Reality and efforts of dental surgeons in community Dentistry

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ABSTRACT

This article concerns to the context of the Family Health Strategy of a large city in the state of Santa Catarina, Brazil, in order to discuss aspects of the reality of the oral health work process and the commitment of dental surgeons to ensure comprehensive individual and collective dental practices. It is a qualitative, exploratory-descriptive study, carried out with six dental surgeons through semi-structured interviews and adjusted thematic analysis. The results indicate a mismatch between the number of oral health teams, per registered population, absence of regulatory parameters and goals for the different dental-based clinics, and absence of structural alignment between the practices developed and the sociocultural reality of each territory. A great effort was identified by the collective of professionals in order to: a) take ownership of the Family Health Strategy (FHS) philosophy on a daily basis and/or expand it; b) recognize that is necessary to be willing to learn the public dimension of oral health in the act of doing it, because graduation is not always enough to ensure the appropriation of individual and collective oral health clinics; c) recognize the importance of becoming a creative and organic intellectual, who takes on a social rule; and d) overcome the effects generated in the practices due to the lack of political representation of the Family Health Strategy oral health. The guarantee of comprehensive dental practices is considered to be on the horizon, waiting for conditions of possibilities to make real what is still in the plan of autonomous efforts, of the institutional framework and of good intentions.

Descriptors: Community Dentistry. Family Health Strategy. Primary Health Care.

The main task [...] is not to judge, but to understand [...].
The difficult thing is to understand.
Eric Hobsbawm

1 INTRODUCTION

The project in defense of a national health system for Brazil, running since the mid-1970s and enshrined in 1988 as the Unified Health System (SUS, Sistema Único de Saúde, in Portuguese), aims to transform historical social inequalities in health care and illness into equal rights[1]. To make it viable, the project foresaw, still in the 70s, a movement of teaching assistance integration aiming at the modification of teaching practices[2].

At the beginning of this millennium, the National Curriculum Guidelines, created by the National Education Council to promote training for Unified Health System in undergraduate courses in health areas[3], were linked to this project. Since then, Brazilian universities have been invested in new pedagogical matrixes. Among the measures that were taken, we can mention the inclusion of the Collective Health discipline in pedagogical projects[4], the creation of Bachelor courses in Collective Health[5,6], and the expansion of supervised internships in Primary Health Care services, in response to the struggle for the transformation of teaching practices, which were initiated in the teaching assistance integration movement, in the 70s[2].

However, the historical process has revealed that health education in Brazil remains mostly unsustainable for the Unified Health System because a broad and organic political-pedagogical movement for this purpose has not yet started[7]. Since the 1990s, the struggle for the teaching of Collective Health in undergraduate health courses has faced the expansion of the neoliberal project[8]. A fundamental reason is the fact that Brazilian universities have not yet surpassed specialist training[7], which dialogues with the liberal-privatist logic.

In the scope of services, in turn, the professionals working in the Family Health Strategy of Primary Health Care of the Unified Health System deal with the absence of continuing training on theoretical and practical models that are created by the federal government to replace models that were subjects of their graduatios. Changes usually arrive at the tip (in services), to be carried out according to decrees, ordinances, resolutions, provisional measures and laws, without the simultaneous training of workers[9]. This reality is historically contradictory, just as it is the process of building public policies aimed at comprehensive dental care in public health services.

From the proclamation of the Republic until 2004, Brazilian governments, regardless of political orientation, invested in sectorial public dentistry with priority for dental extractions for adults and prevention and treatment for school-age children[9,10]. The roots of the initiative are in the avant-garde thinking style of the time, since taking care of children's teeth we will have adults with teeth. On the other hand, for adults whose teeth have advanced in the natural history of caries or periodontal disease, there is tooth extraction.

Still during the Empire, in 1880, dental offices began to be installed in "Santas Casas de Misericódia", for the purpose of executing tooth extractions[10]. With the proclamation of the Republic, in 1889, through an initiative decreed by the State of São Paulo[11], Brazil began to disseminate the theoretical model of school hygiene, of American origin[12], which anchored the implantation and expansion of the School Dental Service[12,13]. From the university reform of 1968, Brazilian universities started to adopt the biomedical model as an anchor of the teaching-learning process in health[14]. However, this model fails to transform social inequalities in health into equal rights[9], since by sharing the totality to study the parts, the model promotes a distancing of academics from the social

determinants of the health and disease process. People and/or families get sick (are affected by caries and periodontal diseases) depending on the way they live, and the way of life of people and/or families is determined by the macroeconomic policy of the particular historic moment in their lives[3].

