

# Dentistry medicalization at SUS: a qualitative practice-based perspective

## A medicalização na prática de dentistas no SUS: um olhar qualitativo para os sentidos da prática

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### Abstract

This study explores the senses and meanings attributed to dental work in the Brazilian National Health System (SUS) focusing on dentist-patient relations. A qualitative research was conducted with 20 dentists working in a medium-sized municipality in São Paulo, divided into three focus groups and asked the guiding question “What sense or meaning do you attribute to your work here in the city?” Data were audio-recorded, fully transcribed, and analyzed using thematic content analysis. Floating reading, categorization, and peer discussion of the findings were performed for the final validation, resulting in two categories: 1) **Strangeness to patients’ needs and the subsequent medicalization of life**, and 2) **Power and consumption as meanings of practice**. In this context, the dental practices showed the differences between patients’ needs and those considered relevant by dentists. It also showed the power imbalance between patients and professionals as a hindrance to patients’ autonomy. Such meanings seem to cause suffering to these professionals. In conclusion, reflections on health work are paramount to avoid suffering and understand that the practice of these dentists bears many senses and meanings.

**Keywords:** Medicalization; Qualitative Research; Dentist-Patient Relations; Public Health.

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## Resumo

Este artigo explora sentidos e significados do trabalho odontológico no SUS, no contexto da relação profissional-paciente. Pesquisa qualitativa com 20 cirurgiões-dentistas que atuavam em um município paulista de médio porte, abordada por meio de três grupos focais, com a pergunta disparadora “Qual é o sentido ou significado do seu trabalho, aqui na prefeitura, para você?”. O material foi áudio-gravado, transcrito na íntegra e analisado pelo método de análise de conteúdo temática. Procedemos a realização de leitura flutuante, categorização e discussão dos achados junto aos pares de pesquisadores para validação final. Como resultados, aponta-se a construção das categorias 1) Estranheza às necessidades percebidas pelos pacientes e a consequente medicalização da vida, e 2) Poder e consumo como significados da prática. O trabalho do cirurgião dentista, nesse contexto, evidenciou as diferenças entre as necessidades percebidas pelo paciente e aquelas que o dentista considera. Além disso, revelou o poder que emana da assimetria entre paciente e profissional como dificultador da produção de autonomia do paciente. Tais significações parecem trazer sofrimento para esses profissionais no seu trabalho. Concluiu-se que há necessidade de reflexão sobre o trabalho em saúde como forma de se evitar sofrimento, e que a prática desses dentistas é carregada de sentidos e significados.

**Palavras-chave:** Medicalização; Pesquisa Qualitativa; Relações Dentista-Paciente; Saúde Pública.

## Introduction

The technologies employed in biomedicine (a preponderant paradigm in traditional health services), such as diagnosis, disease categorization, industrialized medicine use, examinations, and procedures, produce degrees of medicalization (Cardoso, 2014; Tesser, 2006). Such practices tend to reduce the autonomy coefficient of society and increase its degree of dependence to cope with illness, pain, and death (Illich, 1975; Santos, 2002). Dentistry (an area permeated by hard technologies) has historically been centered on disease and procedures up to today and strongly expresses this rationality.

The healthcare providers who adhere to this logic consciously or unconsciously take a hierarchical position toward patients' disease and thus patients themselves, a relationship that generates healthcare providers' dominance and power and annuls patients' autonomy.

However, this logic has been shown to be insufficient in comprehensively addressing the health-disease process. One of its limits lies precisely in professional-patient relationships, which are often superficial and alien to senses, meanings, and affections (which is no different in dentist-patient relationships), evincing the reductionist biomedical addressal of complex realities (Cardoso, 2014).

The process of expanding the object of medicine preceded the explosion of the medicalization phenomenon since the beginning of the 20th century onward. By entering the social space for the first time, medicine prepared the ground that enabled the biopolitical exercise of medicalization (Foucault, 1984a), which can be understood as a phenomenon of medical interventions to produce healthiness and as an unrestricted extrapolation of medical science to other aspects of individuals' lives, i.e., evincing that no phenomenon could evade description by the relationship between the body and medicine.

