its immersion in the totalizing matrix , will demand a work of permanent questioning about the truth that requires a break with the normality of the model, separating itself from the medical-administrative categorization that endorses its existence to the ontological construction of another truth, therefore, it is necessary to describe the instances of the subjectivity produced by the government of others to understand the ethical evolution of the subject once objectified and achieved by the production of signifiers of the system at the same time the critical inflection occurs.

For understanding of the production of subjectivities between the government of self and others, it is relevant to dimension the effects of power and the instances that from objectification display not only the evident subjection, but also establishes another ethical alternative such as the terminal subject that could modify the relationship with the totalizing context, particularly related to health and the outcomes of the illness from the production of another signifier and its transformation into an expert patient.

**2.1 Subject as object of knowledge – power**

Interpreting the background of the regulations and truth regimes of biopolitical management allows us to clarify the scope and limitations of the terminal subject in the System, facilitates the understanding of the production of the way of life and a certain subjectivity resulting from the interaction between the subject and the techniques of control, specifying how this is shaped physically and emotionally by power, that is, the production of the

subsumption of the government, guides the totalizing experience that transfers the social to the body or vice versa, Laurell explains it clearly:

This way of understanding the relationship between the social process and the health-disease process points, on the one hand, to the fact that the social has a different hierarchy than the biological in determining the health-disease process and, on the other, it opposes the conception that the social only triggers immutable and a historical biological processes, and allows us to explain the social character of the biological process itself. This conceptualization, thus, allows us to understand how each social formation creates a certain pattern of attrition and reproduction and suggests a specific way to develop research in this regard [3]

Each social formation produces a pattern of biological wear; it could be said that a bio political phenomenon is reproduced that acquires a certain systematicity over the time horizon and replicates certain hierarchical structures that facilitate defined objectification that triggers effects on the biological processes of a group of people with ethical, territorial, gender, or pathological differentiation. In this way, a pattern of the disease is established, which individually produces adjustments in lifestyles under a heterogeneity of categorization variables such as the prevalence and distribution of breast cancer in Colombia ,women from Indigenous and Afro-descendant ethnic minorities show a low connection to the Health System, with a participation of 0.99% for Afro-descendants and 0.67% for Indigenous people, as well as differences are observed from the territorial approach given the low coverage for women with cancer in the Pacific and Eastern regions, the proportion of cases in early stages (In situ, I – II) in the subsidized regime is lower than in the contributing regimes and women with stage IV breast cancer in the subsidized regime represent twice more than those with a contributory regime.[11]

The analysis of the subjects reveals that the greatest effect is the production of the terminal patient as a certain life condition forced to categorization and consequent exclusion. This problem, as mentioned by Foucault, deals with the relationships between experiences, knowledge and power: as I told you before, this problem deals with the relationships between experiences (such as madness, illness, transgression of laws, sexuality and identity), knowledge (such as psychiatry, medicine, criminology, sexology and psychology), and power (such as the power exercised in psychiatric and penal institutions, as well as in other institutions that deal with individual control)[6].If the relationship between the social and the biological were proposed in two ways, the body of objectified groups submerged in the totalizing, another perspective would be established from another signifier such as the expert patient that establishes another relationship with the knowledge-power , which determines other possibilities in the pattern of the disease that evolves over time thanks to self-government, in Laurel's words, a social formation with patterns that contribute to a life in better health conditions for historically excluded groups.

**2.2 Terminal subject**

The disruptive moment of the diagnosis of the disease produces confusion, fear and pain with few options when immersing oneself in the totalizing as a terminal patient, the disease is the communicating path that channels the devices in a sequential way that makes visible the previously unnoticed objectification. Assume reality as a terminal subject, the production of an administrative clinical statement in the Colombian Health System suffering diseases such as cancer, HIV, terminal kidney disease, is the product of the intertwining of knowledge - power during the process.The experience of extreme situations under the regulations of the System and social inequality in Colombia configures the terminal patient statement as a product of model discourses from a reductionist perspective in the face of plurality and independent knowledge that excludes the singularity, which guarantees the economy of control and generalization through clinical-administrative management of the disease. In this way, the circulating discourses defined a docile subject categorized by the factual order,normalized by state dynamics that fragments the ontological status, hence the question: ¿What are we ?

