Provision of dental services in public dental schools and integration with the health care network

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Received January 30, 2017. Accept June 03, 2017.

ABSTRACT

The purpose of this study was to analyze the services provided by federal public dental schools (DS) in southern Brazil, particularly the organization and the integration with the Health Care Network (HCN). This is an exploratory, descriptive and analytical study with a qualitative approach using observation techniques, documentary analysis, and semi-structured interviews, carried out from June to October 2014. The full integration of the dental services with the HCN is still a challenge to be overcome, which has compromised the effectiveness of the national health system principles and has consequences on professional training in dentistry. It is necessary to consolidate the relationship of the DS with the public health system so that dental services provided by DS can, effectively, be part of the HCN.

Descriptors: Dental Clinics. Students, Dental. Dental Staff. University. Delivery of Health Care.

1 INTRODUCTION

The dental professional's insertion in the public health sector has resulted in concerns regarding the profile of dentists on the new professional practice settings[1]. It has been discussed new ways of working knowledge within a critical and reflective perspective, focused on comprehensiveness, following education and health public policies[2]. The Brazilian National Curriculum Guidelines (NCG)[3] has oriented health education in accordance with the population's needs. It is proposed to DS the challenge of training dentists adjusted accordingly with the current health care system[4]. The need for modifications in undergraduate courses faces some obstacles. Thus, new ways are being sought to respond to this challenge, including the implementation of

new educational projects in courses and curriculum changes[5].

The gap between the academic world and the current delivery of health services has been pointed as one of the reasons for the health sector crisis[6]. This context reveals the need for adaptation to the professional training and real life, between theory and practice[7,8].

The public DS are providers of dental services for the population and are part of the Brazilian National Health System (NHS). The clinical practice that happens in their environments must be in accordance with a new pedagogical model that prioritizes both the technical quality and the social relevance, contemplating aspects such as healthcare subjectivity, production of technical and thinking skills, as well as the adequate knowledge of the NHS[9].

In order to expand the oral health services supply and access to the population, to qualify services, to promote cooperation between NHS managers and DS, it was established a partnership between the Ministries of Health and Education, known as the GraduaCEO - a National Oral Health Policy component[10]. Thus, DS become services into the Health Care Network (HCN), which is described as organizational arrangements of actions and health services, of different technological densities, that seeks to guarantee the comprehensiveness of care through integrated systems (technical, logistical support and management)[11].

Thus, the services provided by DS, in the context of NHS guidelines and principles, and curricular changes and their relationship with HCN are the focus of this article. The argument is based on the detrimental consequences of the health system and the population health due to inadequate health education over time. Among the characteristics that contributed to the inadequate training of health professionals, there is the fragmentation and decontextualization of contents and centralization of the specialist teacher in the learning process[12]. The adoption by the DS of theoretical references based on the expanded concept of health, on a comprehensive health care model, patient-centered - both in terms of teaching and the provision of dental services for the population - is a challenge that must be overcome[9,10].

In this context, the aim of the study was to analyze the integration of dental services with the health care network, in three southern Brazil Dental schools.

2 METHODS

This is an exploratory, descriptive and analytical study with a qualitative approach. The methodological strategies for data collection included observation, documentary analysis, and semi-structured interviews.

The study was conducted in three public DS in southern Brazil, from June to October 2014. DS were intentionally selected by proximity criteria of the researchers' place of origin. The study population was also selected intentionally and prioritizing individuals with greater engagement with the object of investigation, using the snowball technique.

Initially, educational and health system municipal managers were interviewed. They indicated teachers, technical-administrative servants and students to participate. Therefore, the sample consisted of municipal oral health managers of the municipalities where the DS are located. To limit the number of interviewees, the theoretical saturation of the data criteria was used.

Twenty-four interviews were carried out, eight of which were conducted at DS 1, nine at DS 2 and seven at DS 3. In relation to the

interviewee's characteristics, seven interviews were conducted with teachers, nine with students, three with servers responsible for the admission of patient's sector, two with DS academic managers and three with oral health managers (public service managers).

The interviews were recorded on an audio recorder and took between fifteen minutes and one and a half hours. The interviews with students were the shortest and with the other participants were longer. After the transcription verbatim, the interviews did not return to the participants for comments or corrections.

