Dental care integrality for women in violent situations: a narrative review of professional conduct

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ABSTRACT

Improving integrality on dental care for women in a violent situation depends on how the dentist conducts the care practices and how to comprehend the violence. For that reason, the goal of this review was to gather evidence and concerns about the role of dentists in addressing violence against women, professional responsibilities, and social obligation. At PubMed, SciELO, and LILACS were selected research and studies to substantiate and deepen perspectives about integrality on dental care attendance considering the social conflicts implied in the main complaint. Violence against women is produced in gender inequality arising from historical and social processes. Physical aggression is the main complaint. Women assaulted by their partners have a high prevalence of suffering head and face injuries. The violence's sequelae spread to countless problems beyond the physical traces. Dentists do not be able to identify, conduct, and purpose alternatives of global treatment even though with protocols of investigation through the anamnesis. Multiprofessional discussion expands the knowledge and it is an opportunity to reinforce oral health inclusive criteria avoiding mechanical treatment with no respect or affect. Thus, this is a collective construction strategy to establish and maintenance of the ethical and social commitment of Dentistry, on what dentists improve the dental care screening, intervening, and changing behavior according to the real demand of our society.
Descriptors: Violence Against Women. Integrality in Health. Dentist-Patient Relations. Education, Dental.

1 INTRODUCTION

Violence is one of the concerns of contemporary dentistry, because, in general, physical aggressions, blows and impacts can displace, break or crush maxillofacial and dental-alveolar structures [1,2]. It is a consciously hostile and intentional behavioral phenomenon that causes losses of various natures[3], so it occupies a significant space in world politics and constitutes a challenge to public health, the economy and socio-cultural and educational coexistence worldwide[4]. Among the various types of violence, that one practiced against women has alarmed society about the rates of feminicide and also about the acute and chronic injuries resulting from physical violence[5,6].

Several observational studies[3,7,8,9,10] reports that the head and face region are areas frequently affected during aggression, a fact that highlights the urgency of discussion with health professionals including dentists. Often, lip edema, tooth loss and masticatory or respiratory dysfunctions are identified in patients seeking dental treatment[9,10]. Damage can be severe, reach multiple sites, and result in numerous returns. However, more than pre-establishing curative procedures, dentists may offer an opportunity for the patient to report the cause of injuries.

Signs and traces of aggression, patterns of injuries, conduct during care, validation of the patient's reports, repudiation of violence against women, and information about the places and support networks to perform referrals are topics to be explored with the health professionals and dentists [9-11], regardless of their specialty or region of activity. The management of care based on the integrality of the patient fosters dialogue practices related to the integral conditions of the main complaint that the patient presents[12]. That is, the dentists plans with the patient alternatives of global treatment in which the professional repudiates violent practices and occupies the position of facilitator of information about the support networks.

Appropriate conduct for dental care requires deepening socio-cultural issues that subordinate women and generate inequality between genders[3,12-14]. Because dentists will only be able to consider violence against women as a hypothesis of the etiology of injuries that it presents, if he/she is able to listen to her and understand the dimension of the violence suffered, from the exposed social conflicts. The importance of this theme in Dentistry teaching stands out in the continuous renewal and reflection of the role of Dentistry in society, since pedagogical changes in curricula are significant parameters for maintaining the ethical and social commitment of the profession according to current demands[15,16].

In Dentistry teaching, the health-disease-conduct approach does not contemplate principles of the Unified Health System (SUS) [12], in which the dentists is prepared to act in an inclusive, emancipatory and intersectoral perspective. The stages of fragmented care detach the patient from the violence suffered and the role of the dentists is restricted to a merely operator. On the other hand, academic training focused on the political-social discussion of patients in situations of violence will promote analysis about the situation and possibilities of interventions directed to welcoming skills to collaborate with the fight against violence[16].

Thus, the objective of this narrative review was to accumulate evidence of the professional responsibility and social obligations of the dentists and their attribution in coping with violence against women, discussing the strategies proposed by several authors over the last 20 years. And highlighting the gaps that can be filled and developed in educational institutions, scientific associations and societies, and in partnership with other sectors, such as health departments, police stations and reference centers.

2 LITERATURE REVIEW

Research Strategy

The scientific support of this narrative review was carried out in the bibliographic databases PubMed, SciELO and LILACS, since they gather most of the publications directed to the health area. The research was carried out between November 2019 and February 2020. Scientific articles in English and Portuguese were selected, according to the team's preference, considering title and abstracts, type, and a number of citations from the papers.

