


“I rather have someone handling my heart than my mouth”: reflections on oral health care


“Prefiro mexer no coração a mexer na boca”: reflexões sobre o cuidado em saúde bucal

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Abstract

This article shares reflections on oral health care that emerged from the dialect relation between professional practice and theoretical research. It interrogates the concept of care disseminated by the biomedical discourse, in which care is a technique geared towards cure. We believe care to be an ontological dimension, an intrinsic characteristic of the human being from which they constitute themselves in the world. As such, we use the notion of buccality to situate the mouth as a territory that take part in the social production and reproduction process, completely penetrated by the culture and psychism. The mouth is, therefore, socially produced—a body-territory endowed with subjectivity that is crossed by multiple experiences throughout life. Hence, dentistry’s concept of care fails to encompass oral health care in all its complexity, making it necessary to renounce an odontological *a priori* to understand that people’s socio-historical realities and experiences are materialized on their mouths, making room to understand care as an intersubjective encounter crossed by potent and transformative affections.

Keywords: Buccality; Affect; Oral Health.

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Resumo

Este artigo tem como objetivo compartilhar as reflexões sobre o cuidado em saúde bucal produzidas a partir da relação dialética entre a prática profissional e as pesquisas teóricas. Propomos a problematização da concepção de cuidado difundida pelo discurso biomédico, que o remete a uma certa tecnicidade voltada à cura. Apostamos no cuidado em sua dimensão ontológica, como característica intrínseca ao ser humano, a partir da qual os sujeitos se constituem e se realizam no mundo. Para tanto, utilizamos o conceito da bucalidade para localizar a boca humana enquanto território que está inserido no processo de produção e reprodução social, sendo completamente penetrado pela cultura e pelo psiquismo. Apresentamos, portanto, a boca que é socialmente produzida, um território-corpo dotado de subjetividade e que é atravessado por uma multiplicidade de experiências ao longo da vida. Por esse motivo, a ideia odontologizada de cuidado não dá conta de apreender o cuidado em saúde bucal em sua complexidade, tornando-se necessária a renúncia ao *a priori* odontológico, compreendendo que é na boca em que se materializam as realidades e experiências histórico-sociais dos sujeitos, abrindo-se espaço para o cuidado enquanto encontro intersubjetivo atravessado por afecções, com enorme potencial transformador.

Palavras-chave: Bucalidade; Afeto; Saúde Bucal.

Introduction

A woman from Pernambuco, about 60 years old, seeks oral health care in a Basic Health Unit (UBS - *Unidade Básica de Saúde*) in the South region of Brazil. During a first conversation, she tells about her migration process from Recife to Santa Catarina, also talks about her experience in her current city and mentions about her offspring and some problems she has been facing with one of them. The need for a cleaning of her teeth had motivated her to go to the UBS in search of a dentist. When I suggested that we put the dental chair in position to start the service, she immediately said: “Son, I must tell you that I am afraid of dentists. I’d rather have someone handling my heart than my mouth”.

At first, the statement provided an atmosphere of relaxation and laughs, but then it was used as a starting point for questioning and reflections. This paper aims to share reflections that are the result of the dialectical relationship between theoretical studies and daily practice. The title of the article draws a line connecting these reflections: how to produce care in oral health when the performance in this field is closely linked to unpleasant situations? For this reason, it becomes imperative to think about how we have conceived care in healthcare, more specifically in the field of oral health.

Commonly when addressed by the health field, care is referred to a set of therapeutic measures and procedures, a kind of technicality aimed at cure. Thus, care is embedded in an individualizing and interventionist rationalism, completely captured by the biomedical technicist logic. This technicality is what constituted dentistry as a profession in the 19th century, and it would not be surprising if oral health care was referred to the numerous procedures of surgery, dentistry and prosthetics (Ayres, 2004; Botazzo, 2000).

This article proposes lines of escape from biomedical care, speaking of cure, treatment, and control, because we believe this static and objectifying care empties an intrinsic characteristic of the human being. Caring, therefore, is not about building an object and intervening in it. We believe in the production of care from the encounter, considering that subjectivity is ipseity, that’s why it is built in

the experience of the encounter with otherness; an encounter crossed by affections, with a rupture in the established subject-object relationship, allowing subjects to constitute themselves together in act, crossed by their existential territories, their histories, and desires (Ayres, 2001; Franco; Hubner, 2019).

