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The interaction of several fields of knowledge for the articulation of collective oral health actions: the mapping of a family health team

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Abstract *This paper maps the experience of a family health team (FHT) in the creation of a knowledge and responsibility field to practice Oral Health (OH). Institutional analysis was used to establish the theoretical and methodological framework, supported by the concept analyzers, implication analysis, territorialization and de-territorialization. Cartography was used to monitor the procedures and the order of events and to facilitate understanding. The subjects were members of an FHT in a training context. Data production took place during the FHT meetings on administrative and family discussion matters. The case study presented here was one of the research analyzers. As results, the process of building the case study was identified, which revealed how the FHT took the family into care; the movements broadening the perspective of care, finding ways for disciplinary interactions in order to construct a collective OH approach, which emerged from the day-to-day tensions of the FHT work process. The conclusion reached is that this case study revealed the stresses involved in the process of deconstruction of dental assistance and the movement towards the interaction of several fields of knowledge and practices for the production of care from the perspective of OH attention.*

Key words *Oral health, Dentistry, Primary health care, Interdisciplinarity, Collective health.*

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Introduction

The organization of the work process in the Family Health Strategy (FHS), one of the possible forms of primary health care in Brazil, is based on approaches to health care that are guided by an integrative[1] and interdisciplinary[2] form of practice that has been prioritized by the Ministry of Health. These approaches are described in the guidelines of Primary Health Care[3], in the Family Health Strategy[4] (FHS) and in the Guidelines of the National Oral Health Policy[5]. Furthermore, interdisciplinarity in health practices has been the object of research in the area of Collective Health[6,7].

The FHS has the potential to replace the current dominant and unsuccessful biomedical model, broaden the understanding of the health-disease-care process, focus attention on health care in families and in the territory, prioritize prevention and health promotion activities, all of which can lead to the construction of projects for health and for living.

The Ministry of Health[8] encourages the inclusion of oral health teams in the FHT, denoting the insertion of one team into another, but provides little information on the details of this process.

This way of structuring work brings us to the question as to the context in which a work process is developed, which implies a group process[9], that generates misunderstandings, exposes differences and distances between the two teams, and requires a reconfiguration of the underlying frameworks[10].

It is understood that if the teams take it upon themselves to work in an integrative/interdisciplinary manner, they will be faced with the need to facilitate exchanges of knowledge and practices among their professionals on a day-to-day basis. In the context of integrating the family health and oral health teams, the reconfiguration of knowledge and practices will certainly trigger, among other processes, the expression of subjectivities related to the object of dentistry, the mouth, and to dental treatment; as well as demonstrations of feelings of loss (of power) by some, and of satisfaction by others, since it is effectively a strategy for the democratization of fields of knowledge; and even, an expression of feelings related to individual experiences which are sometimes traumatic.

Making it possible to initiate a dialogue on these issues may be a way to facilitate the construction of a field of collective oral health in the FHTs, strengthening the replacement of traditional dental assistance, centered on the surgical-restorative procedure[11], by a model of oral health care[5].

In the area of collective health, the discussion about the profiles of the objects of health care, from the perspective of broader clinical treatment[12], has been well ventilated. But in the area of oral health, it is still an incipient practice, although, in the field of collective oral health, there is an ongoing discussion that is polarized between assistance and care in relation to oral health.

Assistance[11], as a practice of oral health, is restricted to a surgical-restorative field. This has the merit of having achieved a high level of scientific-technological development and a recognized production of scientific knowledge in post-graduate courses in Brazil[12], and comprises a body of knowledge that is necessary to ensure the completeness of dental practices. However, its capability is more related to the recovery of oral health from injuries to the mouth, than to the control of oral diseases[13].

Oral health care[5,11] incorporates the surgical-restorative practice within the actions aimed at the causes of diseases, whether they be of a biological, social, economic or political nature. It is positioned in an extra-clinical field of study, encompassed by health practices and in other social sectors, and seeks to reach population groups through collective actions with the purpose of maintaining oral health.