As far as the documentary analysis, it was taken into account the political-pedagogical projects of the courses, programs of the clinical disciplines or programs that provided dental assistance to the population, as well as the curricula matrix and the document that implements the teaching-assistance network. These documents were obtained on websites.

The non-participant direct observation was chosen with the purpose of allowing to follow and record the movements, speeches, and actions of the various social actors involved. A field diary was used to record the data obtained in the observations. This observation occurred within the DS, including waiting rooms, patient admission department, services that provide direct care to the population (diagnosis and stomatology support services), DS pregrad dental clinics and DS Center for Dental Specialties (CDSp).

The data obtained through interviews, documentary analysis, and observation were analyzed separately. The methodology of content analysis proposed by Laurence Bardin guided the data analysis.[13] Following the content analysis method, all transcribed material from individual interviews was read. The main parts of each sentence were highlighted so that the information could be coded. Based on the interviews coding, the subcategories and main categories were elaborated. The data obtained in the DS were analyzed concurrently, aiming don't highlight the specificities of each institution. The data obtained from the documentary analysis were used to know the history, the political-pedagogical project, the curriculum matrix, the clinical disciplines programs. The data obtained from the observation subsidized the individual interviews as well as served as support for data analysis.

The research was approved by the Human Beings Research Ethical Committee of the Federal University of Santa Catarina (#711.411). All the interviewees were invited to participate and signed the Informed Consent Form.

3 RESULTS AND DISCUSSION

The results are presented below, along with the scientific literature discussion, according to the categories analyzed (chart 1).

The population's access to dental services at public dental schools

Spontaneous demand is one of the forms of access to dental services offered by the DS. In some cases, the patient is evaluated in the admission sector by dental professionals or students and subsequently referred to dental clinics or emergency care. In other cases, the patient reports their complaints and treatment needs and this information will compose a waiting list from which they will be contacted later for care. Patients can live in any area of the city or even in other cities, so there is no geographical limitation to access.

Some DS have an agreement with NHS, and the service is free from payment, except the services that need to be performed externally,

for example, dental prosthesis laboratories. In other DS, the service is not integrated with the NHS, and the patient must pay both a consultation fee and for external services.

Chart 1. Categories e sub-categories elaborated from the data analysis process.

Categories	Sub-categories
The population's access to dental services at public DS	- Access via spontaneous demand - Access via formal referral - Access via informal referral - Mechanisms for sorting and waiting lists - Access to pathology, radiology and extension projects
Patients scheduling for dental care	- Patient call organization - Mechanisms for patient scheduling - The Center for Dental Specialties appointment - The scheduling of patients who formally did not attend the DS - Future perspectives for patient scheduling
Patients internal flow in the DS clinics	- Characteristics of DS clinics and integration between them - Referral between clinics/disciplines through the screening / reception sector - Referral between clinics/disciplines through teachers - Referrals between the clinics/disciplines through the students - Clinics / disciplines that were not integrated - Integration between pre and postgrad clinics - The dental emergency services
Dental Specialties Centers at DS	- Characteristics of Dental Specialties Centers operating in DS - Referral and counter-referral in the Dental Specialties Centers operating in DS
Integration of DS with the municipal public health network	- Historical aspects of the DS integration with the municipal oral health care network - Integration of dental clinics with the municipal network - Integration of basic health units with DS - Partnerships between DS and municipal network - Patient records - The future of integration: DS clinics with the municipal network
Interaction with other services/courses	
Effects of the organization of the dental services provided by DS in the teaching-learning process	- Curriculum changes and the municipal oral health network - The GraduaCEO initiative

Access by spontaneous demand hinders the integration of the dental clinics of the DS with the Oral Healthcare Network (OHN). This kind of access is considered inappropriate considering the GraduaCEO proposals, which is based on a regulatory system[10]. At the time

of data collection, DS enrolled in this study did not join the GraduaCEO, but this kind of access needs to be rethought.