The keywords were combined with Boolean operators, AND and/or OR, commonly used to search systematized. However, the search strategy for this narrative review was not structured from the perspective of methodological reproducibility.

In addition to the databases, laws and official bulletins were also examined and regularly re-examined, as the team observed the need to confirm or confront certain concepts, data or methods described.

Overview of violence against women

Recognized for a long time as a social disease and an acute public health problem[17], interpersonal violence has reached very high rates in Brazil[6], mostly the disproportionate incidence in women stands out [7,8]. Violence against women has no single reason or motive that can be classified into determining criteria [9,18]. In fact, it is the result of historical-social processes of dominance, power and structural, cultural and individual exploitation that inferiorizes women in different situations. That is, it is a question of inequality and not of gender difference, so it occurs worldwide [4,5,8,10].

Several contexts that violate human rights are deeply [9,17] built-in societies and permeate acts of disrespect to women, humiliation, verbal abuse and threats (verbal and psychological violence); physical and sexual attacks (physical and sexual violence); and sometimes homicides (feminicide)[19]. However, the women's profile standardization in violent situations is not elucidated from the investigation of their race, ethnicity, economic class, education, or religion [5]. These characteristics are important markers of strategies to prevent and assist in coping with violence, so they should not be understood as argumentative assumptions or as defining the reason why women suffer violence [3-5].

The quality of the available data on violence against women represents an obstacle in the knowledge of the real dimension of the facts [3,8], because often the cases are underreported. Despite the lack of complete information, physical aggression stands out among the main complaints[1,20], in which the excessive force used constitutes physical violence that impairs their autonomy and integrity[3,9]. Recent statistics indicate not only that the aggressor is part of the woman's coexistence and that violence occurs in the domestic environment[10], but also that women are four times more likely to be physically assaulted by their partners than men [7,8].

Domestic violence and the mechanism of aggression are factors associated with maxillofacial and dental alveolar traumas, for example. In other words, women assaulted by their partner have a high prevalence of suffering head and face trauma [8,10]. These areas are more easily reached, as they are at the height of the aggressor's raised arm and it has been plausible to infer that the perpetrator of the violence, consciously or unconsciously, chooses these regions to affect the woman's self-esteem [9,10]. Jaw fractures, zygomatic fractures, dental avulsion and soft tissue injury are diagnoses repeatedly described in the studies[1,2,11]. However, the sequelae of physical violence go beyond visible traces and spread to numerous problems: stigmatizing scars, chronic psychic or systemic injuries, joint disorders that affect swallowing, respiratory difficulties and/or distortion of speech[17,18].

In Brazil, records of bodily injury due to domestic violence was 7.4%, in 2020. However, in absolute numbers, the 230,000 mark was reached [21]. These data are reflected in public spending on the health system and in the general economy, since they generate costs for the multidisciplinary treatment of acute injuries and long-term care[7,18]. Frequently, injuries and complications resulting from trauma comprise a

set of signs and symptoms of patients seeking dental care. The dentists can then offer a chance to the patient to talk safely about the cause of these injuries[10,18], based on the identification of the pattern of physical aggression, the affected region and other markers that have a high degree of specificity to suspect that a woman is in a situation of violence [9,10,17].

Professional responsibilities and social obligations of dentists

According to the World Health Organization, health professionals are responsible for the victims of violence[4,5], therefore identifying the etiology of injury/trauma/injury, documenting, recording and notifying cases and referring patients to the coping networks are identified as basic anamnesis procedures[13]. Several studies[13,14,18,22,23] expressed concern about the lack of trained personnel to detail maxillofacial and dental-alveolar injuries in environments such as emergency hospitals, police stations or forensic institutes. Most authors suggested training dentists to work in programs created or incorporated into reference institutions in the care of women in situations of violence. However, some professionals did not feel responsible for the situation or did not conduct care beyond regular curative treatment.

Noteworthy that the further away the dentists (formed or in training) have been from this issue, the more unlikely it is that the hypothesis of violence against women is considered to be the etiology of dental complaint[8,13] and, consequently, that the management of care is appropriate, for example, making the environment safe for reporting. Identifying a patient in a violent situation is not a simple task. Since there is enormous difficulty in reporting and even recognizing the abuses experienced[17] besides violence is not determined by a single episode. They are painful experiences that gradually progress from blackmail and offenses to the destruction of objects and aggressions. That is, repeated attempts to leave and return[3,9,24] from the relationship contribute to embarrassment, remorse, guilt and self-responsibility of their condition, so patients commonly prefer to omit some informations[7].