To better understand the construction of the field of oral health within the FHS, a survey was carried out taking as its object the production of oral health by a family health team and as its objective the monitoring of the work process a of family health team in the production of care, understanding this process as an area for the production of knowledge, practices, subjectivations and subjectivities, a field whose nature is continual movement, which required a methodology appropriate to enabling the monitoring of the production of reality.

The cartography method is a research practice that seeks to monitor the processes, where reality is presented as a plane composed of elements that are heterogeneous and with a hetero-genetic function[14]. This method showed consistency with the object and objective of the study.

This article is an extract from this research. In this extract, the objective is to map the experience of a family health team in building a field of knowledge and responsibility for oral health

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practices based on a case study of one of the families being attended.

Methodology

The approach adopted was that of research-intervention, a methodology that is related to the paradigm of participative research[14] and is interested in the movements, in the procedures, where the intervention takes place through a dive into the experience that is the agent of subject and object, theory and practice in the same plane of production and of co-emergence. It is a device for intervention, in which one affirms the political act that all research constitutes, at all times, the link between the theoretical genesis and the social genesis of the concepts.

Cartography is the method of research-intervention that proposes a path that tracks the goals along the route, considers the reciprocal effects between researchers, research object and the act of production itself. It is composed of a movement such that at each step the results and the possibilities are reviewed with the family health team. Therefore, the path of the research was built from the information gathered, interpreted and/or understood, which then determined the subsequent activities.

The research-intervention approach is associated with the construction and/or use of analyzers, a "concept-tool" of institutional analysis. The analyzers can be events that cause disruptions, crises, catalyze flows, produce analysis, decompose, deconstruct what has been established. This type of research allows each participant to report on his/her implications and enables the understanding of the power relationships in organizations.

The field for the research intervention was a family health unit in the municipality of Ribeirão Preto (Ruby USF), consisting of a physician (MD), a nurse (EF), two nursing assistants (AE), five community health workers (ACS), one general services assistant, a team coordinator and a dentist (CD). Also part of the team were: resident medical students for family and community health (RMFC), physiotherapy (RFI), nutrition (RNU), speech therapy (RFO), occupational therapy (RFO), psychology (PS), pharmacy (RFA); students from the courses of nursing (ALE), medicine (ALM), dentistry (ALO), occupational therapy (ACT), nutrition (ALN); professors (DO) responsible for field internships. The CD and the professor of the Dentistry Course, participants in the research group, carried out the interventions in the family health team.

The team at the Ruby USF was considered a benchmark for health care in a middle-class area of the municipality. Its organizational procedures included meetings to discuss family cases, with the purpose of discussing the risk situations for illness, and administrative meetings for organizing its work.

Data production was carried out between February 2010 and February 2011, during the administrative meetings and the family case discussions. It was recorded in digital audio and noted in a field journal. Another movement of data production consisted of the meetings of the group of researchers, where data was also recorded in a field diary.

The research group consisted of four nurses trained in institutional analysis, one of whom supervised the research, in addition to the CD and the professor of the Dentistry Course. The group of researchers prepared preliminary and definitive diagnoses, identified analyzers, developed intervention plans and evaluated the actions taken in relation to the team.

Initially information on the research project was distributed to the family health units in the local district and presented at the administrative meetings. At this time the researchers explained the reasons for conducting the research, its purpose, the methodology and the possible products that could be generated in the course of the study in relation to the unit's organization of oral health care.

The opinion given by the Ruby USF, on the research project, highlighted the inclusion of the researcher on the team, as a dentist in the unit and for the interest in the area of oral health, concluding that the research should be conducted on this service.

In the process of selecting a unit for the research, we considered the implication of the CD in relation to the Ruby USF team from the moment it was set up, which allowed the sharing of the team's real utopia[15], that is, its highest and most noble goals and objectives that guided the productive-desiring-revolutionary processes, that in this unit were related to the building of a team work process based on SUS principles, FHS guidelines and, especially, with regard for interdisciplinarity and the humanization of health care.

The relations between team members were of cooperation and solidarity, but also of reflection and intensive debate, of involvement in the pro-

cesses for evaluation, planning and execution of actions, moments that revealed the existence of internal differences.