There is a formal referral mechanism between the municipal healthcare and the DS that occurs for the CDSp operating in the DS and, exceptionally, for the so-called "low complexity" clinics. This modality of access, organized by the municipal regulatory system facilitates the integration of the dental clinics with the OHN. Thus, as recommended by the NHS guidelines, primary health care should coordinate the care and order (or guide) the network, including DS dental clinics as one of the service units of the HCN[11].

As concerns the services which have a cost to the patient, the municipality does not perform a formal referral of the patients. In such cases, the municipal dental surgeon can make a technical report and, in possession of this document, the patient can seek care at the DS by spontaneous demand, without a formal referral.

The patient will not have a guarantee of vacancy for the attendance in the DS clinics. Whether vacancies are available, the patient will be referred for care. Otherwise, he will be advised to return to the DS in the periods of selection of the patient admission sector.

This situation highlights a fact that was reported in the study of Gonçalves and Verdi[14]: patients who seek care in DS clinics may go through several situations that make the access to dental assistance more difficult, permeated by shortcuts and detours.

Waiting lists are organized by discipline, procedures or dental clinic. Sometimes patients stay for long periods of time on the waiting list, and when they have the appointment scheduled, the need for treatment has already changed, requiring a reassessment and perhaps a re-route to another clinic or discipline.

According to the Brazilian HCN[11] organization rules, the waiting list transparently regulates the use of services, establishing planning criteria to needs and risks in order to balance supply and demand. In the case of the DS, the offer is directly related to the need for academic learning. However, this supply often does not match the demand.

Access to diagnostic support services (pathology and radiology) and extension community projects often happens distinctly from clinics and disciplines. These services have a separate waiting list, and the care is offered directly to the population, without a greater involvement of the patient admission sector.

Patients scheduling for dental care

Waiting lists are arranged according to the order of arrival. When a vacancy is available, contact is made with the patient. However, several situations may prevent the next patient on the waiting list from being effectively served: the costs of telephone calls, the patient not answering the call, the wrong telephone number, the patient has already gone to another health service or cannot attend at the time provided by DS.

It is possible to perceive the difficulty in access in relation to convenience: the difficulty of contact between the DS and the patient, as well as the hours of care that are not convenient, especially to those who work during business hours[11].

Some studies [15-17] reported that the health services in DS clinics are used predominantly by women, possibly due to its lower insertion in the formal labor market, facilitating the scheduling of consultations.

Scheduling patients referred by the municipality services can facilitate the

integration between the DS clinics and the municipal OHN. Currently, this mechanism is working only to the clinics of "low complexity". However, with the implementation of GraduaCEO, it can expand these referrals to other clinics[10]. For more complex procedures (prostheses, implants, orthodontic appliances) there is a waiting list of the DS that operates on spontaneous demand.

When a place for attendance is available, students schedule patients who have not gone through the formal process of accessing the services. Including friends, family or people who have treatment needs that meet their learning needs.

In these cases, the available vacancy will not be filled by those who are on the waiting list and have passed the formal process of accessing DS services. In some DS this is allowed, so the teachers are responsible for the authorization and justify why a patient from outside the waiting list will be attended to. However, this justification is often not presented. This reality was also reported by Gonçalves and Verdi[14] which showed disrespect to the principle of autonomy since the access has given privilege to some people.

Since the offer of vacancies in the DS clinics is related to the students' need to perform the practical activities necessary for their training, it is important that these procedures were identified in advance and that the offer of these vacancies happened to patients who have passed by the formal access process, either by spontaneous demand or by the municipal OHN regulatory system. Waiting lists promote transparency in the process, being necessary to comply with the regulation of the use of services[11].

The lack of informatization was pointed out as a problem to be overcome. It generates a huge amount of papers and forms to be filled in, besides the possibility of these documents being lost. The informatization of the patient admission sector integrated with the dental clinics will facilitate the scheduling process, registration and storage of medical records, enabling integration into the HCN organization in the NHS.[11]

Patients internal flow in the dental school clinics

There are situations in which dental clinics integrate different disciplines, being separated only by levels of complexity of the procedures performed: low, medium and high complexity clinics. The students receive the patients in the first integrated clinic and follow-up them during the next clinics. Thus, most internal referrals do not need to happen.