Thus, we present this critical and reflective text, structured in three sections: the first one aims at discussing the construction of medical knowledge and its conception of care, which is subjected to serialized and specific techniques. The next section is dedicated to discussing the mouth beyond the biological field, understanding it as a social territory inserted in the processes of production and social reproduction. The last section seeks to rescue care as a central category of human life, taking it from the intersubjective encounter.

Care trapped by Biomedical Discourse

In the health field the biomedical discourse is hegemonic, capturing the notion of care by referring it to a set of technical and individual actions. This discursive hegemony is the result of the historical process of conformation of scientific medical knowledge which, like all discourse, is directly linked to desire and power. The production of different discourses translates power relations and systems of domination, configuring themselves as their own regimes of enunciation. In this context, medicine constructs its discourse on health, disease and care based on the interweaving of different elements: the status of those who speak – based on the experimentation of knowledge; their position as subjects who observe, touch, describe and name; an institutional and technical space from where they speak (Foucault, 1996; 2008).

The medical discourse on life processes also operates mechanisms of control, interdiction, exclusion, and coercion of other enunciations. Medical knowledge defines the correct ways of living life and assumes the responsibility of caring for people, using its framework of practices and techniques. Care, therefore, is reduced to a process of objectification, guided by normative conceptions of what is configured as health or disease. The medical compass guided by the notion of norm imposes

a certain stability on health and, consequently, the concept of health is constructed as a value to be desired: to be healthy, strong, resistant, reproductive, and productive, while to be sick is seen as something harmful, undesirable, socially devalued (Canguilhem, 2009; Foucault, 1996).

Health, for the French physician and philosopher Canguilhem, is the ability to institute new norms in new situations, while deviations from the norms – the **abnormalities** – are not necessarily pathological, because, as the author recalls: “pathological implies pathos, a direct and concrete feeling of suffering and powerlessness, a feeling of life thwarted” (Canguilhem, 2009, p. 53). Thus, the search for care appears as a need from the point in which the subject feels the need, since he who determines, from his subjective experience, the point of passage between a state of health and a pathological state.

The dentist’s office, as a historical derivation of the physician’s office, is a space guided by supposed objectivity, which ends up obscuring the subjective crossings – the fears, anxieties, projects, and desires – extremely relevant for the production of care. This concealment is the result of the division operated by health establishments and the biomedical discourse. Since they delimit the outside and the inside: on one side, the subject and his discourse, related to the private sphere, of his subjective and singularized perception about life, health, and disease; on the other side, the discourse of the health worker who, in a process of objectification, is responsible for translating and building a narrative about the other in a public sphere. This meeting is permeated by power relations, in which the health professional, occupying a place of domination, is responsible for determining what fits (or not) as a health need. While the maximum objectivity is sought, the subjective content of the encounter is placed in the background (Botazzo, 1999).

The preference for “handling my heart than my mouth” says a lot about this subjective field, which is often forgotten in the impetus of the objectivity of clinical practice. For that woman, the experiences lived with her body built a way of giving meaning to dental care. Despite the signifiers of anguish and displeasure, the subjective perception of a need led her to seek a health care facility in order to find

a resolution to her issue. Despite the importance of this subjective perception, medicine built its discourse from a place of power that, in a process of objectification, operates the desubjectivation of the other, transforming him into a deviant object that must be reestablished in its norm, regardless of the experiences that conform the subjectivities of these subjects. In this way, health care ends up taken by the incessant search for cure, the return to a kind of normativity (Canguilhem, 2009).