This context permitted that the researcher inserted into the unit contributed to the construction of health practices directed to the population's health care as a whole, and not exclusively to dental assistance, while at the same time participating with the team in building the oral health actions. This insertion revealed an offering of the team's CD professional as a researcher-institutional analyst, as a "health militant[15]", having as the formal agreement a pact with the team participating in the research-intervention to be experienced.

As is the case of any group of people that gather together regularly, the team at the Ruby USF developed a group process[9], resulting in the group formulating rules that would allow their functioning, such as participation in all the meetings, discussion of team problems only in the meetings, affectionate concern of participants in relation to the welfare of each other and the belief that the Ruby USF team is "the team that is a success." Also rules were established for communication among participants, such as the prohibition of the use of people's names when discussing family cases, identifying them only by a family number.

These processes led to feelings of gains and satisfaction in the team members, due to the users' recognition of the work performed, the credibility of the health model being practiced and, sometimes, a sense of loss and frustration, because of the mistakes made by its members, the feeling of impotence when faced by complex social situations, situations for which they lacked tools, principally, when dealing with inter-sectoral needs, for example, that made resolution impracticable.

This process was based on participatory discussions and the collective construction of therapeutic projects, and led to the construction of a work process, which sought to break away from disciplinary isolation and build interdisciplinary knowledge and practices, however, most of the time, what happened was the overlapping of the knowledge from the various disciplines.

As a result, difficulties arose in the team's process of construction of a field of knowledge in oral health, to the point where it was not included in the health care practices carried out by its members.

The starting point of the research was marked by the Ruby USF team's process for drafting a provisional diagnosis, identifying analyzers and preparing a preliminary plan. Thus, some analyzers were proposed during the development of the investigation and this triggered processes of deterritorialization, reterritorialization and implication. At this stage the proposed intervention and a contract for the intervention were also discussed with team members.

For Deleuze and Guattari[10], cartography is building a map which aims to experiment but is anchored in reality, thus contributing to connecting fields of knowledge and practices. The fields and the various connections form plateaus, which can be defined as a continuous region of intensities, vibrating around itself, and that develops, without any kind of guidance in terms of an ending point or a purpose.

The knowledge related to a CD's practices composes a plateau that is connected to other plateaus, composed of knowledge from other disciplines such as microbiology, biochemistry, materials engineering, epidemiology, statistics and sociology. The clinical dental specializations will intensify some of the connections on the same plateau. The collective oral health specialization, which has specific characteristics in the public health service, SUS, the social sciences, epidemiology, breaks with purely clinical activity, composing another plateau, connected with the plateaus established by each of the area's specific characteristics, by the other disciplines and, crucially, by dentistry.

The objective of schizo-analysis is scraping away, a deconstruction of the unconscious, of beliefs and representations, allowing subjects to undergo processes of deterritorialization and reterritorialization. Institutional analysis, within the perspective of schizo-analysis, consists of perceiving that, behind the hierarchy individual/group/society and its various sociological forms, fluid and unstable constellations move endlessly under active and inert forces that organize and disorganize under the influence of crises, desires and commitments. They possess the characteristic of being temporary, which suggests qualities of social fluidity and dynamism[16].

René Lourau, an institutional analyst, stated that implication is the crux of socio-analytic work and does not consist only of analyzing others, but also of analyzing yourself at all times, including at the time of the intervention itself, individually and collectively, which is an activity that is intense and often painful. The implications may be of a libidinal order, which are present in groups and in every life situation, and concern feelings of affection whether homosexu-

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al or heterosexual. They may occur in the form of games of seduction, seeking to exercise a certain dominance of power and can be ideological and political, which, during the investigation, may provoke conflict situations[17,18].

The action of researching was shaped like a spiral, where one executed a planned intervention and then carried out evaluations, which were moments to pause in order to identify the results and to reconsider the implication that had been produced, and then a new intervention action was prepared, in relation to the group of researchers. The intervention was carried out with the Ruby USF team, thus initiating another cycle.

