The clinic in dentistry: connections and disconnections with the expanded clinical practice of oral health

A clínica em odontologia: nexos e desconexões com a clínica ampliada de saúde bucal

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Abstract

This article aimed to understand the representation that the clinic assumes in dental practices, in a medium-sized municipality in the state of Santa Catarina. It is a qualitative study, whose participants were dental surgeons linked to public oral health services. Data were collected with three focus groups. The audio-recorded material was transcribed and analyzed with the help of the dialectical hermeneutics. In the first category of analysis - clinic conception -, the participants demonstrated difficulty in formulating a concept for the clinic, translating it as the development of technical procedures, understood as being central to this type of practice for dentists. Integrality and resolvability appeared as central elements, but assume a dentistry-centered view. In the category "resources and organization of the dental clinic," the advantages of using the electronic medical records and the limitations of tab division that narrow the access to information were observed. In treatment systematics, there is little room for listening and the odontogram emerges as a synonym for treatment plan, reinforcing the tooth-focused character of the practices developed. The study showed diversified challenges to incorporating the clinic, whether understood in the traditional molds or in a broader way, in the practices developed by the study participants.

Keywords: Dental Clinics; Dentistry; Oral Health.

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Resumo

Este trabalho visou compreender a representação que a clínica assume nas práticas odontológicas, em um município de médio porte do estado de Santa Catarina. Estudo qualitativo, cujos participantes foram 20 cirurgiões-dentistas vinculados aos serviços públicos de saúde bucal. Os dados foram coletados por meio de três grupos focais. O material gravado por áudio foi transcrito e analisado pela hermenêutica-dialética. Na primeira categoria de análise – concepção sobre clínica –, os participantes demonstraram dificuldade para formular um conceito para a clínica, traduzindo-a como o desenvolvimento de procedimentos técnicos, entendidos como centrais neste tipo de prática para os dentistas. Integralidade e resolubilidade apareceram como elementos centrais, mas assumem uma visão odontocentrada. Na categoria "recursos e organização da clínica odontológica", observou-se as vantagens da utilização do prontuário eletrônico e as limitações da divisão de abas que restringe o acesso de informações. Na sistemática de atendimento, há pouco espaço para escuta e o odontograma desponta como sinônimo de plano de tratamento, reforçando o caráter dentarizado das práticas desenvolvidas. O estudo mostrou dificuldades diversas para incorporação da clínica, seja ela compreendida nos moldes tradicionais ou de maneira ampliada, nas práticas desenvolvidas pelos participantes do estudo.

Palavras-chave: Clínicas Odontológicas; Odontologia; Saúde Bucal.

Introduction

The hegemonic technical healthcare model in dentistry is privatized and commodified, characterized not only by procedure production, but also a prosthetic-surgical approach aimed at dental injuries from an individual perspective, as well as an uncritical consumption of hard technologies, whose technological dimension in healthcare consists of structured knowledge, physical infrastructure and equipment, such as examination machines, cutting devices, orthoses and prostheses (Merhy, 2013; Chaves; Botazzo, 2014; Pires; Botazzo, 2015). Accorded with this model are the so-called traditional or classic clinical practices, marked by healthcare fragmentation, work subject reduction and predominant attention to health professionals, which generates little resolvability (Cunha, 2011).

Throughout the history of public oral health policies, this model has been vigorously criticized in oral health conferences since 1988. In order to overcome its breakdown, the Brazilian Oral Health Policy (PNSB), implemented in 2004, proposed an alternative premise, centered on health care and surveillance. This policy considers the creation of flows for resolution actions, promoting and protecting health, preventing diseases, recovering and rehabilitating people (Brasil, 2004; Pucca Júnior et al. 2009).

The traditional clinical practice model, however, fails at operationalizing the PNSB proposals and prevents it from transforming the organizational micropolicies. The new policies required innovative solutions, such as the inclusion of an expanded clinic, which refocus attention, usually restricted to dental lesions, to singular individuals (Campos et al., 2014). The expanded clinic focuses on health as an object and commits to the production of lives (Cunha, 2011).

Around the world, there is an idea of Person-Centered Care (PCC), a model that seeks, from communicational dialogical processes, to respect values, desires and needs of individuals and their families, building shared therapeutic projects and taking part in their development (Walji; Karimbus; Spielman, 2017).