Dentistry (the scope of this research) is no different, developing a formal system of knowledge based on the biomedical paradigm—although its focus has remained on mechanical or prosthetic activity (Carvalho, 2006), with medicalization as

one of the potential effects of its practice. The very differentiation of dentistry as a specific area within health knowledge and practices can be understood as a manifestation of medicalization due to its technical specialization, characteristic of the modernization of the world (Tesser; Pezzato; Silva, 2015), which, “[...] with the use of highly sophisticated equipment, urban-centric locus, exclusion of alternative practices and essentially curative treatments [...]” (Emmerich; Castiel, 2009, p. 97; our translation), has become synonymous with good quality standards.

Over the years, the insertion of dentistry in the Brazilian public health system has been marginal and aimed at schoolchildren and poor populations (Freitas, 2007), so the appropriation of tools to act in the current context of the Unified Health System (SUS) demands a redoubled effort in this field.

This research assumes that dentists attribute senses and meanings to their work in the public sector and that they can show how medicalization phenomena and power relations manifest themselves in this context. This study aims to know what senses and meanings dentists working in a public health network have of their own work.

## Methods

This project was approved by the Research Ethics Committee under CAAE number 54300715.8.0000.5418.

A qualitative approach was used in this investigation, allowing for reality to be understood in a deeper space of relationships and phenomena that prohibits reduction to variable quantification (Minayo et al., 1998).

The exhaustive sample (Fontanella; Ricas; Turato, 2008) was composed of 20 dentists who worked in the Family Health Strategy and in the Dental Specialties Center of a medium-sized municipality in the state of São Paulo and agreed to participate.

The focus group method was adopted for data collection since this study explores the perceptions of subjects working in the same context and performing the same function and that interactions could enrich results by exposing consensuses and contradictions. Focus groups are a form of group interviews based on communication and interactions

that aims to obtain detailed information about the understanding of perceptions, beliefs, and attitudes on a given topic (Kitzinger, 2000).

In total, three focus groups with six to eight subjects lasting about 50 minutes each were carried out with participant observation in three periods. The guiding question was: *What is the meaning or significance of your work here at City Hall for you?* The material was audio-recorded, fully transcribed, and evaluated by content analysis (Minayo, 1998). After a floating reading was performed, comments and emerging impressions were elaborated and their categories, discussed and validated among peers.

The main researcher in the report and the health service was considered an implicated observer and participant since she played the role of worker and researcher. During the groups, she took notes, rather than guiding the group.

A field diary was also built. In it, the researcher recorded her impressions about group participants' reactions, the “unsaid,” non-verbal expressions, and other attitudes related to the subject as captured by her observation.

## Results and discussion

This study listed two main analytical categories for discussion based on the focus groups and participant observation data during them: Category 1 - Strangeness to the needs perceived by patients and the subsequent medicalization of life; Category 2 - Symbolic power and its perceived asymmetry in social relations.

### **Category 1 – Strangeness to the needs perceived by patients and the subsequent medicalization of life**

The statements from dentists evinced the differences between the needs patients perceive and those that dentists consider relevant. The latter show strangeness and perplexity in the face of these disparities, reinforcing this distinction in patient-health professional relationships.

Knowledge is currently considered a form of power and rationalism. In this context, the foreign element resists reason and standardization. “Strange” and “strangeness” are categories semantically linked to

the other and otherness (Melo, 2011). This explains the difficulty of participants accessing the other (in this case patients) as they carry something “strange,” i.e., that can escape the rationality imposed by the objectivity of scientific knowledge.

The emergence of modern medical rationality has objectified knowledge and practices to exalt the objectivity of diseases, exclude subjectivity, and construct generalities (Luz, 1988).

The scientific knowledge this objectivity structured dictates the unequal power relationships between healthcare providers and patients. However, the presence of subjectivities and other elements rationality and objectivity are unable to explain permeates this relationship, emptying the power constituted by scientific knowledge.

*He'll go to five dentists and the fifth one will perform the extraction! And he'll be pleased! So, sometimes, what is best for you is not always best for the patient! (D13)*

*Sometimes you say to the patient: Oh, there's no such remedy! You have to buy it! But it's cheap! (and the patient responds) How much, doctor? (and the dentist) Oh, it's 20 [bucks]! And the patient will say: 20? I don't have it!! So, like, it's something like, so absurd for us, [...]. (D13)*

Dentists, bearers of their values (such as the concept of “expensive or cheap” based on their purchasing power) and those exclusive to dentistry (such as the importance of tooth loss) marks a position that ensures their social distance from users. Public service users are often excluded from a certain consumption pattern (Bourdieu; Wacquant, 1992). Science offers a presupposition for this social legitimacy (practiced according to the biomedical model), following the supposed scientific “dental authority” who produces the truth (Barros, Wimmer, Botazzo, 2007).