In the course of the study analyzers were identified, which emerged from the initial meetings and stayed on the agenda during the course of data production, including the Thrush case. This case referred to one of the families being attended and that, due to its complexity, generated processes of deterritorialization and reterritorialization within the team, thus revealing the team's mode of operation and work process.

In the course of this investigation, it was possible to give summaries of the data from the administrative staff meetings to the team, present the products generated by the team itself in this process and perform interventions that were aimed at motivating everyone involved to build a field of competence and responsibility for collective oral health.

The research project was approved by the Committee for Ethics in Research of the Sumarezinho Center for School Health and met all the requirements of Resolution CNS 196/96[19], since it ensured full protection of the subjects of the research and the anonymity of the participants, by using fictitious names for the members of the family being studied and an acronym that identified the participants professional category or condition of being a student that had already been indicated when the team was presented.

Building the case study

The case study referred to a family that was in a complex situation in relation to health problems, and its own functioning, and having a significant need for oral health.

Although the team had discussed this case in previous meetings, most of the time it had been presented by the ACS responsible for the local district, and the group had not yet developed a capability to reflect upon the case of Thrush's family.

The entry of this family into the study had two dimensions. The first dimension was the discussion of the case by the Ruby USF team, where it began to understand the family's problems and the objective of the community health worker in trying to convince the team to make an approach to the family based on a disciplinary and sectoral interaction that would provide care for health and for living.

At the meeting to discuss family cases, the ACS expressed his concern for one of the families in his district. The family was composed of three people, the father, Mr. Bullfinch, his eighteen-year-old daughter Swallow, who had a mental disability, and his seventeen-year-old son Thrush, who was behind in his learning, had the behavior of a twelve-year-old, but had not yet been diagnosed. (Report on the Family Case Discussion Meeting, 04/02/2011)

The other dimension of the introduction of this family into the study was Thrush's arrival at the UDBS emergency dental service the day before the meeting to discuss family cases and which event was reported to the team.

*Thrush came to the dental emergency service the day before for treatment to one of his front teeth, which was fractured but did not cause him any pain. He came alone, had no identification and claimed to be 12-years-old. Thrush had a central incisor with one third of the crown fractured and blackened and which would probably require an X-ray, anesthesia and an endodontic intervention, which required the presence of a person responsible for him in order to accompany his treatment. Thrush was asked to return with his parent or guardian to receive treatment. It was noted that he lived in the area served by the Ruby USF family health uni*t. (Report on the Family Case Discussion Meeting, 04/02/2011)

Thrush's appearance for urgent treatment made the CD the person responsible for dental treatment, which involves invasive procedures, and at the same time, required the presence of a person responsible for Thrush. On the other hand, there was a indication of possible health and living problems that required an expanded view in order to understand the subject Thrush within the wider context of his family and the world. Because of this, the Buriti CD presented the case to the Ruby USF team for discussion.

These circumstances did not mobilize the team immediately in the sense of making his case the object of their work process. It only gave suggestions for scheduling a time for Thrush's treatment and for referral to one of the specialized institutions that attended people with special needs,

thus counting on these possibilities to solve the problems.

A psychologist undertook to verify the situation of Mr. Bullfinch's children with CADE, an organization that specializes in the treatment of people with special needs.

[...] *carried out a cognitive psychological evaluation of Thrush and he was found to suffer from a greater degree of mental retardation than they had imagined. Since he was mentally retarded, they could make a report through CADE and present this report to PANAN so he could be enrolled in a course for administrative assistants that is specifically aimed at people who are mentally retarded. So the boy is now attending the PANAN course, four times a week in the morning, and is enjoying it a lot.* [...] *it was stopped and they said they were able to make this evaluation and, based on it, they could also get CADE to receive the boy...*[...] *will take care of the whole family*. [...] *it is what the family really needs*. (Report on the Family Case Discussion Meeting, 29/04/2011, psychologist)

At this time the team's understanding of Thrush's health-disease process could have been linked to viewing him as a work object, whose profile was restricted to biomedical issues, and which resulted in a tendency to act according to a pathology framework, leading to institutional and medicinal actions.