This rigid way of meeting with people that scientific medicine has consolidated is the result of its conformation as a knowledge-power throughout history. Foucault (1999) discusses the consolidation process of this medical conformation during the moment of rise of the capitalist mode of production in Europe, when the human body was taken as a target by the power devices, since this body was the one that produced (and still produces) the value extracted by the capitalist. The philosopher points out two mechanisms of power that articulate each other. On the one hand, a disciplinary power focusing on the individual body, which must be trained, watched, and used in the best possible way, increasing its useful force and optimizing its productive capacity. On the other hand, a power considering life and targeting the man-species, seeking to ensure not a particular discipline, but a regulation. According to the author, the action of these mechanisms happens in a way that:

[...] Discipline attempts to control the multiplicity of men insofar as this multiplicity can and must result in individual bodies that must be watched, trained, used, and eventually punished. And then, the new technology that is installed addresses the multiplicity of men, not insofar as they are reduced to bodies, but insofar as it forms, on the contrary, a global mass, affected by processes of the totality proper to life, processes such as birth, death, production, sickness, etc. (Foucault, 1999, p. 289)

In this context, medicine plays its role in the centralization of information and normalization of knowledge, positioned in a function of “education” of the population, with an action based on control and

medicalization. The orientation toward the notion of the norm instrumentalizes medicine so that it exercises an anatomo-politics of the individual body to be disciplined, as well as the biopolitics of the populations to be regulated. The human body, taken as a biopolitical subject, has its various spaces scrutinized, disciplined, and controlled. The field of health enters all spheres of social life, setting norms of sociability and determining acceptable ways to live life. Not surprisingly, health services are structured as environments in which a specific pedagogy, highly prescriptive and normative, ignores the real possibilities of the subjects (Foucault, 1999).

The configuration of the office and the dental care, in particular, carry the appearance of intervention, considering the originality of dentistry was built on the basis of a specific technique. This space constructs an organization that delimits a hierarchy both in the symbolic and the concrete field: the one who sits in the dental chair is placed (by others) in a supine and inferior position. This conformation explains a lot about the discomfort associated with this place, considering that people are in a position of vulnerability - lying down and conscious, being observed by another person who inserts objects in their oral cavity, while a series of touches, sounds, smells, and tastes are produced. It is an encounter crossed by sensations linked to memories and affections, thus conforming ways of giving meanings to that place and to that practice (Botazzo, 1999).

Furthermore, the biomedical field, as a practice covered by a political-ideological dimension, has historically been used by the capitalist mode of operation, having its functions referred to the maintenance of the *status quo* of the bourgeois social order. As it tries to adapt workers to the rhythm of the capital, medicine operates an intense biopolitical management of life, managing, guiding and controlling human actions, habits and values of societies. In this scenario, the biopolitical body has its several spaces scrutinized, disciplined and controlled, and there is no escape from this specific territory called mouth (Donnangelo; Pereira, 1979).

The human mouth is a space of intimacy, in which the everyday pleasures of life in society are satisfied: eating what one feels like, speaking what one feels like, enjoying the desired body. It is also through

this mouth that gases, secretions and smells come out of the digestive tract. In this context, the mouth is a place with multiple functions, and social norms are defined about its adequate use, a normalized use: to speak correctly and only what is convenient, to eat enough with the mouth closed, to be discreet when using the mouth in affective relationships, not to spit or burp in public. Crossed by permissions and denials, in the dental office this intimate mouth is put on full display, which makes room to know how the subjects relate to the world and to their own bodies (Kovaleski; Torres de Freitas; Botazzo, 2006).

The social production of the human mouth

Because it is a space crossed by social norms and moralities, we dedicate ourselves to the discussion about the mouth, treating it as a **territory**, after all it does not represent only an organ or a homogeneous tissue. It is composed of mucous membranes, glands, bones, and muscles, disposed and articulated by a singular physiological synergy, but such anatomical-physiological diversity cannot, by itself, apprehend its social functions, therefore we move away from a merely odontological - or **odontologized** - discussion, as we consider that dentistry, constituted as a biological construct, was historically dedicated to teeth and dental functions. Since its emergence at the end of the 19th century, dentistry has been dealing with an alienated object, an object that is detached from the subject, as it does not take as its object a subject - sick or not - but a specific disease and a sick place (Botazzo, 2000; 2013a).

On the contrary, we think of the mouth as a territory crossed by discourses, since it gains different meanings before the diversity of statements produced about it: from the dental to the psychoanalytical, besides the discourse of the subjects about their buccal experiences. We start from this apprehended mouth in belonging to the human sciences, the one that is socially produced, and that, therefore, has its origin from the detachment of its biological animality, placed in social relations in its process of hominization. The social production of the mouth is connected to the experiences of the body in society. Thus, when the mouth is inserted in the processes of social

reproduction, awareness is raised about the existence of this territory-mouth, its production *in* the world and its action of consumption *of* the world (Botazzo, 2000).

