

The dental professional after productive restructuring: ethics, the job market and dental public health¹

O profissional da odontologia pós-reestruturação produtiva: ética, mercado de trabalho e saúde bucal coletiva

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Abstract

Objective: to uncover ethical problems in dental professionals' new labor reality after productive restructuring. **Methods:** exploratory and descriptive qualitative research, carried out through an individual, semi-structured interview with 10 dental professionals within a universe of 30 interviewees. The analysis method was Textual Discourse Analysis. **Results:** 1. Ethical problems in the dental job market after the productive restructuring: the new reality of health plans, private health insurance and popular clinics does not seem to meet the professionals' needs; rather, it seems to meet the needs of the market, entailing diversified ethical problems. A growing inter-peer resentment seems to be directly related to the crisis in the job market and to transforming the old concurrence into competitiveness; and 2. Transformations in dental public health: it debates the social need constructing excellence in public health dentistry as an ethical problem, different from the logic of the market. **Conclusion:** a professional crisis points at different ethical problems: transformations in the job market strengthen a commercial sense in the profession, building business configurations with increased capital accumulation in realities of precarious labor; the exclusive action of the dental public health professional stimulates his leading role in transformations towards a new professional excellence: that of the public service. **Keywords:** Ethics; Healthcare Professional; Dental Health; Dentistry.

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Resumo

O objetivo deste artigo é desvelar os problemas éticos na nova realidade de trabalho dos profissionais da odontologia, pós-reestruturação produtiva. Pesquisa qualitativa do tipo exploratório descritivo realizada por meio de entrevista individual semiestruturada com dez profissionais da odontologia num universo total de 30 entrevistados, utilizando o método de análise textual discursiva. O mercado de trabalho da odontologia pós-reestruturação produtiva apresenta uma nova realidade de planos, convênios e clínicas populares que não atende às necessidades dos profissionais em vários quesitos, mas, sim, às suas próprias necessidades comerciais, ocasionando diversificados problemas éticos. Um crescente ressentimento interpares parece ter relação direta com a crise neste mercado de trabalho e com a transformação da velha concorrência liberal em competitividade. Diferenciada da lógica de mercado, as transformações na saúde bucal coletiva direcionam a um importante e contemporâneo debate: a necessidade social de construção da excelência para a odontologia pública como problema ético. Conclui-se que uma crise profissional na odontologia aponta diferentes problemas éticos, uma vez que as transformações no mercado de trabalho reforçam um sentido comercial na profissão, construindo configurações empresariais com ampliação de acumulação de capital em realidades de precarização no trabalho; e que a ação exclusiva do profissional na saúde bucal coletiva estimula o seu papel protagonista nas transformações rumo a uma nova excelência profissional pública.

Palavras-chave: Ética; Profissional da Saúde; Saúde Bucal; Odontologia.

Introduction

The profession of dentistry, historically, was forged at the junction of an intellectualization of medicine itself, based on a specialized branch named stomatology, with the practical art of dentistry. According to Botazzo (2000), stomatology was not really born unless it was at the moment at which anatomy was cultivated in Europe and when the intimate details of the organization of the mouth became known. However, the art/trade/craft accompanies and differentiates this profession limited to the mouth: the hegemony of the liberal-privatizing ideal, a strong artisanal component and market constructed work relations - the classic confrontation between good service and the desire for profit. Inter-subjectivity was created intertwined with the ontogenesis of the profession: an academic ethos and an ideal of the successful professional who naturally and invisibly transmits different alterities.

For Cristina Carvalho (2006), achieving public recognition for the profession overcame the commercial profit focused vision of the craft and poor social self-esteem, to become a standardized, indispensable scientifically based oral health service. A professional identity constructed in strong corporative resistance in the dispute with differentiated groups of informal service providers until the creation of councils who established monopolies in the provision of oral health services to this specific category. A reality that can still be perceived today, as a defensive objection to the training and practice of oral health technicians and to team work.