However, creating a reliable environment to identify the etiology of oral health problems and propose global treatment alternatives depends on how professionals structure their care practices and how they attribute meaning to violence[12,13]. The observation of the set of signs related to the physical and emotional well-being of the patient complements the suspicions and alerts the dentist to initiate rigorous documentation of facts, clinical findings and record of clinical examinations and tests. The woman's uniqueness is often invisible because, during the anamnesis, the social conflicts implied in the main complaint are disregarded by the dentist[18]. Similarly, the performance of practices based on common sense (issuing hunches, value judgments and/or warnings, etc.) is an embarrassing and offensive resource[25] that disperses the dialogue on the etiology investigation. In addition, this approach is part of what has been described as “moral deficiencies of the profession”[15] - to which all and all of us are subject.

Acquiring skills to build a relationship of trust with the patient and covering care in various instances contribute to a better understanding of social obligations and professional responsibilities[1,8-10,26]. In addition, some authors[3,7-9,21] discussed the presence of barriers in the perspectives of patients, professionals and institutions and listed criteria and processes for minimizing obstacles. Therefore, priority actions were directed to dentists to perceive themselves as a collaborator of the violence coping network,

that can be achieved by normalizing and standardizing the questioning of the previous dental history elaborated to promote specific assistance: humanized recognition of injury patterns, particularization of clinical conduct and referral to services and reception programs.

Protocols were established[9,13,18] with: 1) objective questions that contemplate information related to aggression; 2) professional conduct that validates any type of violence as an illegitimate practice (reiterating that it is a condemnable, improper act and a health issue to be combated – these actions strengthen the trust between patient and dentist); 3) careful completion of the documentation with descriptions and notes in the patient's own words, highlighting dates, type of aggression, type of objects to assault, time elapsed until dental care and others[7] – these records are essential to reduce underreporting and can serve as expert evidence[8]; 4) guidance on support networks and local and regional reference centers, informing addresses and telephones, because it is not acceptable to simply indicate another service[25].

The processes implemented suggest that clinicians, specialists, teachers and teaching managers in Dentistry promote a broad and constant debate on this subject[3,13,27], deepening it on issues of gender, sexuality, global health and sociocultural plurality. In addition to defined and up-to-date information on locations, services and support networks. These fundamentals will support dentists to perform examinations and treatments that transcend the oral physical evidence of its patient, in order to consolidate inclusive and integral health criteria[9,14,17,18]. Otherwise, mechanical care, without bonding, affection and respect, does not give visibility to the political and social issues that revolve around oral health and ends up reproducing dental practices detached from the Brazilian reality and the primordiality of the profession[12]. Therefore, building bridges to face and combat violence against women, using all the resources developed and under development, is part of the challenge of higher education in Dentistry.

Politics in Dentistry teaching for the development of integrality in care

The renewal of Higher Education in Dentistry, provided for in the regulations and recommendations of the National Curriculum Guidelines of the Undergraduate Course in Dentistry[16,28] establishes ethical and social commitment of the profession beyond the technical activities inherent in Dentistry and also in the expectations of society about oral health care, in accordance with the precepts of the integrality of the Unified Health System (SUS)[12,27,28]. Thus, when the actors, in all spheres of education, recognize their professional responsibilities and integrate them into social obligations, positive transformations expand and the processes of improving the profession is evidenced.

In this context, dentists, graduated and/or in training, becomes part of the support network to face violence against women[13,29] when the design of the teaching plan for the teaching-service-community integration is collectively built with affirmative interference in the academic and scientific community to initiate and promote consistent changes[16,30]. Achieving such changes, essential attitudes must permeate the expertise of the dentists continuously[13,15,25], for example, expansion of knowledge, respect for the patient's autonomy (regardless of race, religion or level of education), alterity and constant multidisciplinary discussion on social topics[16,26,27].

At the institutional level (universities and education centers), explicit violence repudiation is a fundamental and indispensable requirement, followed by the establishment of horizontal

gender relations and stimulation of internal politics of qualification, dialogue and support for debate, evaluation and dissemination of active practices of violence against women, internally and externally [27,28,31]. In the teaching sphere, qualified and suitable attitudes are expected to mediate and assist the deepening of the individual reflection of students and their peers, working directly beliefs, thoughts and feelings and, indirectly, dissolving attitudes based solely on personal experience[12,26,28]. It is also the role of the teacher, in any specialty or title that they carry, to know and understand the expectations and adversities that the insertion of the theme in the curriculum brings, to be vigilant about their own behaviors [10,12,15] and to pedagogically manage the activities, exposing themself to contexts that help them in the construction of critical thinking own citizen and students.