When situated in the dimension of man in society, the mouth is presented by Carlos Botazzo as a sociocultural product from the concept of **buccality**: the ability of the mouth to perform its buccal - and social - jobs. Buccal works comprise **manducation, language, and eroticism**, all of which are part of a continuous and articulated process of production and consumption. In **manducation**, far beyond a mere mechanical and physiological activity, the process of taking in, mashing, diluting, and swallowing the food involves a production that puts in relation the structures of the digestive tract, as well as a consumption that is also a producer of the satisfaction of oral enjoyment. **Language** produces and consumes words - permitted or not; just as in **eroticism**, we produce oral sexual acts in order to consume the other's body. This social production points to the mouth as a territory located between reason and psyche, and thus completely penetrated by culture and the psyche (Botazzo, 2013a).

The multiple cultural and psychic crossings configure the most diverse oral experiences. The woman described in the opening of this article has 60 years of experimentation with her body, her buccal work is guided by culture and psyche - the foods that were part of her life, the accent and expressions learned since childhood, the affective encounters produced in the course of life. This mouth, therefore, goes beyond its static and merely biological function, since being in society it is set in motion, taken also as an object of psychoanalytic discourse, linked to the psychic formation of the subjects. In this context, the human mouth is the means of contact with the world and with otherness, being the territory of the first human experience of drive satisfaction. This process happens when the newborn has an internal stimulus (hunger) that cannot be satisfied by his own actions, and through an external action performed by the mother it is then satisfied. The first experience of human satisfaction is realized through the mouth, or rather, the experience of satisfaction requires a first buccal work, suction, the first buccal enjoyment (Botazzo, 2000; Garcia-Roza, 2009).

The father of psychoanalysis, Sigmund Freud, presented the body beyond its organic constitution, showing that it is also ruled by a psychic apparatus. Using the concept of drives, Freud points to the existence of erogenous zones in the human body, regions that work as sources of partial drives that will constitute the organization of libido. The mouth, as the territory where the first human satisfaction takes place, is presented in its complete erogeneity, when a newborn's sexual drive is satisfied supported by a drive for self-preservation, as Garcia-Roza explains:

[...] In instinctive terms, the suction function has the purpose of obtaining food and it is this that satisfies the state of organic need characterized by hunger. But at the same time a parallel process of a sexual nature also takes place: the arousal of the lips and tongue by the breast, producing a satisfaction that is not reducible to food satiation even though it finds its support in it. (Garcia-Roza, 2009, p. 100)

The human body, beyond its organic functionality, works as a tool to know the world since birth, starting this process of apprehension of the world through the mouth. Through this territory we make our first contacts with everything that constitutes us in the course of life: via the mouth we acquire the liquid necessary for our survival, besides being our first affective bond with the other; and it is also by means of the mouth that we indicate our needs. The subjects' bodily experiences are permeated by memories, affections and desires, shaping the psyche and the different ways to give meaning to the world. In this respect, Botazzo (2013b) made an interesting approximation with psychoanalytic writings and presented us the mouth as a territory of desire, the mouth in its immanence. Thus, its synthesis impels us to understand the centrality of the mouth in shaping the psyche of the subjects, since it is inserted in the processes of production of connections and experiences throughout life, in a movement permeated by culture.

This body that moves through the world does not only carry with it a collection of organic structures, it is the very ground of experience, after all we know the world through our body: "to

have a body is, for a living being, to join a defined environment, to become confused with some projects and to continually commit oneself to them" (Merleau-Ponty, 1999, p. 122). In this movement of knowing the world, the subjects have experiences with their bodies, whether positive or negative, of permissions or denials, but all of them guide the way these subjects give meaning to the world and build, in a very unique manner, their **ways-of-being** in the world. The mouth, inserted in the processes of social reproduction, is the stage for different ways of apprehending the world and, therefore, it is about a territory crossed by multiple experiences that we are dealing with, experiences that together are expressed as buccal experiences, pleasant or not, which finally conform the ways in which subjects relate to the world and to their own bodies (Botazzo, 2013a).