Bucality plays a major role in this discussion, not only because it explains how human mouths are socially produced by oral functions, but also because it considers humans as seamless individuals, emphasizing the influence of social determinants in oral diseases. When incorporated into clinical work, bucality allows us to understand that the oral experience goes beyond a "disease". On the contrary, we can understand the clinical relationship as an assistance relationship, in which those who seek healthcare have a necessity that does not always entitle them as "sick" (Botazzo, 2000; 2013).

Hence, the clinical dimension assumes a relevant role in ensuring comprehensiveness, since it requires us to identify individuals as historical, social and political beings in order to achieve resolvability (Machado; et al., 2007). In other words, the capillarity of the PNSB and safeguarding its objectives are linked to how, within micropolicies, oral healthcare dental surgeons perform clinical practices. Consequently, the representation these professionals make on this issue carries out a critical function on the dimension of expanded and resolutive practices.

We used representation here in the sense attributed to it by Foucault (1999), meaning the apprehension of empirical categories in the subjectivation process. They are, therefore, "psychic". Such categories concern life, work and language, "of which the subject may not be aware, but which would not be remarkable if that same subject did not have representations" (Foucault, 1999, p. 376-377).

This study aims at understanding the representation that clinic assumes in dental practices, among dental surgeons (DS) working in the public healthcare system of a medium-sized city in Santa Catarina.

Methods

This is a qualitative study, conducted in a medium-sized city in Santa Catarina, whose Health Care Network (RAS) consists of 35 facilities, comprising low, medium and high complexity. In PHC (Primary Health Care), there are 27 Family Health Centers, composed of 53 Family Health Teams, 31 oral health teams (Type I) and five teams of the Expanded Family Health Center (NASF-AB), which serve almost the entire municipal territory. In addition, there are 16 DS that provide "support" to oral health teams - which were hired before the implementation of the Family Health Strategy, with employment contracts different from those of 40 working hours per week. Regarding medium complexity facilities, there is a Type III Center of Dental Specialties (CEO), where 13 DS work in different specialties.

All 44 DS who work at the PHC and the CEO were invited to participate in the study per email, with a list of email addresses provided by the municipal oral health coordination. The sample was defined by convenience, depending on whether the professionals accepted participating or not. This way, 20 DS joined the study, 13 of which were linked to PHC, taking part in family health teams, and seven linked to the CEO. The inclusion criterion used here was being for more than 6 months in their current position. Three focus groups were held - two consisting of PHC professionals, with seven participants in each; and one of CEO professionals, with six participants.

The focus groups were held in April (groups with PHC professionals) and December 2019 (group with CEO professionals), in classrooms of a federal higher education institution located in the city, with an average duration of 60 Minutes. They were conducted by the researcher (moderator), unknown to the participants, with the help of a guiding script with the following central questions: a) what does "clinic" mean to you?; B) describe your clinical approach to new patients served in the health service you operate; c) what is the central element of the clinic for you?; and d) do you use the odontogram? What do you think of it?

Participants were encouraged to interact with colleagues, therefore fulfilling one of the main objectives of the focus groups, which is the production of data from the interactivity between intentionally selected people. A second moderator also participated in the FG: a dental surgeon who was part of the research team, whose responsibility was to observe the development of the discussions and to help the moderator conduct them.

The narratives shared in the focus groups were recorded in audio and transcribed. Subsequently,

we carried out the floating reading of the material, for later organization into analysis categories and coding. Each participant received a DS (dental surgeon) code, followed by a number that was defined according to the order in which the statements were presented in the focus groups. Two analysis categories linked to the guiding script questions emerged from the speeches.

The material was analyzed according to the hermeneutics-dialectics framework proposed by Minayo (2013), deriving from the reinterpretation of the authors Hans-Georg Gadamer and Jürgen Habermas. Hermeneutics allows us to comprehend the text, focusing on revealing what the others consider as truth, bearing in mind that speeches say more than what the authors intended to say. It enables interpretation, establishing relationships and drawing conclusions in different directions. In addition, comprehension denotes exposure to errors, understanding that "nothing that is interpreted can be permanently grasped", that is, it is not a mechanical and closed procedure (Minayo, 2013, p. 86).