The differences marked by dentists' and patients' social positions can cause strangeness between them, “a process through which a thing or person is removed from its own context and submitted to an unknown, unfamiliar, or differently structured

context from the original one” (Ritter; Gründer; Gabriel, 1972, p. 509; our translation).

Subjective elements, the social issues that purely technical knowledge is unable to address, and all that escapes a pre-established and strictly objective pattern of problems and solutions exemplify this strangeness. These examples evince the discomfort the sciences striving for objectivity experience when dealing with strangeness as it resides, a priori, in the uncertain and singular experience of addressing it (Melo, 2011).

When the biomedical model configures the reference for care, it reduces the health-disease process to its biological dimension so that it becomes difficult for professionals to understand ill-adjusted demands to this rationality (Barros; Wimmer; Botazzo, 2007). These mismatches are interpreted as noise in the daily routine of services and occur in the intersecting space of soft technologies (Merhy; Franco, 2003), which are characterized by essentially relational technologies established in the encounter between users and workers, i.e., between two worldviews.

*The lack of hygiene... When I did extractions, the patient would return with an acute condition. From then on, I started to prescribe antibiotics as a prophylactic measure. And that was that. It completely ended! So, I started to not trust patient's oral hygiene because I already knew their history [...]. So, when I see an individual with a questionable hygiene, this is the attitude I take, preserving myself from the unpleasant encounter with the individual and the odor resulting from the surgery I did! (D1)*

As clear as users' difficulty exercising self-care is professionals' difficulty managing this issue. It is simpler and easier for professionals to use non-relational technologies. Medicalization and its objective, rational, prescriptive, and normative knowledge lie at their disposal. On the other hand, the management of human issues, such as the difficulty of following guidance, can offer challenges requiring efforts in the face of which professionals feel incompetent due to unfamiliarity. Motivating patients to change their habits, for example, requires

understanding the difficulties they have following guidelines and having the time and willingness to welcome them and bond with them; i.e., to go beyond the biomedical rationality.

This priority appeal to hard and soft-hard (non-relational) technologies has led people to consume often unnecessary professional care in the face of everyday life situations, impoverishing their autonomous administration of suffering and pain (Illich, 1975; Tesser; Pezzato; Silva, 2015).

Thus, the surveyed subjects ignore that medicalization influences the popular perception that “everything is a professional demand” and their own “posture” of tutelage, restricting people’s autonomy and causing double the damage: those under tutelage (patients) lose their autonomy and professionals become overloaded and frustrated.

*Sometimes, they come to us as a lifeline, and we can't always handle it! And sometimes we get a little frustrated with it because we can't keep up with the demand! Sometimes I think they place great expectations on us! (D15)*

If, on the one hand, dentists make choices on behalf of users, protecting them, on the other hand, when they receive demands related to this protection, they feel trapped in the medicalizing production model surrounding them. Thus, the biomedical model encourages healthcare providers to adopt a Cartesian behavior of polarization between “observers” and “observed objects” (Barros; Wimmer; Botazzo, 2007).

*I think it's become a paternalism so great that we're held hostage. [...] I think patients get off too easy. [...] Oh, you have to do this, you have to do that! Go to their house! You missed it, the vaccine is overdue. (D2)*

*If you missed [your appointment], take the referral [with you]. (D8)*

This tutelage posture from professionals toward patients and the fragmentation of care characteristic of the biomedical paradigm reduce the possibilities for offering satisfactory answers

to health problems and needs, especially due to the subjective components of this relationship.

Thus, they clearly evince professionals’ dissatisfaction and the frustration of their expectations.

This scenario of strangeness that lead to the consumption—mostly medicalization—of technologies is further accentuated by the current demographic and epidemiological context, which, due to population aging and chronic diseases, creates pressure for preventive behaviors, which encourages patients’ dependence on professionals and induces them to blame themselves for their diseases and injuries. Blaming configures a mechanism by which people are (and feel) responsible for their illness, which hides the malfunctioning of public services and the lack of commitment of governments to such services (Valla, 1998).