A constructor of individualized practice, directed at high tech and specialization, something that does not happen in a more complexified vision of the human being and of the social dimension of the health-disease process, but rather supported by bio-medicine. Its scientific modern base is built on the bacteriological discoveries of Miller, in 1890: responding to the new profession's scientific anxieties, originating a scientific way of thinking about dental caries and consolidating a collective of dentistry thinking from a solid base of "multi-causal biologist" facts (Gomes; Da Rós, 2008, p. 1083).

The "practical" component, the foundation of training in Brazil, especially surgery and prosthe-

tics, marked the first Brazilian faculties, which only later came to incorporate the “clinical” component (Warmling; Marzola; Botazzo, 2012). The Flexner teaching model, introduced in the 1960s, accompanied the late industrialization of capitalism in Brazil and deepened the specialized technical-scientific character of dentistry training. Consolidated know-how/power in an airtight clinic practice, the “de-reconstruction” of which remains a challenge for dental public health. A traditional way of thinking and professional profile that entered in crisis with the epidemiological transition of dental caries associated with saturation of the labor market, no longer achieving professional status.

A professional transition that took place together with productive health restructuring: constructing the Unified health System - *Sistema Único de Saúde* (SUS) occurred in a neo-liberal environment of strong conflict with the constitutional principles of uniqueness and universality, established in the public-private mix. Citizens’ rights, linked to the statute of full employment and its protective power, is rocked by transformations in the world of work – a profound breakdown of work and contestation of social protection. Health needs that had acquired the connotation of consumer goods in the “golden age” (Hobsbawn, 2002), began to form part of a lucrative approach with even greater potential to accumulate capital. New issues came into play, not only in the ambit of understanding material processes in producing life, as well as a related subjective transformation.

Nowadays, the consumption of goods and services is no longer about meeting needs but producing them which, according to Mészáros (2002), obeys the abstract imperative of profitability. Aesthetic mass-consumerism is a fetish if apparent happiness, an ideology necessary to dissimulating the social risks of development, especially financial, (un)controlled by the market. For Harvey (2011), the search for self-expression as a sign of individual identity within the collective becomes embodied in models of consumerism and lifestyles. The need for discipline, standardize and control bodies and, in particular, the workforce appears to combine standardization, repression, familiarization, cooptation and cooperation, traversing all the intricacies of

human relationships.

Ethics is constantly in confrontation with commercial interests and “[...] the dehumanization of relationships between health care professionals and patients has been one of the most commonly mentioned causes for the increase in complaints and legal cases” (Fortes, 2011, p. 15). Some significant changes in dentistry, in both the work market and public oral health, appear to govern the search for new alternatives. On the one hand, the moral of dentistry is constructed on a model of cure linked with aesthetics, now added to aesthetic/specialized consumerism with the increased capitalization of work - precariously salaried and/or organizations of groups/businesses. On the other, incorporating oral health teams into the Family Health Strategy (FHS) forming a body of professionals linked exclusively to public oral health, although outside of the ideal of the market and directed at a new socio-collective perspective. A paradigmatic crisis was originated with “[...] diluting the identity matrices of dental surgeons” (Emmerich; Castiel 2009, p. 341), making room for possible epistemological and ethical-political changes. The aim of the article, therefore, is to uncover ethical problems in the new work realities of dental professionals.

Methodology

This was exploratory descriptive qualitative research using semi-structured individual interviews. The study design was based on analyzing the data obtained from ten dentists from a total of 30 interviewees (doctors, nurses and dentists) with experience working in the public-private mix. These professionals were contacted beforehand to request their permission to interview them, starting with those working in public health services in the Municipal Health Department of the metropolitan Region of Florianópolis. The sample selection was defined using the snowball method, in which the initial interviewee recommended another, repeating the process with the new interviewees until saturation of information was achieved. No institutional limits were set, now was access limited exclusively to this method.

Subjects who agreed to participate were provided

with more detailed information and interview conditions. The subjects, known as “P”, were allocated a number according to the order in which they were interviewed, maintaining anonymity. The results were analyzed using Textual Discourse Analysis (Moraes; Galiuzzi, 2011), organized by breaking down the texts into base units and creating categories (with the help of ATLAS.ti software) and capturing new emergent by the new combination of meanings expressed in a meta-text, followed by a cycle of analysis based on criticism and validation. The project had been approved by the Ethics Committee - CEPESH/UFSC/2461. Participation was voluntary and participants signed an informed consent form, meeting the conditions of full autonomy set out in Resolution CNS 196/96.