Albuquerque *et al.*[18] showed that the integrated curriculum values the space of articulation between education, service, and community, allowing the students a process of critical reflection and learning about their actions and the community reality. As the student follows up the patient throughout the clinics, aspects such as comprehensiveness and longitudinally of care can be better perceived by the student.

Often the referrals between the various clinics/disciplines within the DS happen in a disorganized way. Patient follow-up throughout treatment is also reported as a problem because: if the patient is referred to another clinic, the student and the counselor teacher are not aware of the treatment performed.

In the Ferreira *et al.*[19] study, dental students showed that problems related to organizational process within the DS (as times, bureaucracy, an insufficient number of teachers, lack of computerized system, lack of patients and shortage of materials) have a

profound influence on their educational performance. It is important to overcome these problems to ensure that these issues related to the DS organization process do not have negative impacts on the training of students and the care provided to patients.

The referral between the clinics/disciplines can happen through the patient admission sector. The patient is placed on the waiting list of the discipline to which it was referred. Patients who are already being treated are always prioritized. Also, the referral can happen through teachers. In this case, the student sends the patient who is already in care in a clinic/discipline to the teacher in charge of another clinic/discipline without going through the patient admission sector, once the treatment plan and all procedures are recorded in the patient's chart.

If the patient needs to be referred from one clinic/discipline to another and the student knows a colleague who needs a patient like this, the referral between these students is carried out without going through the admission sector also. Students report that is positive when this happens because the patient does not have to wait on the waiting list of the other clinic/discipline and there is a commitment on the part of the student to attend to this patient.

The NCG for undergraduate courses in dentistry and the guidelines for the NHS organization highlight the importance of comprehensive care provided to patients[3,11]. These principles should also be considered in the provision of services that take place in the environment of the DS clinics. According to Ferreira *et al.*[19], conducting complete treatment plans is a key point of an integrated clinic, overcoming the segmentation of care offered in most of the DS clinics.

Toassi *et al.*[5] believe that the difficulty of teachers in conducting curriculum integration is a justification for weakness. This situation may be due to insufficient training or lack of knowledge of the teacher in relation to teaching-learning methodologies that are conducive to such integration.

The DS also offer emergency services to the population. These services work in conjunction with compulsory, elective and internship disciplines.

Dental Specialties Centers at dental schools

The DSC operating in the DS are the result of an agreement between the University and the State or Municipal Health Secretaries to provide dental specialized services.

The way that students act in the DSC is diverse: it can be a compulsory or optional internship for undergraduate students, in the most advanced semesters of the course, and for postgraduate students. These DSC are differentiated as they are both a service provider and a teaching location. Graduation students sometimes attend all the specialties offered by the DSC and rely on the assistance and supervision of DS teachers and hired dental professionals.

The DSC that operate in the DS are part of the NHS and receive funding from the NHS to carry out the activities. Like other DSC, it has a goal of dental procedures to be monthly performed[20].

The DSC operating in the DS receive referenced patients from the municipal health network to perform treatment in a specific specialty and, after completion, the counter-referral is made to the primary health unit, which is responsible for maintenance and follow-up. Currently, these DSC are the main form of integration between the OHN and the services provided in the DS clinics, composing the OHN as a secondary point of attention and

the forms of access, happen according to the recommended for the HCN organization[11].

Integration of dental school with the municipal public health network

The formal referrals of primary health units (PHU) are given only to the DSC. The service offered by the DSC is restricted to the specialty service, and later the patient returns to PHU. However, indications are made for some specific projects within the faculty, which are a reference in care such as tooth trauma, oral diagnosis, among others.

The DS have given important support to the municipal network in the organization of some training courses, distance modality courses, support to permanent education, especially in the area of Collective Health. The municipal network proposes to be a field of internship, receiving students in the PHU and also in other points of attention of the network. The teachers accompany the undergraduate students, supervising, together with the dental surgeons. According to Toassi *et al.*[21] this kind of discipline that allows the presence of students in local public services have the ability to make closer the University, the service, and the people.

As the DS are not yet formalized as belonging to the public oral health care network, it not possible to refer patients to other points of the network beyond primary healthcare. DS does not yet have a defined geographical area to cover, a population assigned under its responsibility, and does not participate in the regulatory system. It is still necessary to make agreements between the University and NHS managers on how to organize the insertion of the DS clinics into the OHN.