Facing social exclusion projects[9,10,15], the Smiling Brazil Program was established in 2003, with the purpose of guaranteeing comprehensive community dental care in the Family Health Program[16], edited the following year as the National Oral Health Policy [17]. Before the achievement of this policy, what we had achieved in terms of public health in Dentistry were financial incentives to boost the reorganization of dental practices in the Family Health Program, which were made possible by two ordinances: Ordinance no. 1.444, of December 28, 2000[18], and Ordinance no. 673/GM, of June 3, 2003[19].

With the National Oral Health Policy[17], dental practices began to bring, at the same time, collective actions for health promotion, maintenance and education; collective diagnostic actions and specific protection against oral diseases; individual actions for diagnosis and treatment of oral diseases (basic clinic); disease prevention and rehabilitation in accordance with health surveillance and planning guided by epidemiology and information from the territory. Health surveillance is one of the prerequisites for reorienting the care model, whose performance focuses on the assessment and monitoring of damage, risks, and determinants of the health-disease process. Likewise, the use of epidemiology and information about the territory are presuppositions for this reorientation, in order to enable "actions preceded by a diagnosis of the population's health-disease conditions through the family approach and the relationships that are established in the territory where the health practice is developed".

In 2006, Brazilian society won the National Primary Care Policy, which gave to the Family Health Strategy the function of reorganizing actions at the level of primary care. Its implementation requires a multidisciplinary team composed of at least a doctor (family and community doctor, preferably), a nurse (family health specialist, preferably), nursing assistant and/or technician and community health agents. The Family Health Strategy can add a dental team consisting of a dental surgeon, preferably a family health specialist, an assistant and a technician in oral health. Each Family Health Strategy team is responsible for a maximum of 4,000 people from the territory assigned. The workday for all professionals is 40 hours, including dental professionals, if any[20]. From the 2006 National Primary Care Policy, Brazilian municipalities began to invest in the coverage of dental practices through the Family Health Strategy.

In 2008, the Department of Primary Care of the Ministry of Health prepared the Primary Care Booklet, no. 17, as a reference for the restructuring of dental services, in an integrated logic of the work process. This document describes the need for primary care dentistry *"to take a new stance towards the population [...] break with old ways of working [...] know the territory in which you work [...] understanding it as a peculiar social space, historically constructed, where people's lives take place and relationships are established between them and with the various existing institutions that exist (cultural, religious, political, economic, among others)"*[21].

The conquest of the National Prime Care Policy and the launch of Notebook no. 17 leveraged the Smiling Brazil National Policy,

which resulted in the expansion of access especially to primary care services, through the insertion of Dentistry teams in the Family Health Strategy[22-24], as well as in the expansion and qualification of specialized care, through the implantation of dental specialty centers and regional laboratories in dental prostheses, and high complexity care[17].

The guidelines of the National Smiling Brazil Policy recommended the care model, as opposed to the assistance one, to trigger programmatic integral care in primary care through two axes: care lines and living conditions. The lines of care axis segments the populations according to specific clinical and/or epidemiological characteristics to each programmatic target population: group from 0 to 5 years old, group of children and teenagers from 6 to 18 years old, group of pregnant women, adults group and elderly group. The living conditions axis foresees the approach of the population through its family universe and the social relations experienced in the territory. In both axes, the integrality of health promotion actions, disease prevention, health education, recovery (diagnosis and treatment), data and risk reduction, urgency and emergency must be ensured[17].

As for recovery actions, the National Oral Health Policy guidelines did not mention the regulating agent for the clinic's programmatic actions and urgent and emergency actions, but empirical studies show that the regulation of the primary care dental clinic is based on the notion of completed treatment, which is a legacy of the incremental model, instituted in the second half of the 20th century, and that urgent and emergence actions are regulated by the notion of pain[25].

The National Primary Care Policy/2006[20] was revised and updated in 2011[26] and also in 2017[27]. In this latest update, the Family Health Strategy was maintained as a priority strategy, but new modalities were introduced for the execution of primary care, in order to make the working day more flexible, tending, therefore, to return to assistential Dentistry.

In this article, aspects of the reality of the oral health work process and the commitment of Family Health Strategy dental surgeons are discussed, in order to guarantee comprehensive individual and collective dental practices to the respective territories of operation.