Dialectics connects, in its concept, the ideas of criticism, denial, contradiction, opposition, change, transformation and process. In other words, it is expressed as the "opposition of things to each other", each thing being a process chained with other processes, bringing contradiction, as well as quantitative and qualitative changes. The combination of hermeneutics with dialectics facilitates a comprehensive and critical look at the analysis of empirical material (Minayo, 2013, p. 94)

The project was submitted for analysis by the Research Ethics Committee (CEP) of the Faculty of Public Health of the Universidade de São Paulo (FSP-SP) and approved by evaluation report number 3,176,420 of February 28, 2019 (CAAE: 90068218.3.0000.5564).

Results and discussion

Most of the study participants graduated from Federal Higher Education Institutions (70%), with the average elapsed time from graduation being 19.15 years. The mean age of the participants was 46.6 years old and all of them had at least one specialization, 70% of which were specialists in Family Health or Public/Collective Health.

The average working experience in the public sector, whether in the current city in other ones, was 15.5 years. All professionals, including those linked to the specialized service, were PHC workers. Besides, 90% of them work or have already worked in the private sector.

The categories that emerged from the speeches were: 1) Understanding about clinic; and 2) Resources and dental clinic organization. They are presented separately here to facilitate understanding, but both are interconnected and influence each other.

Understanding about Clinic

In the understanding about clinic category, we assembled the speeches regarding the answers to the question "What does 'clinic' mean to you?" during the focus groups. In general, we noticed the difficulty of the participants in verbalizing a concept linked to the classical notion of clinic, strongly disseminated in the medical field as a set of four main elements: semiology, diagnosis, etiology and therapy (Dunker, 2000).

Moreover, considering the concept of expanded clinic as a model that adds to the classic clinic the centrality of the subject and its subjectivity (Campos, 2003), along with the concept of person-centered care, as one that focuses actions on user demands (Lee et al., 2018), the understanding of both of them was little present in the speeches.

We can also pinpoint the theoretical-conceptual vagueness of the term 'clinic' and the trend, noticed between the lines of the speeches, of understanding it in a restricted way and materialized in the development of technical procedures. This approach is deeply rooted in the predominance of technicism and hard technologies in dental practices (Lee et al., 2018; Pires; Botazzo, 2015).

In a self-reflective manner, clinic was placed in a central position in dental practice, being understood as the main purpose of the profession, which would characterize its existence:

Clinic is our purpose. Since we are dental surgeons, we were trained in clinical practice, theoretically. We were trained for combat. So what is the clinic? It is our existence. I don't picture myself acting outside of clinic (DS-06).

It's about doing what I know best to whom I will serve (DS-08).

Technical knowledge appears in the speeches as a central element of clinical practice, reinforcing that the current model reproduces the old lesion clinic practices dating from the eighteenth century, in contrast to the expanded model (Botazzo, 2000; 2017).

I think technical knowledge [is the central element of the clinic], without it we don't perform clinical work (SD-16).

I still see it as fundamental in dentistry in primary care because we still have a sick population, we don't have a stability in the sense that you just have a preserve health or something. We still have an extremely sick population, so we create, through the clinic, this bond and give health back so we can try to preserve it through preventive actions or some other situations, but in Brazil, I still think that the clinic is fundamental in primary care dentistry (SD-15).

Some participants referred to the clinical performance in a sense of reestablishing health and brought aspects related to comprehensiveness, although they expressed a clear separation between the clinic – understood as the development of dental procedures – and dentistry or care, understood as something "bigger".

It's about trying to restore health. Not so much about aesthetics (DS-20).

In addition to the clinic, it's about practicing your own dentistry, a humanized dentistry, integrated with the patient's entire health. Seeing the patient as a whole and giving special attention to that patient (DS-14).

[...] the clinic is very important, although when talking about health it seems to be much broader. Through clinic, we establish this close relationship with patients, in addition to all other actions. But the clinic, the technical aspect, the aspect of being competent in the technical part, is important and working in primary care consists of much more, we work in collective actions, along with the unit, together with a whole team (DS-17).

When analyzing the PNSB, from a foucaultian theoretical framework, Pires and Botazzo (2015) conclude that the comprehensiveness portrayed in the policy permits the response to a greater number of demands – oral diseases – that people may present, through different levels of complexity, organized as hierarchical flows, covered by excessive bureaucracy. We point out that there is little conceptual or practical proximity to healthcare, suggesting that transformations should occur in work processes, by incorporating innovative knowledge and practices, capable of breaking free from traditional and dichotomous views, such as clinic *versus* public health, for example.