Since the 1993 reform, the terminally ill patient dared to analyze the word, question the actions of the System and interfere in the discourses, detaching himself from government knowledge from his epistemological independence, who proclaimed a manifesto of resistance through discursive and non-discursive practices of an antagonistic nature to enter into the debate for which the ethical production of the subject would draw different discontinuous intensities in the fight – resistance process. It is an evolutionary work, faced with the crisis of the context that proposes the development of an attitude, it assumes the leading role in the institutional and governmental relationship, the principal event is the ability to disassociate itself from the production of the terminal subject of the system regardless of the conditions of health to confront the government of others and the government of oneself through the criticism that corresponds to the exercise of freedom that clarifies the points of contact of struggle and resistance.

The statement in defense of the right to life and health that is the premise of the mobilization, shared in all instances of social struggles that includes the future of minorities that make up an alternative that guides and teaches how to face the disease and its difficulties, initially proposes techniques for making the effects visible, for which virtual tools have been developed with the support of expert patients to resolve risk situations, which systematizes the information to support the patient's process and identify difficulties in access, such as the case of Vital Return Foundation. This has made it possible to identify the main problems faced by patients such as access to technologies (medicines) and specialized medical care, account for risk situations through primary sources, disseminate the results to competent authorities and to public opinion, enhance the interpretation of the phenomenon from an own independent dissertation.

The policy promotes collective actions aimed at the sustainability of practices for the care of patients and communities, unlike other moments of the social struggle for health in Colombia, the subjects are proponents of changing the order of discourse through new technologies of their own, the purpose is to connect the reality and possibilities for patients with terminal illnesses, making visible the efforts to improve the conditions of patients and their families from different regions of the country and the world that explores alternatives based on the diversity of experiences that go beyond the local context and are part of the collaborative dynamics of World Patients Alliance, All can, Idealist, Global Cancer Control and CLAYCOP.

**2.3 Expert patient**

The expert patient embodies ethical subjectivity in the context of indocility, his performance is the epistemological independence that allowed him to identify challenges to sustain himself as a commitment to resistance and courage includes transforming devices in possibilities of innovation to constitute a technology of itself that adheres to new experiences in the social context. The expert patient is the terminal subject who has acquired a prominent level of knowledge and understanding about his or her medical condition that allows them to establish another type of legal, social, and health relationship that condenses the following skills:

Knowledge: We care about learning about your illness, its signs and symptoms, available treatment options, and possible side effects. Tested online, talk to health professionals and seek information from trusted sources.

Self-management: We take steps to manage your illness effectively in your daily life. This may include following a treatment plan, taking medications as prescribed, keeping track of symptoms and changes in your health, and lifestyle adjustments.

Communication: We are proactive in communicating with your doctors and other healthcare professionals. Ask questions, express concerns, and help make decisions about your health care.

Participation in decisions: We actively participate in making decisions about your health care. They work together with your healthcare team to choose treatments and approaches that fit your needs and preferences.

Problem solving skills: They can identify problems related to their health, evaluate different options and make informed decisions.

Continuous assessment: Provide regular feedback and follow-up to ensure the patient is acquiring the necessary skills and is comfortable with their role as an expert patient.[12]

The critical inflection leads to the addition of tactics that question and articulate strategies for care, such as the technical synthesis of regulations, national and international alliances of patients, and proposals for technological innovation that represents another way of relating in their environment, configures the point of contact between emancipation and action, this expert patient leverages patient communities from his knowledge, active in academic and political interaction for care. The scope of the mixed analysis of rules and regulations by the unruly subject includes revealing the problem from the daily experience of patients to the instance of objective evaluation to account for the effects on people's health, duly documented through systematized collection of information, results, and discussions are taken to different scenarios. It is not only the tone of denunciation given by the difficulties in access and untimeliness of treatments, but the revelation of the inefficiencies of government processes that added to the health context.

- They draw inefficient alternatives with a negative impact on health, exposed in the opinion column COVID-19 and ceilings, a painful formula for patients. Opinion column in El Espectador August 31, 2020.

…analyze the impact of the ceiling standard due to the short time of its application. However, for the organizations that represent them, that work every day with all of them, it is impossible for us to remain silent in the face of the increase in management difficulties, which is having effects on the quality of life of patients and caregivers.