From this biomedical perspective, the CD, when confronted with Thrush's complaint of a fractured tooth, could take action with the central objective being the recovery of the tooth, restoring it, depending only on the subjectivities present at that time: the professional commitment to rehabilitate teeth; the pleasure of exercising craftsmanship offered by restoration; the feeling of fulfilling a duty; stimulation by the challenge that the case presented; a very interesting case for students; the feeling of brotherhood or charity; the idealization of a beautiful smile.

But the objectification of the work process for Thrush as a subject seemed to have expanded, given the conditions in which he presented himself at the time: confused, struggling to relate, without identification, alone, weak and helpless. These conditions triggered other issues in the CD, such as family, family organization, family protection, autonomy, possibilities of mental disorders.

The expanding perspective for the care of thrush

The distinction between practices for assistance and for care in relation to oral health can be understood from the health work process[20], thinking of it as a transformation process, where it is possible to identify the constituent elements of the production of health care: the object to be transformed, the instruments and means of production and the workforce or professionals.

According to the standard for the work process, the object does not present itself in a natural way, but is altered by the eye of the agent of action - health professionals, who imprint the object with the qualities of the product they intend to generate. This quality is actively evidenced by the agent that foresees in the work object the result desired by the transformation project. It should be emphasized that this view is guided by a certain purpose, which generates the entire transformation process. This quality, inherent in the object and directly linked to the desire to turn it into something, is the intention behind the work process, that is, the pre-existing project to achieve the desired product that is, already, in the mind of the worker. This relates to the direction and the perspective in which the transformation of the object into a product will be performed.

Thus, the object of the work process, under dental assistance logic, is located in the oral cavity which is seen as the CD's morphological area of operation, and to which he directs his practices. The object, the matter which is to be transformed, in dental assistance, refers to the biological needs, that is, the tooth, the gums, the mucus or, in synthesis, the soft and hard tissues of the oral cavity and its physiology.

The instruments and methods used in this work process relate to everything that the worker uses to transform the object. They consist of appliances, instruments, consumable materials, equipment and specific fields of knowledge for the operation of these devices.

From the perspective of oral health care, one additionally recognizes the elements of the production process of health care. In this field, oral health practices transcend the limits of the mouth and are constituted by a set of actions that include individual dental assistance and extend their theoretical and practical fields depending on the social determinants of the health-illness-care process. These elements link the disease to the conditions of living, work, income, housing, sanitation and recreation. This situation de-

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mands an approach to care that transcends the scope of dentistry and also that of health, requiring actions that involve other sectors of society. One must articulate, also, with other disciplines in the health field, to identify risk situations that are common to oral and systemic diseases, seeking to interact with them to develop interdisciplinary health actions[5,11,21].

From this perspective, the bodies of knowledge and practices of collective oral health are present in the production of health care by the oral health team workers, by the family health team, by professionals from other areas of health and other sectors of society[5]. Therefore, the practice of dental health care will occur when the health worker recognizes the object of his work as the subject, minimum homogeneous entity, autonomous, psychic, the subject that speaks and is spoken about[15]. It also considers the subject, singular, unique and irreplaceable in society, where the relations subject-professional and subject-patient relationship occur according to a horizon of possibilities, moving from individuality-I, noun, to individuality-myself, verb, reflexive and constructed in an act, that is, the selfhood[22] of the subject, historically constituted and the protagonist in his own health care.

This leads us to understanding the need to expand the instruments or means of work, incorporating soft and soft-hard technologies and creating devices to express new meanings about what one does, how one does it, for whom one does it, in the sense of making it possible that the building of inter-subjectivity, between the subjects involved in the care aspect of health services, will contemplate an intention that is centered on support for projects of living[22].

Later on, when the team was more attuned to the complexity of the family's case and already acting in the context of health care and from an expanded clinical perspective, it was possible to understand Thrush's process of health-illness as related to his family's circumstances, the difficulties for his coming to appointments and the relation between the "broken smile" and the affectivity of a teenager. This process enabled the team to develop a common therapeutic project, improving Thrush's level of engagement with the dental treatment, the therapy and the stimulus to develop his sense of citizenship and to take oral health prevention actions.