Based on the understanding of comprehensiveness, resolvability was placed as the main objective of clinical practices:

It's during clinic practices that we are able to put into practice what we have learned in theory, mostly, returning our product to the customer, which is the solution to their problem. That would be in the mechanical aspect [...]. The final product is solving their problem. A list of guidelines comes with this product, also a list of problems, what we should take care of in that problem. So, all of this is the clinic (DS-06).

[clinic] is my daily work. What I'll solve during my working hours, to whomever I need. My client, patient, our SUS users, whoever comes to be served and seeks solutions. This is what we do on a day-to-day basis at the clinic. That's clinic for me (DS-08).

I believe it's the service provision. Serving the patient. The patient comes and complains and you,

using all the knowledge you have been acquiring, both theoretical and practical, will serve the patient aiming at solving their problem in the best possible way (DS-09).

Patients seek the curative part, they are not very interested in prevention, in education. They want to solve their problem when they have a problem (DS-18).

Before moving on to the discussion about resolvability, it is essential to highlight terms that appeared in previous speeches: "customer", "product" and "service provision". All of them allude to the traditional concept of clinic, strongly marked by a mercantilist logic (Carvalho, 2009), reinforcing the ideological transposition of market dentistry to the public sector. This model, hegemonic within dentistry, is guided by the production of procedures, with a prosthetic-surgical focus, centered on diseases in their individual and biological aspects (Chaves; Botazzo, 2014). In this model, the clinical encounter demands promptness and the prescription of a product, that should be consumed by the user (client) to solve their problem (Campos, 2009). In the following excerpts, the professionals point out the need for consumption felt by users: "[...] a doctor is only good when they ask for exams and prescribes medicine. And the dentist is only good when they fix a tooth. If you don't do that..." (DS-13), "Doctor, aren't you 'gonna' do anything?" (DS-15).

Throughout its history, dentistry has been treating tooth repair as a product (Figueiredo; Brito; Botazzo, 2003) and, although the PNSB identified care as the axis of the model reorientation, there is a mismatch between what the policy proposes and what is operationalized in the daily life of health services in different parts of Brazil. Such a mismatch keeps practices centered on allegedly outdated organizational strategies, based on technical-biological knowledge (Pires; Botazzo, 2015).

Returning to resolvability – previously placed as the objective of clinical practices –, it can be defined as the problem solutions and demands undergone and presented by users, based on the expanded concept of Health, which encompasses the social variables in the health-disease process and its subjective meaning (Santos; Assis, 2006). However, for the participants, the clinic assumes a curative role, which allows us to relate resolvability to the development of technical procedures, reducing its concept, we witness in the following speeches:

Our clinic is curative, that whole story we learn about the importance of promotion, prevention, is not what happens in practice, it's all about extraction and paper over the cracks (DS-05).

[...] we apply knowledge to treat patients, an that is a curative treatment most of the time. We learn a series of prevention concepts, but we apply much less than we should, so clinical practice ends up being very focused on immediate cure (DS-02).

It's about science, a technical-scientific application, in that complete context of prevention, from prevention to the cure (DS-04).

Similar results were shown by Santos and Assis (2006) who, through the observation of the practice of DS linked to PHC, recognized that individual care is specific, fast and centered on the user's dental complaint.

The symptom remission and the search for a cure are other characteristics of the traditional clinic (Cunha, 2011), generating frustrations, since it is not always possible to "cure", but it is always possible to care, which is the main function of healthcare work (Souza, 2011). The predominance of curative actions harms the work flow and, consequently, the expanded oral health clinic (Sherer; Sherer, 2015).

In previous speeches, the word "prevention" appears as an area of expertise in the clinic. Much could be discussed and deepened from these excerpts, but we will stick to what Pires and Botazzo (2015) stated: the preventivist ideology, even after the implementation of the PNSB, which proposed to direct the focus to health promotion, remains present in the practices and ideology of professionals. Preventive approaches have limited effect and may contribute to accentuate health inequalities (Watt, 2017). In contrast, adopting a promotion model is ideal, considering the user as an individual inserted

in a complex context that involves multiple dimensions (Nascimento et al., 2009).