2 METHODOLOGY

This is a qualitative, exploratory-descriptive study, developed in accordance with Resolution 466/12, and approved by the Ethics Committee of the University of Vale do Itajaí, Santa Catarina, Brazil, through the Presentation Certificate for Ethical Appreciation no. 76943317.5.0000.0120, developed between May 2018 and February 2019.

The study concerns to a large-size municipality. According to the consultation carried out on the official page of the Municipal Health Department on June 19, 2018, it has 52 Family Health Strategy teams and 8 Oral Health teams, composed of a dentist, an assistant and a oral health technician.

The first methodological movement was to present the research to the city's Oral Health Coordinator and request the addresses of the 8 Basic Health Units with Family Health Strategy and Oral Health teams, as well as the names of the dental surgeons. With this information, an invitation letter was prepared for each professional. On the first day of exploration of the territories, four Basic Health Units were visited. Dental surgeons from the Family Health Strategy were invited and agreed to participate in the study. Dates and times have been scheduled.

In another moment, during a visit to the

Basic Health Unit furthest from the center of the municipality, it was known that the dental surgeon of the local Family Health Strategy no longer had a connection with the primary network. Then, we visited the last three Basic Health Units indicated by the Coordinator. The dental surgeons preferred not to schedule a date and time for collection, but they provided their cell phone numbers for future scheduling, according to their work schedules. Thereafter, data collection began.

Four interviews were carried out without complications, with three taking place in Basic Health Unit spaces, and one in another location, which was suggested by the participant.

However, two interviews had to be rescheduled, since the professionals were not present on the scheduled date and time. In the first case, it was known that the reason was a delay in coming to the Basic Health Unit due to traffic. A new appointment was made, but again there was an unforeseen event with the professional. In a third moment, the interview was scheduled via WhatsApp and carried out. In the second case, the rescheduling of the interview was necessary because the dental surgeon was on leave. The meeting was rescheduled, but the professional was not present. A third appointment was made, and finally the interview was carried out.

At the end, six professionals took part in the study. The seventh interview did not happen because the professional decided not to participate at the time of collection. He/she justified by means of a third person on the team that he/she was busy with the assistance and that other Family Health Strategy professionals could collaborate with the research.

Once data collection was completed, the material recorded in audio, which totaled 4 hours and 10 minutes, was transcribed and organized.

Data analysis was carried out through adapted thematic analysis. Adjustment of the technique was necessary, as the study did not foresee investigating the frequency of messages expressed in words, expressions and/or phrases, but the significance of arguments and ideas seized, regardless of the number of times they were manifested[28].

The analysis process was carried out through six steps[28]:

- Preliminary relationship with the material: academics made sure that the raw content was relevant to answer the overall objective and had representativeness;
- Contamination by material: is was obtained through various readings, devoid of analysis and/or interpretation;
- Selection of recording units (units with significance: words, expressions and/or phrases) and context (broader strata, in which the registration units are located);
- Coding and grouping of codes: assignment of codes to registration units, based on semantic criteria, and grouping of codes by analogy;
- Transverse exploration of the material: deviation from codification and resumption of raw material for cross-sectional reading to verify whether, perhaps, any question had been elucidated in conjunction with another answer; and
- Categorization: in an effort of abstraction, categorization was carried out.

Three categories of analysis were created: "Social and clinical guidelines for dental practices in the Family Health Strategy"; "For a community Dentistry: frontiers in the debate"; and "For a community Dentistry: aspects of the reality and efforts of dental surgeons in the

debate". In this article, we will discuss the third category.

3 RESULTS AND DISCUSSION

Based on the category "For a community Dentistry: aspects of the reality and efforts of dental surgeons in the debate", the results will be presented and discussed in dialogue with the theoretical framework, experiences, conceptions of the world and dental practices in the Family Health Strategy.

When invited to share aspects of professional experience, in order to locate elements of the work process experienced in the Family Health Strategy, dental surgeons have shown a robust commitment to take ownership of the practical philosophy and/or expand it: *[...] I had to learn how to do Family Health Strategy [...] with the Family Health Strategy you learn a little more about yourself, about your abilities [...] and [it] taught me the social reach* (E3) *About my experience is to be able to activate the pillars of the Strategy [...] we first need to listen to the community to know what they want [...] before being a dentist I'm a health agent* (E5) *[...] I fell by parachute because in the contest nothing specific is requested [...] when I left College nobody talked about oral health [...] I had to pursue a specialization in family health and I discovered that I was a strategy [...] It was everything I liked to do* (E6) *[...] I looked a lot in the contest notice to know what I had to do and in instruction manuals that some people gave me* (E2).

