Complementary and Integrative Practices: incorporation into Dental Education

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Received Aug. 07, 2017. Approved April 08, 2018.

ABSTRACT

The present study aims to discuss the inclusion of complementary and integrative practices (CIP) in the Flexnerian and Giesian models and their effects on higher education in dentistry. Thus, a reflexive study based on a literature review was carried out. Indexed publications were consulted in the Scientific Electronic Library Online and Virtual Health Library databases. Official documents and non-indexed journals were searched. The descriptors applied were as follows: *práticas integrativas e complementares, complementary and integrative practices, relatório flexner, flexner report, relatório gies, gies report, Odontologia de mercado, market Dentistry, modelo assistencial em saúde*. It was observed that the features and concepts embedded in the models from the Flexner and Gies reports, dated 1910 and 1926, respectively, favor technological practices and exclude traditional practices. Despite their therapeutic potential, CIP also face scientific, economic and cultural resistance to their full adoption. By this logic, the current challenges as well as the possibilities and potential of CIP in dental care are discussed.

Descriptors: Complementary Therapies. Integrative Medicine. Dentistry. Education, Higher.

1 INTRODUCTION

The integration of education and service in the healthcare sector is achieved through collaboration among university and health services in order to increase patient quality of care and to offer qualified vocational training[1].

Therefore, in the academic community, it is necessary to understand the 'model of care', a polysemic term describing the organization of healthcare services and the development of the practices that consider the values that guide society's definition of health and human rights in relation to life[2].

Notwithstanding, complementary and integrative practices (CIP) are part of the models of care. The term CIP encompasses the practices of traditional Chinese medicine, acupuncture, homeopathy, phytotherapy, thermalism/ crenotherapy and anthroposophy[3]. These practices emphasize the development of the therapeutic link, or the integration, of the human being with the environment and society in the broad perspectives of the health-disease process and the promotion of care[4], in which CIP act as a coadjuvant of conventional treatment[5]. This fact indicates the importance of the inclusion of these practices into health services and, particularly, the role of these practices in higher education institutions in the healthcare sector.

The adoption of such practices, however, faces obstacles that are not only technical and scientific but also ideological and economic. The conformation of hegemonic practices and the training of health professionals is strongly influenced by an ideology that disqualifies initiatives that move away from the model known as technological medicine[6].

Despite major advances in technological medicine, the World Health Organization (WHO) has recognized that much of the population of developing countries depends on traditional practices for their health. In fact, 80% of these populations use plants or their preparations in their basic health care[7].

Among the CIP applied to dentistry, phytotherapy, in particular the scientific principles of phytotherapy care as a component of multidisciplinary care, has been adopted from popular knowledge and incorporated into professional practice[8].

The provision of CIP generates the possibility of changes in the expensive biomedical model, which is hegemonic in healthcare delivery. Studies on this topic make it possible to disseminate information to health system managers about the potentialities of these practices and the mobilization of health teams for their implementation[9].

The advancement of CIP can be comprehended as an expression of a movement that identifies new ways of learning and practicing health, since these practices are characterized by interdisciplinarity actions and by their own languages. Such practices are in opposition to the highly technological vision of health that prevails in the market-based society, the main purpose of which is to generate profit and to fragment the treatment of the individual into specialties that do not account for the totality of the human being[10].

In this context, the visions described in the reports of Flexner and Gies, dated 1910 and 1926, respectively, characterize attention models that have influenced the conception of dental practice, favoring technical and individual views[11]. These models still influence dental education, which had been traditionally directed toward a specialized clinical practice and technical activities[12], despite changes that have occurred within the National Curriculum Guidelines (NCG) for dentistry courses[13].

By this logic, the present study aims to discuss the inclusion of CIP in the Flexnerian and Giesian models and its effects on higher education in dentistry, as well as the current challenges, possibilities, and the potential for inclusion in the health care models in Brazil.

2 METHODOLOGICAL APPROACH

This is an exploratory and reflexive study

that aims to provide greater familiarity with the problem, with the goal of making it more explicit or constructing hypotheses, having as the main objective the improvement of ideas or the discovery of intuitions[14], based on the literature. Marconi and Lakatos (2003)[15] write that the search for bibliographical and documentary information form an important data source that allows for the demonstration of contradictions or the reaffirmation of behaviors and attitudes.