Thus, when we propose to think about oral health care, we take as a starting point the singularity of the experiences of each body, of each subject, the mouth being a territory of intimacy subsumed by social norms. Reflection on oral health care requires questioning the dental discourse that encloses its object within its discipline. When investigating the constitution of dentistry as a specific segment, Botazzo (2000) demonstrates that the dental surgeon's specialty was structured essentially in a way of doing, in a **technique**. The specificity of dentistry would be in the practical interventions of the dentist and would be based on the replacement of teeth or destroyed parts of them (operative dentistry and prosthetics). Thus, the specialty of dental surgeons rested on manual skill, requiring education by the hands and thus forging a "dental science" (Botazzo, 2000; 2018).

Dentistry is the product of the movement that deals with a type of "care" centered on a specific, defective object that needs to be restored to its function by means of a technical procedure, reducing oral health care to a practical, mechanical process. By projecting an object of intervention on the subject, one ignores his experiences in the world, his desires and fears. It is necessary to make room for a care that promotes listening to the subject-patient, that allows access to the motivations that lead this subject to seek a health service, even when it is a potentially anxiogenic space. This does not imply giving up

the techniques, after all, there is no doubt of their importance, but they do not contemplate oral health care in its complexity. For this reason, we question the dental practice, proposing a shift, placing it as part of a broader concept. We think of oral health care from the concept of buccality, understanding the human mouth as part of a process of production and reproduction: it works, produces, and consumes; it is socially produced and socially determined.

The freedom of care

As discussed earlier, medicine has built a pragmatic conception of care in the health field, trapping it in the biomedical model through a biopolitical management of life. With a focus on illness, it is possible to see a great concentration of knowledge and power that limits care to a series of procedures and interventions. However, caring involves aspects of human existence, from ecological and social issues to cultural and political ones. For this reason, we seek to shed light on this care that is beyond that captured in the clinic, a care in its ontological dimension (Boff, 2014).

Contemporary society, guided by neoliberal logic, which acts both on the political-economic level as well as on the subjectivity, has been structuring itself on the pillars of individualism and competitiveness, enclosing itself in itself and forgetting something essential for our existence: care. The lack of care presents itself as a symptom of the civilizational crisis in which we live, because there is an immense neglect of the common good and the lives of others, since the capitalist production process has been devastating populations and the planet Earth. Faced with an obscure scenario, Boff (2014) suggests the construction of a new ethos capable of rescuing more cooperative and solidary forms of coexistence. The author presents care as the central axis of this journey, unveiling its transcendental dimension, recognizing it as a way-of-being, that is, a way in which the subject structures and realizes itself in the world. As the author reminds us, from birth the human being only maintains its existence if care is involved in this process.

The technocratic hegemony in the health field, like an “assembly line”, deals with an atomized object

disconnected from a social and historical context. By ignoring the existence of a subject that carries with it more than an organic body, oral health care is standardized, being reduced to the repetition of a certain mechanics that removes the subjects from a collectivity responsible for putting them in relation with the world. However, caring is more than simply doing; it is an attitude of occupation, concern, accountability, and affective involvement with the other, and in being an attitude, it encompasses a multiplicity of acts. In this context, care takes a distance from the individualistic way of operating life, **since it is produced in a relation**, implying a movement in which the subject leaves himself and starts to focus on the other, guided by an attitude of care in which the importance of the other’s existence is explicit (Boff, 2014).

The mouth as a socially produced territory is intimately connected to the affective experiences of the subjects, whether in the field of education, language, or eroticism. These are foods and recipes that trigger memories, the regionality of foods, words, and accents, in addition to the kisses exchanged with beloved people. It is a territory with a history and experiences in the world that the excessive technification of the care process has not considered. No wonder that woman prefers to have somebody handling her heart rather than handling her mouth. In this context, to think of an effective production of oral health care requires another ethical-political perception of the clinic. It implies understanding that, to produce oral health care, the clinic needs to be seen as a relationship of alterity, in which subjects are constituted in the intersubjective encounter, in which both the objective and subjective dimensions are performed (Botazzo, 2013a).