The testimonies reveal that, unlike to the imaginary historically constructed in Brazil, the performance in basic public dentistry is not simple, but complex because it requires the deconstruction of individualized procedural practice. They signal the recognition that it is necessary to be willing to apprehend the public dimension by doing, to apprehend it during the doing, and that graduation is not always sufficient to guarantee the appropriation of the different primary clinics and collective actions necessary to the territory. The statements also reflect dental surgeons stripped of the precepts of traditional individualized Dentistry, by demonstrating a great effort to transform the intellectual dentist into a creative and organic intellectual, who assumes for himself and for others that he has/had to relearn his craft in the act of doing it, in another logic. In an [...] *active* logic [...] with the power to discover Family Health Family in it and discover that [...] *it was everything I liked to do*, where you learn [...] *a little more from yourself*, on whose [...] *pillars* [...] is the subject of actions that is called community. A logic based on real Brazil, different from that authorized by the predominant knowledge of the undergraduate program that informs the client of the treatment that should be done, since in the Family Health Strategy the different primary clinics are not merely procedures, but social practices.

A case study, published in 2015 and developed with 24 municipalities in a health region in the interior of the state of São Paulo, analyzed the organizational and relational factors involved in the process of implanting Smiling Brazil. The interpretation of the identified factors in the study emphasizes that "it is necessary to think about changes in the assistance models [...] re-signify the ways of producing oral health care, the professional-user relationships [...]"[29].

A kind of change is presented by the statements mentioned above: a come to be in practice, become creative and organic, in the performance space. To this end, there are two fundamental historical issues to be discussed. The first one concerns the high cost suffered by different basic dentistry clinics due to the need to establish a logic of care in the Family Health

Care, in accordance with "the integrality guideline"[30].

In order to build comprehensive care for individuals, families and communities, architects and most of the executors on Smiling Brazil and teachers of Public Health have been focusing, since the creation of the Health Family Program, on collective foundations such as humanization, welcoming, bonding, accountability, teamwork, intersectoriality, interdisciplinarity, problem-solving, boosting people's autonomy and participation in social control[16,20,21,26,27]. This movement, almost exhaustive, generated by the need for humanistic paving for comprehensive dental practices, ended up marginalizing the qualification and regulation of basic clinics, probably because they made it obvious in Dentistry training, when what is perceived in E6's speech is that *I had to pursue a specialization in family health.* In others words, for the Family Health Strategy clinical dental practices to represent the construction of a primary public Dentistry that is, at the same time, of clinical and integral community excellence, it is necessary to resort to a graduate or postgraduate course.

Bibliographic research carried out on the changes that occurred in dental practices, since the conquest of national policy, revealed that the new normative scenario did not result in structural changes in the work process. The authors question the incipient understanding of the dynamics in Dentistry in Basic Care and the little progress in qualifying care, and suggest a rethink of traditional practices and an innovative way of doing oral health[31].

The second fundamental question to be discussed concerns the use of the expression "Oral Health" in the Family Health Strategy framework to designate individual, family and community practices.

From the perspective of the authors of this manuscript, historical moments condition the way in which a given practice is instituted and a given theoretical model or concept is thought out. In 2004, for example, there were conditions of possibilities for the country to generate the happy expression "Smiling Brazil" as opposed to a Brazil whithout teeth. However, when officializing the expression "Oral Health" to support the National Policy, Brazil does not seem to have made a happy choice.

Despite the considerable progress made possible by the creation of the "Collective Oral Health" field in the 1980s, as a way of overcoming Sanitary Dentistry, Simplified Dentistry, Preventive and Social Dentistry, and raising awareness of community practices, the fact is that the Collective Oral Health itself has not yet found conditions to expand the space for struggle and boost the so expansive anti-hegemonic movement to "reverse the direction of ongoing dental practices"[32].