The DS who work in the PHC spoke out, placing the clinic as "a basic service" offered to users, yet being linked to the notion of performing technical procedures: "in the public service we perform the basics. What I said about the basics is regarding the procedures, clinically, we do what we can" (DS-18).

PHC, when well organized, is able to solve 80% of users' health problems (Mendes, 2010). The PNSB reinforces this percentage and also says that dental surgeons should dedicate 75% to 85% of their working time to developing clinical practices (Brasil, 2004). It is believed, however, we can only achieve higher resolvability through innovation in the work flow, with the inclusion of the expanded oral health clinic (Junqueira et al., 2017).

It should be noted that oral health actions in PHC, according to the PNSB, should involve health promotion, disease prevention, diagnosis, treatment and rehabilitation, guided by the perspective of health surveillance, in order to ensure comprehensive care (Brasil, 2004). These assumptions are supported by international literature, which states that actions should be organized in an integrated manner, especially with primary care services, and focus more intensively on the promotion and maintenance of oral health (Watt et al., 2019).

The PNSB, in order to expand and qualify the specialized dental service supply, given that there was (and still is) great repressed national demand, envisioned the creation of CEOs, reference units for PHC, which offer periodontal treatments, endodontics, higher complexity dentistry and surgical procedures (Brasil, 2004; Pucca Júnior, 2009).

The professionals linked to the CEO spoke out about the work developed there as follows: "[...] I worked in the armed forces, in the Navy, so I say that we are the operational battalion. [...] The delta Squad, get it? If the normal platoon can't solve it, send it to us" (DS-06), "Battlefront" (DS-12).

Attention is drawn to the characterization of an increased challenge due to higher complexity cases received by the team and the analogy made with the military services, from the words "Battalion", "battle" and "delta Squad", translating the reality experienced in the service as a war, which presupposes difficult confrontations. For some, however, the challenge is motivating and stimulating:

> *The biggest challenges still come here. That's what motivates me to work here. If I had to act in primary care, working with Class II Amalgams, I think I would've already freaked out [...]* (DS-06).

> *The challenge is motivating! It's so diverse, that it motivates you to research, to update your knowledge, so that you can provide your service and solve the patient's case. There's this idea that we are the reference and when it comes to us, the problem has already reached a second level* (DS-09).

During speeches of the CEO professionals, the reduction of clinic to the development of technical procedures stands out, this time of medium complexity, therefore characterized as more challenging.

Resources and the dental clinic organization

Regarding the resources and the dental clinic organization, we asked several questions that help us understand how participants perceive the clinic.

The DS talked about the electronic medical record used in the city, a relevant tool to record and qualify communication (Mendes, 2010) between team members, as well as informing about the user flow in the service and in the healthcare network. The electronic medical record system also allows the visualization of other tabs, such as diagnoses, medication withdrawal and complementary patient examinations, which, according to the DS, contributes to the development of a safe clinic:

> *Medications, previous exams, everything is there. I know the medication they're taking. What were the last aggravations they had, whether they have systemic complications. [...] It reassures us to work with the patient. We have all their history* (DS-06).

> *You can see the exam results. It shows everything* (DS-07).

The unified patient record, with free access for the entire team, reveals an essential condition for developing an expanded clinic. However, the DS from the target city cannot access the tab in which the other professionals, including those who make up the NASF-AB, record the evolution of users from the healthcare they provided, whether individual or collective, mostly using the problem-oriented clinical registration method (Cantale, 2003). The dental care tab, on the other hand, is restricted to dental surgeons. This reality reinforces the isolation of dental practices from other health practices (Botazzo, 2013) and emphasizes, in the analyzed context, the perpetuation of a body clinic without including the mouth (Fonseca et al., 2016).

Regarding the organization of care, the following statements explain how it occurs:

> *So we call them, open the medical record, serve them, then we close the medical record. In emergencies, the patient arrives at the reception and according to what they feel, the receptionists already assign them as emergency. If it's not an emergengy, they assign them an initial assessment* (DS-01).