[...]*my last contact was yesterday, and I could see changes, so, in him, there are times when he regresses considerably,* [...] *so it's a world of things that are happening in his life and he is experimenting more, you know*. (Report on the Family Case Discussion Meeting, 29/04/2011)

[...] *he participated in a workshop with us, a farewell, it was downstairs and he participated well, in terms of his socializing,* [...] *I found him very polite, now that I thought so, we played a game, dancing, because of the atmosphere, we put on some music and I asked a lady to dance, at the time I called out let's go, at the same time he joined in, he came, he danced really,* [...] *I found it cute, his socializing*. (Administrative Meeting 30/04/2010, ACS)

One can perceive the affection and tenderness in the care given to Thrush and new elements were revealed to the team in the sense of the discoveries that he is having at this moment in his life and that the student knew how to capture this by way of an experiment in living life This production of knowledge about Thrush, very distinct from the beginning, was possible due to the interaction between the subjects of professional and user.

In this sense dentistry and occupational therapy began to integrate their health actions, producing interactions of interests and fields of knowledge that enabled Thrush's dental treatment and improved his oral hygiene.

[...] *we have provided dental treatment to the boy and we are concerned that his central incisor has not formed the root, it is evolving into an endodontic problem and I wanted to inform the team about the fact that this boy has made visits to the O.T. and the O.T. room is next to the dental treatment room, and so it is interesting since the T.O. makes appointments, he has gone there because he has engaged with it and now he is doing his dental treatment. So it was possible to apply a dressing to his tooth on two occasions thus helping to facilitate root formation, the dressing has to be changed every 15 days ... And then at the last visit, the O.T. student commented to me that she visited his house and, since she works with developing manual skills, she taught and supervised him to do oral hygiene and she is using this to develop his manual skills* [. ..]. (Discussion of Family Cases, 01/07/2010, CD.)

Such perspective, on the other hand, seeks to reach population groups through collective actions with the objective of maintaining oral health, strengthening people's autonomy in the control of the health-disease process and in the adoption of healthy living habits. One must articulate, also, with the other disciplines in the health field, in the sense of identifying risk situations that are common to oral and systemic

problems, seeking to interact with them to develop interdisciplinary health actions.

[...] *the group he belongs to also includes another boy and is a group for everyday living activities, which is an activity of self-care and the activity of practical living, which is a part of handling money, of living, of the issues of day-to-day life, and she is investing a lot of time in caring for the two boys' oral health, especially because he didn't even have a toothbrush in his home. Then, she talked to his father, there was only one tooth brush in the house, she spoke about the importance of this and had even worked with him to enable him to purchase a toothbrush, in order to then begin to work on oral health* [...]. (Report on the Family Case Discussion Meeting, 01/07/2010)

From this perspective the professionals sought to discuss the case of Thrush's family with the intention of expanding the profile of care, introducing new elements, that produce deterritorialization and reterritorialization and sensitizing the professional staff to broaden their understanding of the health-disease process.

By adding to the expansion of the object of oral health, one is able to redeem the concept of the mouth functionality, which is composed of mastication, language and eroticism[23].

Mastication corresponds to the work of grasping, grinding, salivating and swallowing. Hence, it is what consumes in the world, an action which relates the organic and visible structures located in the upper digestive tract with the unseen viscera located lower down. This structure ensures the survival of man in nature, the preservation or replacement of elements that constitute its corporeal entity. It also produces taste or the formation of taste, because, for man, the habit of eating is a social activity, produced culturally. Here lies a relation between the activity of mastication and satisfaction, enjoyment, that goes beyond physiological needs. Botazzo[23] says that the satisfaction and enjoyment of the mouth, shaped by culture, collide with reason and desire.