It is important, therefore, to understand the body as subjectivity, the body as history and memory. The woman whose story opens this article carries with her years of experiences and connections produced over time, which have shaped and still shape her subjectivity. In this way, we talk about mouth-bodies that have been composing encounters throughout their lives, experiencing processes of subjectivation that constitute their ways of giving meaning to reality. Fear is one of the several affections that can be managed in encounters in

health institutions, and care is produced when more powerful affections prevail. Caring is configured as a new encounter that produces subjectivities, a dialectic relationship capable of activating those involved and transforming them, it is a powerful encounter - a real becoming inherent in social relations, a possibility of change (Boff, 2014; Botazzo, 2013a; Franco, 2015; Pires, 2005).

We believe in care as an encounter between bodies and their experiences, since, as Spinoza (2009) questioned, one does not know what a body can do. This Dutch philosopher proposed a parallelism between mind and body: the mind could think as much as the body could act. In bringing this discussion, Spinoza pointed out that the body can be affected in multiple ways, having its potency to act increased or decreased in encounters crossed by **affections**, which are result of the relationship with other external bodies. Human life is structured by conformed encounters with other bodies since birth. After all, we grow and develop from and through contact with others, we exist because we care and are cared for. This power to be affected - the potency to act - is influenced by the **affections** that hit our bodies, being modified according to the way we compose our histories and influenced by our experiences and connections, made throughout our lives (Deleuze, 2017; Spinoza, 2009).

Spinoza's philosophy conceives human beings as the union of a body and a mind, thus constituting unique singularities that are essentially relational, thus presupposing an original interbody and intersubjectivity. For Spinoza, the singularity of subjects is the conatus: an internal power always in action, which can increase or decrease depending on the connections it produces with other bodies, so that in this way it can maintain its power to affect and be affected, that is, to guarantee its self-preservation. The fear that instigated the reflection presented in this article is the product of other encounters experienced by that woman, encounters that diminished the power to act and operate as a block in the production of care. Based on the possibilities of connections, we believe care is effectively produced when the encounter enables the stimulation of affections that increase the subjects' potency to act (Chauí, 2006; Deleuze, 2017).

Dental care, as it is still being conceived, is not able to positively determine the conatus, since it is associated with a mechanical subject-object relationship closed in procedures. In this rigid conformation, the encounter is crossed by **affections** and ideas of negative **affections**, such as aversion, shame, guilt, and fear. The inversion of this relationship happens when we become aware of singularity of the other, for the construction of connections providing the increase of the power to act.

It is necessary to integrate what enters the mouth during the dental procedure and what comes out of it during the process of listening and exchange with the other. Recognize that, besides a specific problem, the subject carries a history that demands a careful and affectionate listening. Therefore, it is necessary to go beyond the alleged objectivity that dentistry has been imposing on oral health care. Such overcoming requires the renunciation of an **odontological** a priori, of a rigid conventionality, which starts from human teeth and the phantasmagoric image of dental caries as a justification for the search for oral health care. We know that this is difficult to overcome and, as Botazzo reminds us, it would require: "another theory on buccal disease, another conception of the dental clinic", thus admitting the need for "another semiotics, another look, another hand, another mind" (Botazzo, 2013c, p. 281).

The rupture with the **odontological** a priori, therefore, makes room for the encounter between subjects. Botazzo emphasizes that the clinical case is constituted in the **anamnestic contact** between patient and health professional. More than this, subjects are constituted in the encounter with the other. By renouncing the clinical *a priori*, the oral health professional makes room for listening to the other and lets the story told by the patient be the guide to the diagnostic and therapeutic process. When guided by the concept of buccality, listening to what the other has to say about the history, oral experiences, and real possibilities to perform buccal functions allows the localization of the need of the other in a social and historical context. Oral health care implies assuming the mouth as the territory where the realities and historical-social experiences of the subjects are materialized, which means confirming the possibilities for their mouths to do

their jobs, thus realizing themselves biologically, socially, and psychically. In other words, it is about making room for the mouth in its capacity to be mouth (Botazzo, 2013c, 2013a).