The term Oral Health can be coherent to support the prevention and treatment of oral diseases in primary care assistance practices, guaranteed by working day of 15 hours, because in these cases the focus is on individual prevention and the specific illness demanded by users. However, the expression is not suitable adequate for anchoring the Family Health Strategy, carried out by working day of 40 hours, to answer for comprehensive technical, philosophical and political practices. The reductionism produced by the adjective Oral (Health) limits the necessary boldness to think about actions that transform reality, in the sense that the community recognizes that its right to age with teeth is a political issue, it goes beyond a specific treatment. It also limits collective social practices of health promotion, emancipatory practices of health education and social participation in the inspection of the

National Policy. In this comprehensive line, it is essential to reflect on the contradiction that is verified when the philosophical and political dimension of health is not defended, neither health and disease as distinct mutually complementary phenomena[3], within the framework of Smiling Brazil and the Family Health Strategy.

When exploring the dental practices developed in the Family Health Strategy exercise, the following reports were obtained: *[...] basically we do it like this: we divide between clinic and collective activity: school, daycare, groups, team meeting [...] about 70% of the workload to take care of the clinic [...]* (E1) *[...] all general practice I do [...] periodontics, surgery, dentistry, endodontics, pediatric dentistry, special needs, I accompany pregnant women, I do prenatal dental care [...] then you have a choice, nurseries and home visits [...] I spend more time in the "owl" [...] clinical demand is much higher than collective actions* (E2) *[...] we do home visits [...] prevention work in schools and [...] clinical care. Clinical procedures are basically restorations, provisional seals, coronary access for referral of root canal treatment, extractions not too difficult, radiographs, supragingival scrapes, and referral to injuries. [...] That's basically it* (E4).

The first observation, arising from the relationship with these data, was about the role that the adverb *"basically"* plays on the verbs to do and to be. Reflecting on the context units that expose the term, it is clear that its use was a resource to avoid a detailed report, that is, the professionals who used the adverb did so to briefly announce what they think about the question, pragmatically ending the reflection. Bringing this perception closer to the historical choice of replacing the expression Primary Health Care for Basic Attention (used in Brazil), due to one of the meanings of *primary care* translation in Brazil, to represent selective attention[33], it is observed that semantic escape is not always able to avoid what is not welcome, because the expression "Basic Attention" has not yet been able to make itself robust, to parameterize with "directed reflexivity"[1] what it proposes.

The second observation is about the generality with which the individual and collective practices carried out are expressed: *[...] I do clinic and collective activity: school, nursery, groups, team meeting [...]* (E1) *[...] all clinics [...] periodontics, surgery, dentistry, endodontics, pediatric dentistry, special needs, accompanying pregnant women [...] dental prenatal care* (E2) *[I do] home visits [...] prevention in schools [...] restorations, provisional seals, coronary access for referral of root canal treatment, extractions not too difficult, radiographs, supragingival scrapes and referral to injuries* (E5). The statements denote the absence of parameters for the different basic clinics aligned to each Family Health Strategy territory. They do not refer to a common structural program, evidently related to local peculiarities.

This critical node has one of its roots in the way in which the programming of practices by the ordering of the federal level took place: not knowing where one wants to go with the said comprehensive care in oral health, as a federative unit. The National Oral Health Policy did not present a regulatory framework for programmatic actions nor the operational baselines that would be conducting comprehensive dental practices in the Family Health Strategy[16]. The national conduct of national public policies is known. The Union formulates policies, programs and guidelines, and provides financial incentives[34]. The state of the federation formulates its policy, programs

and guidelines, based on the guidelines of the Union, and transfers some funds to the municipalities. Municipalities execute what has been formulated[34], through municipal health and social control plans, and account for most of the sector's budget. And the question to be asked, considering the principles of universality and equality, still waiting for answers.

Another commitment expressed by dental surgeons referred to engineering to take care of territories in rapid population expansion, without the inclusion of more Oral Health teams in the Family Health Strategy. Due to this expansion, some professionals have chosen to limit care to an area of the territory, leaving the remaining areas discoveries of comprehensive care, although covered by important collective activities such as childcare and prenatal dental care. It should be noted that the municipality has a wide basic network in dental care, made up of outpatient professionals with a weekly workload of 15 hours. However, timely clinical care is far from comprehensive care.

According to the Primary Care Booklet no. 17, the Municipal Health Secretariats must establish parameters for guidance, monitoring and evaluation of the team's work process and goals for guaranteeing care, both by life cycle and by living conditions, outlined after knowledge of the population's sociocultural and epidemiological reality: "based on the existing resources to face the problems, a minimum number of procedures and consultations must be followed"[21].