Results and discussion

Ethical problems in the job market after productive restructuring

Agreements and dental plans

“[...] most of my clientele had Agreements and it came to a point where it wasn't worth it anymore, because the prices the Agreements paid the professionals was minimal” (P8).

“[...] they're always trying to get around the law, they're very creative, and we're shut in between the four walls and can't think of all the tricks... remuneration from them is very poor... you're paying to work... the profession is marginalized” (P10).

Following the logic of other areas of health, health care plans and agreements have become increasingly important in Brazil over the last few decades. Increased demand for such services has been encouraged and sustained by State direct purchase, transferring a significant part of its function as provider over to private initiative: “[...] scarcity of provision and poor quality public services, both resulting from progressive lack of financing, encourage the public-private mix dynamic of health care in Brazil” (Bahia; Scheffer, 2010, p. 27). It is a commercial mode initially ruled by the free market that, due to the increasing dissatisfaction among professionals and users, came to be regulated by

the National Supplementary Health Care Agency - Agência Nacional de Saúde Suplementar (ANS).

Intermediation became established between professional and patient that substantially modified the liberal practice, when part of the administrative responsibility and remuneration for the services is taken on by third parties. The lack of an employment relationship with the liberal practice itself in the mix, even detaching all or part of the work instruments, leads to a new type of precariousness. A reality based in free exercise of profession, stated to be the ideal, which encourages unnecessary services and impedes strong external social control (Vianna; Pinto, 2013). Even while booming, this “outsourcing” is not directed at meeting various types of professional needs, but rather at meeting the needs of the business market.

“[...] I believe the Agreements are trying to cheat the dentists, a class that is already disunited and does not fight for its rights” (P10).

The professionals' adherence to private health plans without broad knowledge of the limitations and significance for autonomy demonstrate the increasing difficulties of maintaining status through liberal clinical practice: the Agreement would be an attractive option for empty practices (Bragança et al., 2011). Lack of knowledge of management concepts on the part of professionals and not knowing the cost/revenue/profit relationship results in a new form of control and making the liberal style of work more precarious, producing dissatisfaction in the majority (Saliba et al., 2011). A perverse reality constructing a relationship of indispensability with the professional in an attempt to keep them in a highly competitive labor market. Instead of questioning its assertiveness, they are made more disposed to learn to deal with its pros and cons.

The following ethical problems were found: 1) controlling the professionals' work to check procedures conducted, leading to an atmosphere of distrust in procedures that are not allowed, rather than an atmosphere of respect in working in health care; 2) the excess of corroborative exams result in the patient undergoing unnecessary procedures without prior knowledge or consent, creating an

ethical conflict - a reality that drives change in the ethical code of dentistry; 3) a feeling of helplessness and insecurity due to the lack of collective action/protection appears to facilitate spaces in which the Agreements are in the ascendant above the rights of the professional and of the consumer.

The reality of “popular” clinics

“[...] an ex-student of mine told me how she received three reais for prevention and fluoride and she did one every 10 minutes... these popular clinics are for money laundering... it’s demeaning and degrading for the professional to undergo this” (P6).

“[...] my colleague told me that they had 15 minutes per patient, irrespective of what needed to be done... she said that there was a warning light that flashed when the time was up... the professional becomes corrupted” (P10).

A reality of working in “popular” clinics, created in dentistry under the sign of professional business, seeking to accumulate capital on precarious work relationships: the demand for high productivity in situations that do not take into account professional autonomy and the ethical precepts of dentistry generate insecurity. Ethical problems can be seen in relation to workloads and in the professional-patient relationship: submitting to pre-determined appointment lengths; approving the pre-treatment plan designed by another professional; charges that are below those laid out in the Federal Dentistry Council -*Conselho Federal de Odontologia* (CFO); owners and/or administrators with no training in the health or dentistry area, driven by commercial interests; contracting newly-graduated workers in a situation of exploitation.