> *[...] the appointments, they are supposed to happen every twenty minutes, however, ideally we should finish by 10 o'clock, some autoclaves take longer than others. [...] the ASB start getting angry, so I try to restrict the first appointments, up to the sixth one, to twenty minutes and for the last two procedures, I schedule simple procedures that will take between ten and fifteen minutes, then I schedule 15 day appointments in the last procedures, so I can finish at 10* (DS-02).

In the following excerpt, in which the participant narrates the systematic in care, it is possible to capture different elements, such as time - considered insufficient - ; the absence of medical history - replaced by the "initial evaluation" -; conversation as a possible and valued element, but rarely present; and the role of the odontogram:

> *I use the odontogram, it is a good resource, and it's kind of racing against time, for example, during the appointment, while patient enters the room, the assistant already washes the hands and asks why they are there while wearing a glove, everything at the same time. I do the initial assessment. The odontogram is something I always fill out at the beginning of the first appointment, usually, the assistant fills it in or writes it on a paper and afterwards I transcribe it to the odontogram. I fill in with the missing teeth information and scheduled restorations. I tell the assistant the information out lout, and it helps because the odontogram turns red at the next appointment. I also use the observation field, because I particularly like it when I can talk to the patient, and explain, especially patients with a longer history of cavities and so. What has been talked about, for example, to children not to consume sucrose, what the profile is. Lately, I have been trying to write down who accompanied the child in the appointment. So, I realized that it makes bonding easier. [...] I also usually do procedures in the first appointment, at least the small, fast procedures. While I do it, I already ask for an instrument to assist and start to scrape, they are already finish filling out the odontogram* (DS-04).

The speech of one participant, however, contrasts with these collocations:

> *[The preparation of a treatment plan] will depend on the number of curative procedures the person needs, at first that's it. It will depend on the medical history, the reason, the patient's main complaint at the beginning of the treatment. And, in the unit where I work, there are a lot of children, so you always have to link to the family. So, this will rely a lot on the patient's profile, the family's profile, eating habits, hygiene habits so that I can either extend to another appointment to insist on guidance, evaluation, or already start or conclude a previous treatment* (DS-01).

In dental practices, the patient is mute and their story cannot be heard (Botazzo, 2013). The medical history needs to be reclaimed as a fundamental part of the clinical encounter, which urges us to search for possible ways to allow users to express their complaints, which should be heard, accepted and incorporated in the other stages of the clinical method by professionals. In addition, it also constitutes

an important moment for establishing and strengthening bonds, through the (re)construction of the unfolding histories of individuals (Souza, 2011; Junqueira et al., 2017). When this moment is reduced to the nuclear professional topics, there is a great risk of reducing its potentialities (Cunha, 2011).

The clinical case should be constituted using qualified listening, abandoning the diagnostic evaluation sphere restricted to the positivist objectivity of the classical clinic and incorporating the subjectivity and knowledge of the people involved (Cunha, 2011). The clinic should adopt, as assumed before, the care of the user's most relevant oral problems with a social construction of demand and dental decentering (Botazzo, 2013; 2017).

Another issue considered here to understand the cinical organization that, in turn, contributes to reinforce the perception of the clinic by the participants as the "treatment plan" device which, in the logic of the expanded clinic, should be developed from an agreement between the professional and the user, in order to provide greater adherence and achieve significant results, considering the biopsychosocial demands (Cunha, 2011).

When questioned, the professionals explained how this occurs in their routine, revealing the "dentarized" character of what they called a treatment plan. If available, it is linked to the notion of developing technical procedures "fitted" into the daily agenda, based on the time they may need to be done. The following speeches illustrate this:

> *At the first appointment, I already do the evaluation and try to do a procedure. [...] [The initial evaluation is guided] by an odontogram in the system tab, which I didn't even use before, due to a lack of experience and necessity. I started using the odontogram a while ago and I found it to be helpful and it made my life a lot easier. Because when you open the system, you can already see how the patient's mouth is. We kind of have an idea of if it was close to the end or not, if the patient needed many treatments, if they have an adequate hygiene and if they needed a dental procedure, which requires a different approach from that patient who has many cavities and that you constantly have to remind them about brushing their teeth, prevention, taking care of periodontal diseases as well* (DS-02).

> *One thing I usually do is writing down what I should do at the next appointment. [...] But, depending on the day, if I'm too busy and so, I already assess the patient. Sometimes I assist a patient with a simpler situation if I'm too busy; if a patient doesn't show up for the previous appointment, I assist a more complicated one* (DS-05).