Some questions arise here: to program dental practices in a territory, is it necessary to use existing resources and a minimum list of procedures[20] or health needs, emerging and accumulated by an overwhelming historical debt? What does sociocultural reality mean if not socially constructed reality, in process, by men, women, children, adolescents, adults and the elderly in a given territory, according to their living conditions and established relationships? Reports show the reality: *A doctor's office for an area of 10,000 inhabitants is humanly, physically impossible* (E5) *[...] today I am more limited to my area, I started not to handle more, a lot of things [...]* (E1) *[...] my audience is about 8,000 people [...]* (E2) *we need a lot more teams, a lot more [...]* (E3).

Another aspect of the reality, presented by a dental surgeon as a correlate to the obstacles to the development of dental practices in the Family Health Strategy was: *[...] today, Dentistry does not have much political representation [...] the oral health team is not considered very important [...]* (E4). This speech can be discussed at the sector and macro level.

At the sector level, it is a fact that since the National Primary Care Policy the inclusion of Dentistry in the Family Health Strategy is conditioned to the will of mayors. The text of the document itself is very clear: the Family Health Strategy "can aggregate" oral health teams, with inclusion encouraged by federal incentives and carried out inductively. If not possible, assistential Dentistry can replace Oral Health teams.

Still at the sectoral level, the Collective Oral Health movement seems to experience a cooling in its struggle for social practices in Dentistry. A national study carried out in 2017 sought in the voices of the founding agents and precursors of Collective Oral Health the understanding about the permanence of "Alternative Dentistry" in the social field of struggle for oral health. The authors signaled that the "old types of 'Dentistry' in scientific production and practices remain in force", although Collective Oral Health values the critical dimension[32].

At the macro level, the possibility of

insertion of oral health teams in the Family Health Strategy was present at the same time that there was a strengthening of liberal-privatist Dentistry, conforming active markets in the sector, "that dispute the resources of the State and of the families"[36]. Furthermore, it is worth mentioning the expansion of dental and aesthetic specialties in Dentistry, resulting from the exaggerated appreciation of the cult of aesthetics and technological development for this purpose[37].

Obviously, the theme does not end here. However, we make a provocation: it would be reasonable to reflect on the potential of the expression "community Dentistry" in the struggle for a territorial-based Dentistry, not only technical, but also philosophical and political.

As a limit of this article, we must consider the fact that the research was carried out by a single workforce in the dental practices chain in the Health Family Strategy. New studies inserting other workers are opportune.

4 CONCLUSION

In this study, important initiatives were identified to guarantee the social practices relevant to the Family Health Strategy. However, the reality exposes the risk that dental practices may deviate from its philosophy, since the few existing Oral Health teams are assuming population contingents beyond their capacity to act, and without territorial programming that starts from an effective planning that considers where you want to go.

RESUMO

Realidade e esforços de cirurgiões-dentistas em Odontologia Comunitária

Este artigo situa-se no contexto da Estratégia Saúde da Família (ESF) de um município catarinense de grande porte. Objetiva-se discutir aspectos da realidade do processo de trabalho em saúde bucal e do empenho de cirurgiões-dentistas para garantir práticas odontológicas integrais individuais e coletivas aos respectivos territórios de atuação. Caracteriza-se como estudo qualitativo, exploratório-descritivo, realizado com seis cirurgiões-dentistas por meio de entrevista semiestruturada e análise temática ajustada. Os resultados indicam um descompasso entre o número de equipes de saúde bucal, por população adstrita, ausência de parâmetros regulatórios e de metas para as distintas clínicas de base odontológica, e ausência de alinhamento estrutural entre as práticas desenvolvidas e a realidade sociocultural de cada território. Identificou-se um esforço substantivo do coletivo de profissionais para: a) se apropriar cotidianamente da filosofia da ESF e/ou expandi-la; b) reconhecer que é preciso disposição para apreender a dimensão pública da saúde bucal no ato de fazê-la, pois a graduação nem sempre é suficiente para garantir a apropriação das clínicas de saúde bucal individual e coletiva; c) reconhecer a importância de transformar-se em um intelectual criativo e orgânico, que assume um protagonismo social; e d) superar os efeitos gerados nas práticas por ausência de representação política da saúde bucal da ESF. Considera-se que a garantia de práticas odontológicas integrais está no horizonte, à espera de condições de possibilidades para tornar real o que ainda se encontra no plano de esforços autônomos, do arcabouço institucional e de boas intenções.

Descritores: Odontologia Comunitária. Estratégia Saúde da Família. Atenção Básica.

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