As in the field of health, production and consumption are simultaneous, in other words, the effects of the work itself transform it into a tangible, saleable good producing profit on capital, the very act of working in the private sector transforms itself into merchandise - producing profit. Marx emphasized that the mercantile relationship between buying and selling is the fruit of a social relationship, therefore, “[...] the activity of service in capitalist relationships can be productive if it results in adding value to the capital, that is, it transforms itself into

goods capable of producing surplus value” (Pena; Minayo-Gomez, 2010, p. 374).

The hegemonic thinking that the market will regulate democratic access for all collides in a type of clinic constructed based on a competing entrepreneurial/commercial vision. A reality seen by professionals as ethically inappropriate to private service.

“[...] the market regulates it, everyone can earn money honestly. I just see that in the popular clinics, the bigger ones, the owners are thinking about money, it is a business, I don’t know what the middle way is” (P10).

This new style of clinic sells the consumer dream of specialized aesthetic dentistry that would meet the oral health needs of those on low income. However, it often fails to solve technical and human problems adequately or meet working conditions: “[...] falls in prices are often accompanied by falls in quality” (CFO, 2013, p. 3). Some proposals are based on this type of investment in dentistry: 1) the real need of those on low income who have risen to become a consumer health market (social classes c or d) (CFO, 2013); 2) mass advertising aimed at excellency in private health; 3) little individual autonomy associated with lack of specialist knowledge and social vulnerability (Gonçalves; Verdi, 2007); and 4) the target population’s restricted access to demanding their rights

“[...] a patient from the private sector came to be treated - we are not in a position to judge but apparently, from the story - the professional was a bit sloppy, so that the patient is going to lose the tooth. Public sector professionals used to be known for doing shoddy, half-hearted work, but now I see them (as very much the same). I don’t know why, the number of professionals increased greatly and these popular dentistry networks and they work based on output, there are a lot of professionals whose work is not of good quality, and today I see similarities in between the public and private sector” (P10).

The productive standard of the “popular” clinics appear to encourage dubious quality which,

associated with fast service, is similar to a large part of professionals working in the public sector throughout the history of Brazilian dentistry - questioned nowadays for reconstructing the parameters of dental public health. A reality of precarious paid work which, in spite of this, is still experiencing a utopia of liberal practice, dissociated from a broad clinical vision and reflexive and critical know-how - with the active participation of the professional in the social context (Santos et al., 2008).

According to Cavalcanti et al. (2011), private dentistry in Brazil is going through a time of transition: from providing services based on the professional-patient confidential relationship towards mass services, especially after the 1980s, when the practice was subsumed by consumer interests. A professional profile was introduced that damaged dentistry ethics, demonstrated in the elevated number of cases with Procons (small claims court) and professional councils, based on violated consumer rights.

Incorporating a universalizing and transforming meaning in ethical professional-patient mediation appears to be central in order for these singularities to be more than just receptacles for the ideology of hedonistic ethics or ethics limited to responsibility in a business/institution: a behavioral code of pre-defined actions according to functional objectives to which the professional submits. But, within the micro spaces of power, what is reproduced are social contradictions and pluralities, without foregoing an ethical agent as the subject of the processes, “[...] as a rational, conscious being who knows what they are doing, being free to decide and choose like a responsible being who answer for what they do” (Chauí, 2011, p. 379).

Dentistry, as a differentiated health care service of mere commercial activity, mediated by ethics in the professional-patient-health care system relationship, without being highlighted in the collective debate surrounding the dentistry code of ethics. Significant changes in the new code of ethics, enacted in late 2012, are also directed at entities operating within the dentistry ambit - use of the word “popular” associated with the clinics activities being banned. However, in spite of this, these actions do not appear to have been sufficient due to: excess of workers and the work (good)’s strong potential for surplus value;

substantial social inequality which means access to dentistry remains expensive and restrictive; a public system with high demand; and the lack of space for a broad ethical/bio-ethical debate, approaching contemporary inter- and trans-disciplinary problems health care problems (Garrafa, 2006) such as the new realities of precarious work and the ideological role of the market in intersubjective relationships in health care.