Thus, mastication can permit oral pleasures to repeat incessantly, and if there were no regulatory devices, mastication could become harmful to man himself. These elements of mastication are repeated in other activities of the mouth. We produce and consume words, we are forced to think about what are talking about and, often, we say what we didn't intend to say; also the use of an exaggerated or incorrect word can prove to be harmful. Regarding romantic relations, we produce oral sexual acts, the consumption of and delight in the body of the other, can result in a conflict between reason and emotion, now and then, the mouth will do what it shouldn't do, or do it in a way that is not recommended[24].Given that the three activities of mouth functionality are dimensions of man's life in society, resulting in social production of the human mouth, this functioning of the mouth and this physiology are permanently covered up.

By association we can conclude that the demand presented by Thrush to the Ruby USF, may not have represented his real needs or may have underestimated them, due to the lack of perception by the users regarding the functioning of the mouth in its dimension of social production, mouth functionality.

From the perspective of health care, Thrush's demand, a teenager, with a "broken smile", due to a fractured front tooth, might have been due to embarrassment from having impaired one of his ways of expressing his affections, by his smile.

Composing a field of collective oral health

The understanding of Thrush's need in relation to his "broken smile" and the possibilities of his awakening in terms of affectionate relations, was developed through a process of deconstruction and construction of the knowledge obtained about the family, by the occupational therapist, the community health workers, the CD and others that had paid attention to other interpretations of the needs expressed by Thrush. This was a provisional interpretation that was true at that moment and capable of generating actions in relation to health care, specifically regarding oral health and the development of Thrush's affectivity.

The conformation of a field of knowledge and practices in oral health at the Ruby USF unit expanded the access to oral health care, for example, the case of Thrush's family, where the action of supervising the brushing of teeth, which included the acquisition of toothpaste and a toothbrush, was carried out by the Occupational Therapy staff, with three objectives: to develop manual skills, improve oral hygiene habits and encourage Thrush's socialization. Thus, this field of knowledge and practices in oral health in the team produced opportunities for the creation of interdisciplinary actions and permitted subjects/users to be more exposed to health care options. This construction of the health work process leads to an expansion in the provision of care in oral health, and, principally, to an improvement in the quality of health care and the possibilities

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of building projects for living by the subjects/users and subjects/workers, which can be exemplified by the report of a doctor, who was doing a residency course in family health and community medicine, on his perception and experience in another case:

[...] *suffering can be a social pain, the non use of a prosthesis, a tooth missing.* [...] *I treated a case of a toothless person and had difficulty working with a prosthesis, based on a complaint by the patient, I felt responsible for dealing with this issue because there was no other dental professional in the unit, I examined him and found it odd to lack the ability but to have the responsibility to deal with the case* [...]. (AdministrativeMeeting, 03/09/2010, RMFC)

In the interaction between Thrush's family and the family health team, the group of professionals were able to perceive that Thrush had obtained benefits for his life because of the health actions taken by the team, although restricted to Thrush, at the same time, they began to see that such actions are limited by how the parent cares for his children, suggesting negligence. This perception led the team to activate other sectors of society, with the aim of improving the family structure, such as the child protection agency and the public prosecutor for childhood and youth. The family continues to be monitored by the team and there is an ongoing good link between the team and the work.

Conclusions

The Thrush case study, within the research on the practice of oral health in a family health team, demonstrated that teamwork bases on the interaction of fields of knowledge and the articulation of practices is a process of construction and deconstruction, polarized between the approaches to health of assistance and care, but has the power to broaden the horizons for the understanding of the health-illness process and health care organization.

Cartography, as an intervention research method proved powerful for understanding the interactions of the fields of knowledge and practices in a family health unit, allowing the monitoring of the movements of a group of people with in a group process, in a dynamic and temporary manner, since it was true for that team at that time.

The conformation of a field of knowledge and practices in oral health at the Ruby USF unit expanded the access to oral health care and the construction of projects for living, such as the example of the Thrush case, where the action of supervising the brushing of teeth was carried out by the Occupational Therapy staff, with three objectives: to develop manual skills, improve oral hygiene habits and encourage Thrush's socialization.

Collaborations

F Silveira, SM Mishima, MGC Watanabe, CM Fortuna, S Matumoto and MJ Bistafa, comprised the research team, participating in project planning and discussion of results. JC Bregagnolo participated in the revision of the text of article.

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