> *[...] and the odontogram is also good because you lose a little time the first time you do it, then, from the second time on, you already look it up straight and you already know what you need to do. You don't waste your time* (DS-03).

The odontogram is a graphic representation of the teeth, in which it is possible to mark the condition on dental faces. You can also use codes and colors to signal the procedures that will be performed. This tool is widely used by DS and its completion is often understood as a synonym for treatment plan. Proposing not to use it causes strangeness, discomfort and insecurity, but experiences show that other recording devices allow the approach with an expanded clinical approach (Botazzo, 2013).

Some participants stated that they did not use an odontogram, but still kept the systematic "dentarized" record, even using the code format understood only by dentists, in the observations field or in the agenda, as illustrated in the following reports:

> *I used to wite it and put it on the agenda and I would look at the patient at that moment, perform the dental practices and write down on the agenda which tooth I was going to work on in the next appointment* (DS-02).

> *I don't use the odontogram, I use the observations field. I write down everything the patient needs. At the first appointment I only examine the patient, then I write down all their needs. I include the teeth and faces, I put if they need an extraction, endodontics, prevention. As soon as the patient comes back, I copy that note I made before, delete what I've done, and paste it* (DS-05).

Some professionals mentioned the use of the observations field to write down how the patient behaved and what they prescribed at the appointment, aiming at "exacting" it from them later:

> *We write the absences down, also if the patient arrived late and then, if they arrive late again, I already know it's their profile. I know if I asked them to the brush their teeth better, then in the next appointment I ask them to improve their brushing again* (DS-05).

> *I also use the observations field a lot. Everything the patient says I like to write down, or the orientations I gave, if you forget them then you can ask the patient again* (CD-03).

Prioritizing the physical characteristics of the teeth and the procedures that will be performed, instead of general aspects that involve the user's complaint and its subjectivation, as well as the registration of the medical history – as is developed by the other health professional categories – reveals a reflection of the understanding of clinical practices as odontocentric, operating primarily with a therapeutic diagnosis (Botazzo et al., 2017).

The dental content constitutes a striking characteristic of the renowned clinic, reflected and discussed by the study participants. A similar statement was made by Pires and Botazzo (2015), when analyzing the text of the PNSB. This hegemonic imaginary hinders the development of the expanded clinic, opposing to the principles of the Brazilian National Health System.

Healthcare, on the contrary, requires the predominance of Light technologies, so that it is efficient. When the worker and the user meet each other, from dialogue and listening, it is possible to generate complicity, bond, acceptance, responsibility and stimulate individual autonomy (Merhy, 2013). Therefore, the construction a clinical case through a medical history, such as a qualified listening to the user's complaint (Barros; Botazzo, 2011), should prioritize light-relational technologies in the clinical encounter.

Final considerations

This study revealed that there are missing links and remaining disconnects regarding the incorporation of the clinic in dental practices, whether it is understood in a traditional or expanded way.

Although the PNSB represents a milestone in the construction of public oral health policies in Brazil and it proposed various innovations, which include overcoming the traditional clinic, the representation of dental surgeos reveals that, in the work micropolicies, little changed in relation to previous models.

It is no surprise that oral health practices in Brazilian National Health System (SUS) tend to reproduce the mercantilist, curative, biologicist and little resolutive character of the private sector or pre-SUS public services. Nevertheless, this study contributes to the discussion and to the advancement in the process of change, while highlighting the understanding of the representations of dentists about the clinic, since they are the ones who operate policies on a daily basis and micropolicies define the quality of this operationalization.

Thus, the results presented here offer subsidies that can foster actions directed to micropolicies, in order to promote transformations with a possible greater capillarity and outreach, either during service or training. We emphasize, however, that this is complex process, especially due to the hegemony of the biomedical model of comprehending health, predominant in the training of dental surgeons, as well as other health professionals, and in health practices in general.

It is imperative to deepen the understanding of the topic, by developing new studies that can lead to the incorporation of the expanded oral health clinic in everyday dental practices, especially in the scope of the PNSB.

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Authors' contributions

Fonseca designed the study, collected and discussed the data, and wrote the initial version of the manuscript. Botazzo supervised the study and revised the final version of the manuscript.

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