Some challenging issues remain: 1) the leading role that professional councils should play in monitoring the ethics through the frameworks of the new dentistry code and in the collective ethics/bio-ethics debate about the new work relationships that subsume ethics to market interests; 2) the actions of unions in defending workers’ rights in this new configuration of dentistry work; and 3) the regulatory role of the ANS and health monitoring in the functioning of “popular” clinics.

Inter-peer relationships

Perhaps the most accurate and, at the same time, most striking portrayal of the decades of liberal dentistry hegemony in Brazil is in inter-peer relationships. Constructing a competitive inter-subjectivity in forming professional identity, now amplified by the complex competitiveness resulting from the restructuring process, follows three intertwined paths:

- 1) Highly competitive subjectivity constructed in a saturated work market and training directed at clinical-liberal-individual survival in this reality:

“[...] there are lots of colleagues who criticize the work of others, to earn more money, to capture patients, this happens a lot” (P4).

Autonomy in the moral sense related to ethical values is losing space to autonomy based in a technical vision of the profession (Freitas, 2007).

- 2) Ethics subsumed by the need for profitability:

“[...] I know examples of colleagues who use acrylic, telling the patient it is porcelain... the patient is very upset with the dentist when they discover they’ve been tricked” (P6).

A specialist know-how seems to be used in the special professional-patient relationship to manipulate the patient in situations in which private interest substitute the ethical commitment needed to construct dialogue. A construct that undermines inter-peer trust and commitment: in constructing the professional and self identity.

- 3) Inter-peer resentment: towards the other as an equal and towards the other as a collective:

"[...] the dentist views the other as an enemy, seeming to take away their professional space... I have colleagues who start to treat you strangely when they find out you're a dentist. This happens in the building where I live, in the building where I work; I think that a dentist can't be friends with other dentists, he may make conversation and be friendly, but I think there is another feeling behind it" (P3).

Throughout its history as a professional category, the dentistry professional has never been encouraged to develop the feeling of being part of a while, a collective, of a social reality; on the contrary, they were educated within competitive strategies in an individual-healing model. The professional is constructed as a narcissist, perceiving others as threats to their own performance. Lack of collective activity does not empower an atmosphere of solidarity or commitment to one another: achieving higher positions, improving status, getting one over on the others are all discourses constructed as an ideology. The world after productive restructuring under the aegis of the market is one of insecurity, product of precarious employment, associated with the strong relationship between power and knowledge subsumed by interests, providing a fertile soil for growing inter-peer resentment.

According to Ceccim et al. (2009), the profession's meaning is forged in the liberal-privatist imagery and anchored in health care teaching in a concept marked by individual attendance and based on the diagnosis-prescription diode in which the disease is the reference and the biologicist-cure, the paradigm. A successful professional is part technical and/or specialist know-how; part autonomous and hermetic power of the consultation; with up-to-date technology; pragmatism about survival in the market; and

class status. A subjective professional who rejects *a priori* any public regulation seal of approval, and views such regulation as a function of the market itself, centered around the figure of competence and competition and with productive excellence the differential.

For Milton Santos (2011), nowadays the old rivalry is substituted by a type of competitiveness that goes as far as eliminating any form of compassion in the struggle to beat the other and occupy their place. Love, solidarity and commitment lose ground in the growing value of the socially uncompromised I. The ethical problem of inter-peer relationships in forming professional identities is uncovered as a significant milestone in constructing an individuality isolated from social contexts and realities and in market-governed relationships.

At the same time as a more reflexive individual is requested to exercise ethical-cognitive abilities in making decisions and choices, the appropriation of human subjectivity into the restructuring organizational molds - individualization to increase competitiveness/productivity and insecurity because of work relationships - require the atomized adherence of a new type of worker, based on the ideological tempest of market values, expectations and utopias (Alves, 2011).

The ethical challenge between singular and universal, to which humans are exposed by the very presence of others, are being dismantled and individuals are increasingly seeking to liberate themselves from previously socially standardized (socialized) human behavior, transferring them to the political sphere of individuals loves. A great contradiction that results in accepting a relativization of ethics at any given moment, taking refuge in ethics limited to the particular interests of a group or company or in the hedonistic ethics of socially and historically constructed categorical imperative duties (Cortina, 2009).