In addition, the institutionalization of university extension in the teaching of Dentistry, for example, enables multidisciplinary interventions in which several areas point out different perspectives, promote reflection, integrate and propose alternatives[3,31]. University extension is based on the interdisciplinary, educational, scientific and political process that promotes and expands the democratic values of equity to people through access to oral health in its human, ethical, economic, cultural and social dimensions[30]. Likewise, extensive activities can bring the conditions of inequality of patients in situations of violence closer to the causes of the oral health problems found, contributing to the ability to question these inequalities and work associated with other sectors to reduce the so-called "invisible epidemic"[3].

The attitudes acquired during graduation go through contexts that transform the individual[13,15,16,26], so direct student-patient contact, reflection on the personal experience of the student and the teacher, observation, group interaction, analysis of local and regional cultural influence and media persuasion are important criteria of skills and abilities to be developed [15]. Both in traditional academic activities and in extension, research and, mainly, in the evaluation of processes. These performances can vigorously guide the expectations, obstacles, adversities and intrinsic setbacks of the conjunction between oral health and social demand. The sensitization and understanding of the irrefutable certainty that the patient should not go through this situation, minimally ensures that dentists is already part of the network to fight violence.

Consequently, all and all, individually and collectively, we can appropriate our authority as health professionals to discuss, listen to and position ourselves against the types of violence, especially those practiced against women. Essentially because education for citizenship – the one that produces cultural changes – is created in the construction of political subjects and democratic sustainability[31], in which dentists understand the magnitude of their profession and provide their services articulated with social reality.

3 CONCLUSION

Evidence of conduct on dentists' adequate care for patients in violent situations was reviewed. The authors converge and affirm that dialogue and welcoming are essential competencies to build a relationship of trust between professional and patient. Good practices for investigating the main complaint and previous history are fundamental strategies to offer the opportunity to report on the violence suffered and to have information about the places, services, and support networks is part of the comprehensive management of dental care.

Although some studies indicate little aptitude among dentists to identify their role as collaborators in coping with violence against

women, professional responsibilities and social obligations belong to the set of guidelines and recommendations of the National Curriculum Guidelines of the Undergraduate Course in Dentistry. Multi-professional political-scientific discussions about the integrality of care, its gaps and successful implementations have been pointed out as a source of maturity of public health precepts over the years.

Inter-institutional interventions, as well as the pedagogical coordination of activities that include proposals for the management of care and improvement of the professional-patient relationship can guide a teaching plan that incorporates the meanings of comprehensive care and the continuous reflection of the inseparability between the dental complaint and the social context. Thus, the formation of agents concerned with minimizing the sequelae of this invisible epidemic is boosted.

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RESUMO

Integralidade do atendimento odontológico à mulher em situação de violência: revisão narrativa da conduta profissional

O desempenho de atributos profissionais de integralidade do atendimento de mulheres em situação de violência depende de como os cirurgiões-dentistas (CDs) estruturam suas práticas de cuidado e como compreendem a violência. Por isso, o objetivo desta revisão foi acumular evidências da responsabilidade profissional e obrigações sociais do CD e sua imprescindibilidade no enfrentamento da violência contra a mulher. Foram selecionados artigos nas bases de dados PubMed, SciELO e LILACS, a partir de Descritores em Ciências da Saúde, para fundamentar e aprofundar as perspectivas sobre a integralidade do atendimento odontológico, considerando os conflitos sociais subentendidos na queixa principal. Constatou-se que a violência contra a mulher é resultante de processos históricos-sociais de desigualdade entre os gêneros; a agressão física sobressai-se entre as principais queixas e mulheres agredidas por seu parceiro têm alta prevalência de sofrer injúrias na cabeça e na face. As sequelas da violência vão além dos vestígios físicos e difundem-se a inúmeros problemas orais. Verificou-se pouca aptidão dos cirurgiões-dentistas para identificar, conduzir e propor alternativas de tratamento global à paciente, mesmo com protocolos para naturalização da investigação por meio da anamnese. A ampliação do conhecimento e discussão das políticas de ensino são oportunidades para consolidar a humanização e a integralidade de saúde, evitando exames e tratamentos mecânicos, sem afeto ou respeito. Essa estratégia faz parte da construção coletiva para o estabelecimento e manutenção do compromisso ético e social do Ensino em Odontologia, em que o CD compreende a magnitude de sua profissão e presta seus serviços articulado com a realidade social.

Descritores: Violência Contra a Mulher. Integralidade em Saúde. Relações Dentista-Paciente. Educação em Odontologia.

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