The space for listening makes it possible to recognize the existence of the others in their singularity, forging an alternative for the joint construction of a change. Being open to what the others bring with them - stories, experiences, projects, and desires - allows us to negotiate a therapeutic project centered on the subject, considering material and subjective possibilities. To loosen the bonds of technique is to invest in a care capable of recovering the autonomy of the subjects, as well as their own humanity, since this means giving up treating a static object and adopting a posture of care in its ontological dimension. It is necessary to recognize the affections acted in the encounter and give voice to them: what is the origin of that woman's fear? What experiences produced it? What motivated that woman to seek the service, even with fear? How has she been doing her buccal work, or even, what has been impeding her from doing it? What possibilities can be built with her so that other affections can be brought up and make her more comfortable in that space? Care, as a producer and transformer, requires open and qualified listening, which contributes to its singularization:

[...] care needs to be dynamized as a reconstructive practice of the subjects' autonomy, as long as the local/global conjuncture and the correlations of forces for any pretension of change are considered. It is necessary to inaugurate new ways of understanding, interacting, and relating to the other (knowing the other as part of me), developing more shared actions of help and power in the health field. (Pires, 2005, p. 1034)

In this way, dental procedures would no longer be inserted as a simple technique or repetition of mechanical acts in an ahistorical object, but would be provided with meaning, since they would be supported by the experience, history, and social reality of the subject. When we think about the mouth as a body and as a territory supporting social

relations, a dental restoration, for example, ceases to be the end of the care process and becomes the means through which some of the subject's oral functions are recovered. Because we understand that besides recovering a dental part, we are in relation to subjects who are, before anything else, historical beings and beings of relations, recovering also their possibility of continuing to produce social relations and relations with their own bodies, thus realizing themselves as a way-of-being in the world (Botazzo, 2013c).

Final considerations

Reflection on oral health care allows us to balance the established and to outline other alternatives. We start from the understanding that the biomedical discourse has historically treated care with a certain objectivity, imposing a subject-object relationship and using mechanisms that impoverish the multiple possibilities that emerge from the encounter between different subjects. Contrary to the hegemonic idea of care in the health field, we call for a perspective of care in its ontological dimension, understanding that care is a central characteristic of the human being, since through it the subject is constituted and realized in the world.

We understand that the technocratic conception of oral health care is unable to capture its real possibility of production, because the objectivity linked to the mechanics of dental care ignores the fact that care is produced in relationships. For this reason, we propose the renunciation of the **odontological** a priori and the approximation with the concept of buccality, based on it we locate the mouth as a territory of experiences and social relations. This change of paradigm calls into question the biomedical discourse that has predominated since dental teaching, which operates on a productivist and market logic. It is necessary to make room to think about oral health as socially produced, when the subject that gets sick is not reduced to a defective object, or a tooth, a caries lesion, a restoration, or a prosthesis. The subject is a historical and relational individual, crossed by experiences, desires, and life projects that must be considered to effectively produce care.

Thus, we propose to think of care as an encounter that produces multiple possibilities. By presupposing an original interbody, we reaffirm that subjects produce themselves in relation to the other, composing encounters that can increase or decrease their life potentials. To think of care as an encounter is to understand that subjects always seek to compose good encounters, and that care in its ontological dimension is configured as an attempt to deconstruct relations of power and authority in order to expand the possibility of rebuilding the autonomy of subjects, increasing their power of action toward emancipation.

To renounce the **odontological** a priori is to make room for the multiple possibilities that the encounter can produce, is to understand that, as Deleuze states:

[...] Every body extends its power as far as it can. In a sense, every being, at every moment, goes to the extreme of what it can. What it can is its power to be affected, which is necessarily fulfilled by its relation to others. (Deleuze, 2017, p. 300)

In other words, people who seeks an oral health professional is seeking the possibility of increasing the potency to act, even in situations that often remind them of bad experiences. It is this will to increase the potency of life that made the woman cited at the beginning of this paper leave her home in search of oral health care, even though her body carried experiences and memories responsible for producing her fear of the dentist, an affection so strong as to make her prefer “to have somebody handling her heart than her mouth”. Therefore, health professionals must shake the institutions and believe in the possibility of composing these good encounters, which are capable of summoning more powerful affections, producers of a transforming care.

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