An individualization that results in constituting the other as a thing, a direct consequence of competitiveness and social ascension at any cost, transforming affective and ethical relationships into relationships subjugated to having. Following the principle of maximum pleasure means an attitude sustained by the promise of infinite consumption.

A process that makes each of us responsible for setting our own limits, as if by a reflexive instinct: the private overtaking the public in an eternal annexation. Ethics, as well as perceiving the human in the relationships in health care, becomes more subjected to the immediate interests of the market/production/consumption. Together with the human need to refer to themselves in a collective in order to cover the uncertainties of life, traditional inter-human ties lose their institutional protection and become transformed into an obstacle to be overcome.

For Bauman (2011), resentment appears not only in a hierarchical relationship that cannot be recognized as such - because this recognition means accepting inferiority -, but also as a feeling between equals. In order for none to affirm and define oneself in a relationship of similar social positions, the subjects are led into an arduous struggle to reach the summit, knocking down those below. Resentment results in competition, in a struggle to redistribute power and prestige, and this can be felt “[...] at least by members of the middle classes among themselves, inciting them to compete feverishly for similar achievements, to promote themselves, at the same time as they degrade other like them” (Bauman, 2011, p. 43).

A type of behavior in which wealth and opulence based on conspicuous consumption enforces the humiliation of those without the same purchasing power. It is seen as strange if the other does not establish this consumerist pursuit as the standard of normality. Ethics loses ground to relationships scarcely filled with fraternal ties or commitments. Especially at a time of professional crisis, in which the liberal-privatist logic no longer supports the idealized status, the condition of being respected by one's peers, deriving from the conclusion that what I do or think does not make a difference only for “me”, is discouraging. If there is no mobilization of willingness to construct collective projects, the still hegemonic processes of individualism and conformism prevail.

A new critical and reflexive ethos, as a result of new work and education configurations in oral health, is needed to break the persistent distance between humanization and technical/specialization, in both the private and public sectors, forging

a differentiated reflexivity of standards seen as: 1) ethical protectionism: walls of silence construed as a false “commercial loyalty” between peers, contrary to the precepts of the code of ethics and forged by reluctance to “[...] inform the user that the treatment provided by a colleague” does not follow “[...] the appropriate technical norms” (Amorim; Souza, 2010, p. 875); and 2) subjective precariousness: marked professional individualization in the private/liberal framework - made absolute in market oriented technical excellence - constructing the individual's incapacity to view himself as a collective subject, in socially constructed precarious work relationships (paid or otherwise) and as a potential catalyst of change in this progress.

According to Žižek (2011, p. 93), it is only possible to conduct *self* in a relationship belonging to a community; one can only be truly universal “[...] when one is radically singular, in the interstices of communal identities” as participating in the universal dimension of the public sphere takes place “[...] exactly as with singular individuals extracted from, or even opposed to, substantial community identification”. There is, then, an individual and collective need for reflection on work in health care, such as valuing a new collective space in constructing the “individual self”, committed to the other and to the social transformations required by this commitment: “gentrification” (Freire, 2008).

Transformations linked to collective oral health: constructing excellence for public dentistry as an ethical problem

“[...] I don't trust those professionals who work one way in public health and another way in private practice. Putting in more effort in the private than in the public... No, I think that we need to take the same care because, if not, you can get into bad habits that you end up carrying over to the private sector too” (P4).

A variety of ethical problems can be seen in automatically incorporating the traditional liberal and market logic as a hegemonic idea in public

health care services too. Despite the crisis, private dentistry is still the reference for good practice, satisfaction and professional success. According to Narvai (2006), the historic debacle in attempting to construct an oral health care service wrought incrementally from public health dentistry, used in order to eliminate accumulated needs and aimed at schoolchildren, has not advanced public dentistry. On the contrary, “[...] public health dentistry had the historical task of producing dentistry practice that breaks away from commercial dentistry - and it failed” (p.143).