For this study, the Scientific Electronic Library Online (SciELO) and Virtual Health Library (VHL) databases were consulted. The following descriptors in the health sciences were applied: *práticas integrativas e complementares, complementary and integrative practices, relatório flexner, flexner report, relatório gies, gies report, Odontologia de mercado, market Dentistry, modelo assistencial em saúde*. The authors selected scientific articles related to this topic that were published between 1986 and 2017 and written in either Portuguese or English. Official documents and non-indexed journals were also searched.

3 MODELS OF CARE

The literature related to this topic is quite scarce, as few articles exist that relate to the care models of CIP in dentistry. This report therefore sought to articulate the findings of publications that address the subject in general in order to discuss the relationship between CIP and dentistry.

In 1910, Abraham Flexner published the study *Medical Education in the United States and Canada - a report to the Carnegie Foundation for the advancement of teaching*[16], more widely known as the *Flexner Report*. This document was prepared following the evaluation of a variety of medical schools in the United States of America (USA) after it was recognized that a professional elite had been forming. Therefore, the Flexner report recommended the closure of 124 of the 155 existing schools in the country[17].

Flexner concluded that students in these 124 medical schools did not have adequate previous preparation. Additionally, there were no laboratories or relationships between research and clinical work. Teachers did not have control over the university hospitals, the curricula were not standardized, and the teaching was commercialized[17].

The Flexner report was responsible for the most important reform of medical schools in the USA, with profound implications for medical information and for the practice of medicine throughout the world[18,19]. Notwithstanding, this report has extended to other fields in the health sector, consolidating the curricular architecture that was predominant until the formation of the university network in industrialized countries[20]. In practice, the Flexner report introduced scientific and institutional criteria for the regulation of academic and professional training in health care[21].

The establishment of the dental surgeon was also directly influenced by this report. According to Pereira *et al.* (2003)[11], the historical, cultural and social roots of the dental surgeon were guided by the Flexnerian or scientific medical model, generating an individualistic, curative, technical, specialized and biological-based practice. According to the Flexner report, there is no place for complementary practices or complementary therapies, such homeopathy, phytotherapy, and acupuncture, because they are not framed within a scientific paradigm[22].

Consequently, it is a paradox that oral health professionals have continuously been groomed according to the biomedical and Flexnerian educational model, thus not maintaining an adequate profile to operate in the current health model[12]. According to Lima Júnior

(2005)[22], the consequence of this was a professional profile practice that was oriented towards curative, individualistic, fragmented and centered activities in the private clinic, without a place for the development of collective actions connected to the field of basic health care.

According to Oliveira *et al*. (2008)[23], in the development of health professionals, it has been observed that social-related disciplines are on a secondary plane due to the influence of the Flexnerian model, which focuses on the biology, techniques, individualism, mechanism and the development of disease.

In this sense, it is important to note the presence of a historical debt among dental professionals, given that dental education does not prioritize the scientific knowledge related to the social sciences. During approximately 90% of the time dedicated to their education, dental students learn to treat diseases without a health emphasis[23].

After the publication of the Flexner report, the Carnegie Foundation decided to publish a similar report for dental education by conducting a survey on dental education in the USA and Canada[24].

In 1926, William J. Gies published the study *Dental Education in the United States and Canada – a report to the Carnegie Foundation for the advancement of teaching*, widely known as the Gies report[25]. The Gies report is currently considered to be the most comprehensive and influential review of dental education in the context of any profession[24].

The effects of the recommendations of the Gies report, which were visible during the 20th century, highlighted the emphasis on biological and clinical sciences, progressive technological aggregation with early specialization, curative-surgical and rehabilitative practices as the preferential model of intervention, and an election of the private market as a privileged locus of professional practice[26].

The essence of the dentistry market, based on the logic of Gies, is in basic biological and individual clinical performance and in its organicity to the capitalist mode of production through the transformation of health care into commodities, thus imposing mercantilist and ethical deformations[27]. However, it is important to highlight that the Gies report was based on the ideological elements presented in the Flexner report. Therefore, both are characterized by the mechanism, biology, individual assistance, specialization, and technification of medical-dental activities and the exclusion of traditional practices. They are also characterized by an emphasis on medicine and curative dentistry[28].