The knowledge and resources that enable preventive and healthy behaviors are often out of reach for a large part of the population. The medicalization of actual physiological events occurs collaterally in this phenomenon (Illich, 1975), e.g., unnecessary extraction of deciduous teeth, periodic check-ups, unnecessary cleaning procedures, among others. It also reinforces an obsession with health, beauty, perfection, and youth associated with the body. This “modern hygiomania” translates into the compulsion to be healthy and always control risks (Nogueira, 2001).

Despite the proven usefulness of preventive health measures associated with lifestyle, it is necessary to criticize “preventivism” as a priority public health strategy. However, with little social impact, it reiterates the role of the market as a resource for disease and suffering (Cordón; Garrafa, 1991). Thus, biological reductionism—which fails to accommodate subjective issues foreign to the biomedical model—configures one of the drivers of medicalization, alongside the values propagated by industry, media, and commerce (Tesser, 2010).

## **Category 2 – Power and consumption as meanings of dentistry**

*The population has a very high degree of demand as if saying “I pay your salary.” Respect has been lost! (D8)*

This “level of users’ demand,” which seems to surprise the professional, can be analyzed in the light of Bourdieu, who explains that “symbolic power is that invisible power which can be exercised only with the complicity of those who do not want to know that they are subject to it or even that they themselves exercise it.” (Bourdieu, 1989, p. 7-8; our translation). According to this author,

*[...] relations of communication are always, inseparably, power relations which, in form and content, depend on the material or symbolic power accumulated by the agents. [...] The different classes and class fractions are engaged in a symbolic struggle properly speaking, one aimed at imposing the definition of the social world that is best suited to their interests.* (Bourdieu, 1989, p. 11; our translation)

The values of each party emerge from the relationship of power, from distinctions.

*I’ve had a patient. You look at their cellphone, it’s more expensive than yours! It’s better than yours! But their mouth. You look at it and the person is missing a tooth, without the central incisor. I even looked at the girl and said: What a cellphone, huh? (and the patient responds) Oh... I bought it in 15 installments. And I said: Oh... Right! So, you need to have a crown on this one, that one, and that one! (and she answers) I don’t have any money! It’s a cultural issue. Such a pretty young girl! (D15)*

*And Bolsa Família, everyone is on the “bolsa” in my unit. There’s many of them there. All with cellphones! Those mothers, with their babies, two, three already, really young mothers with their cellphones! And sometimes, I notice they don’t watch their children for a while. And the kids there, throwing water from the water fountain on the floor. (D14)*

A certain indignation, related to patients’ choices tending to consume material goods instead of acquiring the required oral health services, underlies the statements above but they evince no equal indignation at patients’ limited access to such

services (such as certain types of prostheses) at SUS, since patients are the taxpayers “supporting” SUS.

It is as if patients were “guilty” for possessing certain consumer goods that are supposed to be exclusive to people of a certain social stratum (such as that of dentists). This indignation is a way in which power operates. Foucault points out that: “To understand power in its materiality, its day to day operation, we must go to the level of the micropactices, the political technologies in which our practices are formed.” (Dreyfus; Rabinow, 1984, p. 203; our translation). Thus, when users seek healthcare providers (including dentists), they demand relief, reduction of pain, suffering, guidance, care, or a solution (even if partial) to their problems. Thus, professionals hold the power to solve the problems in question. This inevitable and natural asymmetry of powers and knowledge is, above all, exercised in a very peculiar *modus operandi* since dentistry traditionally privileges an individual, prescriptive, and still hermetic approach to professionals’ work processes.

Over the years, the inclusion of dentistry in the Brazilian public health system has been marginal and aimed at schoolchildren and specific populations (Narvai, 2006). The appropriation of tools to act in the current context of the SUS demands a redoubled effort in this field. Thus, based on the point of view of day-to-day practices, the micropolitics of dentists’ work, and the relationships with patients’ life scenarios (or rather, dentists’ distance from them), it can be thought that these favor a practice that fails to understand patients’ choices and thus becomes authoritarian toward the values patients should supposedly have. This exercise of power seems to us to be “authorized” by practice, the use of available technologies, and professionals’ training.