“[...] If I wasn't here today, doing what I do, I'm not sure that there would be someone else, similarly qualified or as good as I am at this type of service. That's quite worrying; normally, in public health care services, the idea of dentists is as a spring board or a temporary support, then you get a private practice and sort your life out financially” (P1).

The democratization of access to oral health is a commitment to another - unknown - and this can be seen as a significant ethical problem in oral health today. The duality of interests in the public-private mix reinforces the idea of the private-liberal service as status and financial gain, and public service as a guarantee of stability and employment advantages. Knowledge from university appears as practice of social class, and the profession is identified with capital instead of with labor (Ceccim et al., 2009). Values which construct inter-subjectivity in which the public sector is indirectly or directly aimed at those who cannot pay for care within the liberal contract framework (the poor) and, therefore, are without the power to demand good service. A process constructing a feeling undervalued professionally in relation to collective dentistry which makes room for questioning the quality of activities, although these are very rarely if ever (self)questioned. It builds a naturalized evasion of responsibility in the public sector that affects commitment to each other and therefore ethical mediation guided by “norms.”

“[...] in the public service there is lots of pushing. I notice professionals who don't want to work, referring the patient to others. I think this is unethical,

not towards the other professional but towards the patient” (P4).

However, consolidating an exclusive collective of public oral health professionals, although the minority when faced with the hegemonic labor market in Brazil, encourages a space of know-how that can be ethically and politically reconstructed as a space for reflection. A feeling of professional inadequacy is being constructed in which the collective health care professional questions the introspection of the private logic, contrasting the desire for status and social climbing of the liberal idea, in a new format of collective identity. Professional excellence directed at the right to health as the citizens' achievement and in different bases of the exclusive market constructs, comes to mean professional transformation, under new work paradigms: team work, inter-disciplinary, non-biologist, non market oriented, comprehensive and participative.

“[...] I believe that the trend is for improvement, and it is up to the dentists to demand this” (P9).

“[...] for me, working in the public sector is much more interesting, more gratifying, because of the greater contact with people, the greater numbers of patients, the greater numbers of professionals involved, because it's a big team... in public health, there is obviously more human contact” (P2).

The ethics of “it is what it is” are transposed onto the ethics of “what should be” - historically constructed professional, without renouncing collective and transforming horizons. An epistemology referring to buccality transcends mouth and teach, based on the relationship of the individual himself with the world, is required together with transformations in the naturalized multi causal - biologist style of thinking, and may represent a reconciliation between dentistry and the clinical sphere and later “[...] with society and with oneself” (Bottazzo, 2006, p. 15).

An epistemological transition that, initially, collides with a humanist perspective reduced to the meaning of productivity/cure also within the framework of collective dentistry - by the mismatch existing between social needs and breadth of coverage. A new construction further complicated by

structural and financing problems in the system and poor professional commitment beyond the bare minimum. Incorporating humanizing actions into the collective does not occur without a policy of valuing the health care professional - including monetarily; of investing in professional job satisfaction; in the debate around ethics of responsibility based on the uncovered need of an engaged ethical-political work; and of management which shares spaces of autonomy with the subject/professional in carrying out their actions, uncovering an inter-subjectivity upon new bases: a collective and participative logic, conditions favorable to ethical mediation between professional-patient/user-health care system and subject-community.

Changes requested in training based on the competencies incorporated from the Law of Education Guidelines and Bases and National Curriculum Directives highlight how important it is for the student to “[...] cultivate a new relationship with the community, based on attention, trust, respect and care” (Costa; Araújo, 2011, p. 524). However, they also reveal commitment and valuing teaching that fall short of the objectives and possibilities of humanist, cultural and political education, didactic guidance, teaching-learning scenarios, as well as “[...] in relation to ethical disciplines and teacher training, because of the incipient presence of bio-ethics” as a discipline and cross-sectional topic (Finkler; Caetano; Ramos, 2011, p. 25).