'Flexnerian' dentistry, understood as the practice of biological universality, is focused on curing or relieving diseases or restoring lesions. This model of dentistry focuses on the individual, given man's mechanistic thinking, the appropriation of knowledge in high-capital density technology, the dominance of specialization, the selectivity of its clientele and the exclusion of alternative forms of dental practice[29].

For Albuquerque *et al*. (2008)[30], the model of health care was predominantly 'procedure-centered', based on the fact that the main means of health monitoring were through completing procedures, secondarily meeting the needs of the users. In this context, the form of health care at the time prioritized procedures, disregarding in many cases the main underlying problem. However, this type of marketing practice continues to be included in the higher education curricula in dentistry.

According to Toassi *et al*. (2012)[17], dental education in Brazil still suffers from the influence of the 'Flexnerian' model, as elements

of the Flexner report disregard the diagnostic-therapeutic pluralism promoted by the CIP[31].

According to Narvai (2006)[27], the dentistry market has never lost dominance in the Brazilian health system, and this approach not only predominates in the private sector but also exerts an influence on public services. However, by exerting a strong influence on the development of science and technology, the dentistry market does not seem to respond well to the oral health problems of the population due to its curative approach, high cost, and low population coverage[17].

The need for change in dental practice has been proposed repeatedly by several authors. According to Mendes (1986)[29], in the context of intentions to establish sanitary reform, it is necessary to alter the predominant model of dental practice, 'Flexnerian', to an integral dentistry model. Cordón (1997)[32] affirms that the dental practice should change from the model of 'Flexnerian' dentistry, with a strong 'Giesian' inclination in its academic education, to a model of dentistry that is incorporated into health care, addressing social spaces in a participatory way.

Nevertheless, according to Cordón (1997)[32], healthy life for all means universal access to health care and a better quality of life that is both equitable and fair. Thus, any proposal for health intervention must operate within the reality of each social space in order to understand the individual, the citizen and the social networks involved. In this way, those proposing new health interventions can define people's needs and problems and can identify the collective processes necessary to transform their way of life in society.

The hegemonic model of dental care was characterized, in the final report of the VII National Health Conference, as ineffective, inefficient, uncoordinated, low in coverage and high in complexity. Furthermore, it had a curative focus of the mercantilist and monopolistic nature, which affected the delivery of health care services[33,34].

The need for the review of dental education has been emphasized since the beginning of the 21st century. Article 3 of Resolution CNE/CES 3 on February 19, 2002, which instituted the NCG for undergraduate courses in dentistry in Brazil, determined the following: "The profile of the graduated/professional dental surgeon, with a generalist education, is humanistic, critical and reflexive, and such individuals operate at all levels of health care with a basis in technical and scientific rigor. The dental surgeon is qualified to conduct activities related to the oral health of the population, based on ethical principles that are legal and based on an understanding of the social, cultural and economic reality of their environment; they direct their actions towards the transformation of the status quo for the benefit of society"[13].

In this sense, the legislation substantiates a desire for change in higher education in Brazil and for dentistry in particular[28]. If, as the NCG emphasizes, the dental surgeon's education is generalist, humanistic, critical and reflexive, aiming at the transformation of the status quo, then this fact requires a profound pedagogical reflection.

According to Moysés (2003, p.87)[28], "from an epistemology focused on humanistic pedagogical activities, one can create socially relevant processes and, with subjects, can formulate the critique of hegemonic models, which are exclusively focused to meet the needs of the market". The humanization of the pedagogical practices still presupposes the creation of socially relevant educative processes, beyond the critique of the mechanistic education model and the increasingly technical nature of professional practice, which is focused on meeting market demands[35].

4 COMPLEMENTARY AND INTEGRATIVE PRACTICES

The high demand for CIP can represent advances in cultural movements, which include these practices and more in the process of treating illness. Therefore, these practices can be accessed by the individuals in the population as a right of citizenship[36].

CIP includes low-cost procedures and medicines. It brings low potential profit and requires an additional effort by the professional for establishing the diagnosis or some therapeutic procedures, which conflict with the logic of management focused on the efficiency and effectiveness of flexible accumulation. Furthermore, CIP can be associated with all levels of care, including tertiary care. Although CIP has been defined as an important axis for the promotion of health care and purports to expand of the logic of basic health care services, their inclusion still promotes resistance between managers and professionals[37].