The Brazilian Health Reform movement has obtained great achievements since the 1970s toward organizing a public and universal health system that would guarantee health as a right of all citizens and a duty of the State. Nevertheless, the distance between healthcare providers and subjects demanding care and the great differences in users’, healthcare providers’, and managers’ thought remain evident. This has caused great tension in the construction of the dreamed health model, sometimes reducing

users' access to the system or excluding them (Batista; Gonçalves, 2011).

Thus, it is essential to reflect on a dental clinic that uses soft relational technologies and subjectivities as one of the dimensions of its mode of health care production (Graff; Toassi, 2017). However, the production of care in a broader clinical perspective centered on patients in their biopsychosocial complexity beyond a model of production constitutes an ethical, political, and philosophical posture of caring for the other. Every dentist is expected to have such a stance. However, healthcare providers' mode of care production is related to their subjectivities in the performance of their work. When focused exclusively on technical care protocols, oral health work causes professionals to interact little with people, becoming unaware of their life histories. The caregiving action (hostage to the therapeutic mechanism) occurs to the detriment of adequate listening and starts to guide the clinic by the disease. The counterpoint to this would be a permeable care for professionals and users that would bring about the encounter of subjectivities (Barros; Wimmer; Botazzo, 2007). The effort to change professional practice toward care centered on the person (rather than on the disease), the valorization of subjectivities, and the sharing of decisions between professionals and users has been made for decades. However, it should be noted that all undergraduate and graduate curricula, continuing education, and professor training should include theoretical bases, opportunities for experiences, and clinical simulations focusing on light-relational technologies (Graff; Toassi, 2017).

Regarding this issue, another manifestation that emerged in the groups related to the financial distinction between professionals and patients:

*You know, I can buy it. [...] Oh, I think it's priceless and very few people have it, right?! In our country! Very few people! We are very much unlike others and sometimes we forget that! We are very unlike others! (D14)*

The fulfillment of professionals in a capitalist society is related to the financial rewards they receive in exchange for their work. Adequate remuneration, which is socially and historically defined, plays a role in workers' satisfaction (Pires, 1996).

However, professional performance fails to always directly relate to received pay. The question of the pleasure of consumption emerges in addition to the material reward of work, i.e., the personal fulfillment related to "buying things." This refers to the symbolic power (Bourdieu, 1989) associated with economic domination by a power of constructing reality with opinions and thoughts that can establish social distinctions that somewhat exacerbate the asymmetry of power in social relations and, ultimately, in professional-patient relationships.

The harshness and concreteness of the analyzed work context, its conflicts, anxieties, and relationships make clinical practice complex (and sometimes unbearable) for those who practice it. Thus, the challenge of producing care refers to acquiring a new ethics considering objective and subjective issues.

Considering the leading role of interpersonal relationships, valuing others' particularities, individualities, and emotions configures presuppositions of oral health care in this context (Ferreira, 2002). However, it is necessary to observe the general conditions acting on society and their symbolic production, which directly impact professional-patient relationships.

## Final considerations

This study developed its initial assumptions to broaden the understanding of the senses and meanings of professional practice, which are loaded with tensions in professional-patient relationships linked to the biomedical paradigm, the medicalization phenomenon, and the power that underlies the asymmetrical relationships between professionals and patients.

The meanings and senses this research attributed to work seem to be rich in elements that professionals should better ponder and elaborate in an effort between management and workers to improve work and thus professionals' well-being.

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### Authors' contributions

Celia Regina Sinkoç: Participated in the conception of the research project, focus groups, content analysis of the speeches, and elaboration of this article. Jaqueline Vilela Bulgareli participated in the focus groups, content analysis of the speeches, and elaboration of this article. Brunna Verna Castro Gondinho participated in the focus groups, content analysis of the speeches, and elaboration of this article. Pedro Augusto Thiene Leme: Participated in the content analysis of the speeches and elaboration of this article. Cristiane Spadacio: Participated in the content analysis of the speeches and elaboration of this article. Júlia Vitória Octaviani participated in writing this article and its critical review. Karine Laura Cortellazzi: Participated in the conception of the research project and in the critical review of this article. Rosana de Fátima Possobon: Participated in the conception of the research project and in the critical review of this article. Luciane Miranda Guerra: Supervised this research, participated in the content analysis of the speeches, and in the elaboration of this article.

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