Many advances have already been made in oral health, demonstrated by the diversified data after implanting oral health strategies and teams, such as the falling numbers of the population who have never been to the dentist (from 18.7% in 2003 to 11.7% in 2008); the substantial increase in coverage in the area of specializations (958 CEO in the country, with provision extended to 101 thousand prostheses in 2009); increased prevention and control activities (prioritizing 1,242 municipalities with poor development indices for elementary education, totaling 72.6 million oral health kits); a jump in care coverage (from 35.8 to 91.3 million individuals seen); and establishing oral health teams (in 85.3% of Brazilian municipalities), among other achievements leading the way in a new oral health profile in Latin America

(Narvai, 2013). Great difficulties remain, however, in effectively engaging the professional collective in planning and managing activities, in the teams and inter-disciplinary activities and in co-participative activities with communities.

The role of health councils in social control and in constructing a space for a modern ethical/bioethical debate should take place not only from the perspective of allocating resources guided by the principles of justice and protection (Petry et al., 2010), but also as a space for “de-reconstruction” of professional practice. Wider clinical practice, committed to social needs and patient/user wants remains an ethical-political problem today. Commitment should be sought in building links and autonomy with the patient/user, in sharing know-how, as well as in perceiving the scope of every day practices in emancipating subjects and making them co-responsible (Santos et al., 2008). An oral health mode, according to Gastão Wagner, that should combine “[...] clinical and epidemiological objectivity with the singularity of the subjects’ groups’ and collectives’ history” (Campos, 2013, p. 66), following the new, humanized commitment of the subject-professional-human being.

Final Considerations

Several aspects of the productive restructuring in dentistry construct a precarious reality in the professional work market: 1) amplifying the market of private health plans and insurance guided by a perverse reality: selling the illusions of liberal work, but functioning under the aegis of control and outsourcing services interposed in the professional-patient relationship; 2) forming a tier of paid professionals, especially in the new type of “popular” clinics; 3) incorporating an individual-narcissist inter-subjectivity and competitiveness in the professional identity, arousing inter-peer resentment. New work realities pose various contemporary ethical problems.

Even with the hegemony of a liberal-competitive identity, the expansion of dentistry services by forming a collective operating exclusively in public health strengthens an ethical-political movement and

epistemological transformer: a professional collective oral health space with socially constructed need which, in this condition, transforms the professional reality objectified in health and education policies, and subjectified in a new humanized excellence, in a new collective identity. The path towards dentistry committed to citizenship achievements is extended and the professional appears to be taking on the role of a protagonist as the subject of this process.

However, some myths imported from market logic still have an impact on constructing this new inter-subjectivity: 1) public services as a synonym of treatment aimed at those who cannot pay (the poor) and who thus do not have the same rights; 2) the incipient incorporation of new collective paradigms in trans- or inter-disciplinary team activities and planning; and 3) timid steps taken towards new fields of action in administrative or managerial positions.

As a result, an expanded clinical practice and in consonance with social needs and user wants, in a different sense from dentistry in the market, still facing problems concerning taking responsibility, inclusion and participation on the part of both professional and user as subjects of the process. Collective dentistry continues to be supported by traditional curative/functional know-how, which is now inter-disciplinary and preventative. However, a technical and aesthetical quality with collective/community participation as a base for humanization itself, should follow a different path from that of dentistry limited to cure/functionality, aiming towards incorporating ethics and aesthetics not subsumed by market ideology, but rather in a citizen-professional-inclusive space within the service as an inter-subjective space.

Thus, changes to training and education in order to construct this new excellence have been shown to be insufficient without a policy that values the professional in collective oral health, investing in job satisfaction and in extending the spaces for the ethical/bio-ethical debate, not only in singular professional/patient mediation, but based on a newly uncovered need for commitment to each other - to oneself, to the collective and to history:

Collective meaning still appears uncharacteristic in dentistry, discredited and invisible in the

individualized atmosphere of the consultation, however, its expansion could break with the professional-consultation atomization and bring the service closer to social reality so as to create citizens with the right to health and diminish the distances between subjects' real needs/wants and the health care system.

A debate articulated in spaces which go beyond the consumerist impositions of modern life - impregnated with a market ideology that contaminates the construction of needs and desires - needs to be created in restructuring oral health output, for a new ethical and aesthetical excellence as a collective/social project.

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Authors' contributions

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