Interaction with other services/courses

Formally there are no multi-professional services within the scope of the studied DS. However, there are some reports of multi-professional activities, corroborating with the study by Ferreira *et al*.[19] showed that the lack of a multidisciplinary work in the DS. These authors emphasize the importance of diversifying the practice scenarios, including extramural activities to provide undergraduate students with the multi-professional working experience.

In the dental clinic for children and patients with special needs, it was noticed the presence of other professionals. However, the problems are solved in a more punctual way, without a formal protocol.

Effects of the organization of the dental services provided by dental school in the teaching-learning process

DS clinics are divided between the attendance to the population and the teaching of the students. There is a questioning related to the ethical issues involved with this practice of scheduling patients according to the student's need and not by order of arrival or need of the patient. Eventually, due to didactic interest, the student can schedule a patient who did not go through the formal system of access.

In the DS studied there is a strong orientation towards the, surpassing an old view that the services provided are disconnected from the SUS. In the current curriculum is planned stages of undergraduate students in the network for students to have contact and knowledge of the functioning of the public service and thus be more prepared for work in the SUS[3].

There is a favorable DS movement of to join GraduaCEO with the purpose of expanding the population's offer and access to oral health services and services by promoting the integration of DS in the public services

OHN. This initiative was released recently and it is necessary to make pacts on how this process of change will set up[10]. This goes to what was reported by Freitas, Calvo and Lacerda[21] by stating that the integration between the public system and undergraduate courses is not yet consolidated in the curricular guidelines.

The implementation of GraduaCEO involving representatives of the DS and NHS managers is a process that is underway. Issues related to physical structure, human resources, internal operation and organization, and equipment should be adjusted so that DS can join this initiative.

4 CONCLUSIONS

The integration between the DS clinics and the OHN is in a moment of transience. The population access to the services offered can happen by spontaneous demand or by reference. Waiting lists are organized on a first-come-first-served basis, with no other priority criteria being applied. Schedules of referrals from HCN are performed by the municipal regulatory system. The municipal OHN is linked to the DSC operating in the DS and, in some cases, for low complexity dental clinics.

The integration between DS clinics occurs by their own organization. The findings revealed problems related to internal flows, which need to be better established and disseminated. This reality has detrimental consequences for the patients, whose care is fragmented and often cannot finalize their treatment, impairing the comprehensiveness and longitudinally principals of oral health care.

As from the institution of the GraduaCEO at the DS environment, changes are estimated, and they could bring a better relationship between DS and OHN. The GraduaCEO might clearly define the roles of the service units, formalize the service flows, through the possibility of complementing the provision of dental public services. DS can contribute with the local level which has difficulties in the offering. Thus, the GraduaCEO can also stimulate the alignment of the dental services provided in the DS to NHC principles. In this sense, it will be important to conduct further studies on this subject after the occurrence of the adhesions to this initiative.

RESUMO

Prestação de serviços odontológicos em instituições federais públicas de ensino superior e a integração com a rede de atenção à saúde

O estudo objetivou analisar os serviços prestados pelas Instituições Federais de Ensino Superior (IFES) com curso de graduação em Odontologia no sul do Brasil, compreendendo a maneira como se organizam e a integração com a Rede de Atenção à Saúde (RAS). Trata-se de um estudo exploratório, descritivo e analítico, de abordagem qualitativa, utilizando técnicas de observação, análise documental e entrevistas semiestruturadas, realizadas no período de junho a outubro de 2014. A plena integração das clínicas odontológicas das IFES com a RAS ainda é um desafio a ser superado, o que vem comprometendo a efetivação dos princípios do Sistema Único de Saúde no atendimento odontológico dos pacientes e repercutindo na formação profissional em Odontologia. Faz-se necessário consolidar a relação das IFES com o sistema público de saúde para que as clínicas odontológicas possam, como um ponto de atenção, efetivamente fazer parte da RAS.

Descritores: Clínicas Odontológicas. Estudantes de Odontologia. Recursos Humanos

em Odontologia. Universidades. Assistência à Saúde.

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