On the one hand, it is understandable that we are focused on the COVID-19 pandemic, but we cannot neglect other patients. On the other hand, the pandemic took us in the context of the application of a methodology that is complicating things even more, which is why this should be considered a temporary measure and the real bet should be to have a Single Health Plan. Putting a ceiling on health does not guarantee due care to patients and, consequently, does not allow the effective enjoyment of the right to health.

Jorge García- Director Vital Return Foundation

- The strategic renewal of the subject focuses on central aspects of health care such as access, quality, regulatory context and innovation, consistent with its own work that expands its scope in the construction of care policies as a participant in the formulation of proposals that minimize risks and negative effects on health as exposed by patients in ISPOR Colombia chapter, presentation Board of Directors 2023-2024:

At an international level, it has been recognized that patients have unique experiential knowledge, to obtain this knowledge and optimize its use; we need their participation in the evaluation of health technologies in two different but complementary ways: Patient participation in the technology evaluation process and investigation of patient aspects (patient experiences, preferences, and perspectives) to produce evidence about how patients balance risks, treatment burden, and benefits. All of this can have an impact on determining the benefit of the new treatment or service. Input from patient groups has included surveys that provide information on outcomes

not included in clinical studies such as quality of life data that have been used as utilities in economic models or treatment experiences that indicate more challenges with a treatment than that are apparent in the literature [13].

- The ethical transcendence of the terminal, unruly, expert subject includes critical and reflective exercises protected by the methodological rigor that leads to the analysis of the problem, determining the scope and limitations to shape the power of participatory construction not only of a health plan equitable but the incorporation of the Care Policy in people's daily lives that counteracts the negative effects of policies such as the "All Survey Can Colombia" participated in 800 patients and in-depth interviews with doctors, caregivers and health professionals on 2022 expressed their perception about cancer diagnosis and treatment.
- Additionally, its participation in collaborative work with scientific societies and other sectors of the System is a favorable space to present alternatives based on independent knowledge that synthesizes priorities to consolidate collaborative proposals such as "Patient associations and collaborative work in the search for solutions related to barriers." in access and diagnosis" for early detection – timely treatment from the patient's perspective. Speaker: Dr. Jorge Ernesto Garcia Rojas (Vital Return Foundation) at the congress of the Colombian Association of Hematology and Clinical Oncology in 2023 and collaboration with the Orphan Diseases Route project for Colombia held in September 2023.

Thus, the nascent reflections of unruly subjects with terminal illnesses question the truth of knowledge and power, materializing other critical modes of expression from the individual and the collective before the dominant structures of life and death. The exercise of their free and autonomous spirituality contemplates an alternative in the midst of the dichotomous regimes of the health system, constitutive elements of an emerging ethical subjectivity in relation to policies of denial that will urge those who have been declared hopeless to continue disobeying as experts.

## III. Conclusions

Previous research from Colombia reports on social mobilizations to demand the right to health of patients and communities since the reform of the Social Security and Health System in 1993 from a structural perspective. This work investigates the subject who participates and resists over time thanks to the production of an ethical subjectivity that has allowed him to detach himself from the System and has allowed him to transform himself to propose another constitution of the ethical and epistemological order to continue resisting in the eventual crisis and opts for a political transition of inclusive and equitable care in the Colombian context.

This report delves into the enriching experience of the political ethical production of patients and communities after pointing out the events during the experience of extreme situations of the disease without ignoring the limitations in access to other experiences of patients in situations similar to the Vital Return Foundation from Colombia since there are no previous works in our country. Recognizing health and illness as a social process conditioned by economic and political structures supported by the identification of the pathways of biopower and the production of life possibilities in the context of healthcare expands the scope of Collective Health research and Social Studies.

It introduces a new perspective for approaching ethical and political proposals for social health problems that links individual and collective experimentation that inspires an esthetic, political and epistemic alternatives based on the permanent search for axiological and ontological elements from reflective indocility. It establishes a precedent for research on emancipatory subjects in the context of health in Colombia based on the production of subjectivities as a possibility of resistance of patients and communities, which contributes to a pluralist care system in Colombia.

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