In 1991, the WHO reiterated the important contribution of traditional medicine in the provision of care and requested the member states to intensify the cooperation between practitioners of traditional medicine and modern health care, especially regarding the use of traditional medical therapies that have been demonstrated to be effective, thus contributing to the economic feasibility of medical attention[7]. However, despite the diverse contributions that traditional medicine can offer, the hegemonic models, based on the reports by Flexner and Gies, persist in disregarding these contributions, highlighting their ineffectiveness.

However, the field of CIP constitutes a growing phenomenon in contemporary Brazil, since such resources have been appropriated and disseminated by private clinics, traditional communities, churches, social movements and non-governmental entities, in addition to public health services[31].

In the late 1970s, the WHO created the Traditional Medicine Program, which was aimed at formulating public policy in this area. In Brazil, the legitimization and institutionalization of these approaches to health care had begun in the 1980s, after the creation of the Unified Health System (SUS)[38]. The implementation of the National Policy on Integrative and Complementary Practices (PNPIC) in 2006 then allowed for some CIP to be incorporated into SUS[39].

In relation to dental care, there were public policies governing the incorporation of CIP in Brazil and the Federal Council of Dentistry (CFO), through Resolution No. 82 of September 25, 2008, recognizing and regulating the use of CIP by dental surgeons[8]. Furthermore, Resolution No. 165 of November 24, 2015, recognizes and regulates the use of CIP by dental surgeons for oral health, which is also known as anthroposophical dentistry[40]. Such initiatives emphasize the importance of using these practices in dentistry, given their positive results in the health-disease process.

In this sense, the recognition of CIP in oral health is relatively recent. According to the search criteria, some studies related to phytotherapy and dentistry[41,42] have been identified. However, according to Reis *et al.* (2014)[41], there are only a few studies related to CIP in dentistry. Furthermore, according to Evangelista *et al.* (2013)[42], there are a few reports of the use of natural substances in dentistry, which justifies the need for further studies. There is also a great need for the training of professionals in CIP to ensure the application of CIP in a safe and effective manner.

Gonçalo and Barros (2014)[43] conducted a systematic review analyzing the positive and negative evidence related to the use of CIP in oral health. Among the CIP analyzed, more positive

results were related to phytotherapy. Even so, the authors reported many obstacles to researching, analyzing and establishing the validity and reliability of the results of using CIP in dentistry.

5 FINAL CONSIDERATIONS

The partial overcoming of scientific, economic and cultural resistance has allowed for the legal acceptance and implementation of CIP in the Brazilian health system. However, a dispute persists between the models based on the ideas of Flexner and Gies, in which CIP is disqualified. Nevertheless, much work remains to be completed in the development of educational approaches for trained professionals to effectively legitimize the use of CIP.

Therefore, curriculum changes in dental education are essential to make the institutionalization of CIP more consistent, safe and effective, both in the public sector and in private health care, thus allowing the Brazilian population to benefit from CIP as an effective and low-cost alternative forms of health care.

RESUMO

Práticas Integrativas e Complementares: inserção no contexto do ensino Odontológico

O presente estudo visa discutir a inserção de Práticas Integrativas e Complementares (PIC) nos modelos flexneriano e giesiano, e seus reflexos na formação superior em Odontologia. Para tal, foi realizado um estudo reflexivo baseado em revisão de literatura. Foram consultadas publicações indexadas nas bases de dados Scientific Electronic Library Online e Biblioteca Virtual em Saúde. Documentos oficiais e periódicos não indexados foram investigados por meio de busca ativa. Os descritores aplicados foram: *práticas integrativas e complementares, complementary and integrative practices, relatório flexner, flexner report, relatório gies, gies report, Odontologia de mercado, market Dentistry, modelo assistencial em saúde.* Observou-se que as características e concepções inseridas nos modelos provenientes dos relatórios Flexner e Gies, de 1910 e 1926 respectivamente, privilegiam a prática dita tecnológica, com a exclusão das práticas tradicionais. As PIC, apesar de seu potencial terapêutico, enfrentam, ainda, resistências de ordem científica, econômica e cultural para sua plena adoção. Nessa lógica, discutem-se os atuais desafios, bem como possibilidades e potencialidades da inserção de PIC na atenção odontológica.

Descritores: Terapias Complementares. Medicina Integrativa. Odontologia. Educação Superior.

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