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ORIGINAL ARTICLE

The dentist 'without high-speed instruments': Oral health care in the SUS during the COVID-19 pandemic

O dentista 'sem motor': cuidado em saúde bucal no SUS durante a pandemia de covid-19

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ABSTRACT This study analyzes how the COVID-19 pandemic context affected oral health care in the Unified Health System (SUS) in the state of São Paulo. It was carried out in two stages: an online structured questionnaire aimed at municipal health secretaries and open interviews with 33 managers, 19 health service coordinators, and 7 SUS workers, in two Health Regions. The results are presented and discussed in three moments—suspension of activities, reconfiguration of the dentist's work during the pandemic, process of resuming care—and analyzed according to the concepts of collective oral health, bucallity, health care, health work process, interprofissionality, amplified clinic, comprehensive health care, and instituted-instituting process. The pandemic context emerges as an analytical moment for reorienting oral health care practices and allows us to reflect on the need to expand the clinic and the work of dental surgeons beyond the office and dental procedures.

KEYWORDS Oral health. Comprehensive health care. COVID-19. Unified Health System.

RESUMO *Este estudo analisa como o contexto da pandemia de covid-19 afetou o cuidado em saúde bucal no Sistema Único de Saúde (SUS) no estado de São Paulo. Foi realizado em duas etapas: questionário estruturado on-line direcionado a secretários municipais de saúde e entrevistas abertas com 33 gestores, 19 coordenadores de serviços de saúde e 7 trabalhadores do SUS, em duas Regiões de Saúde. Os resultados são apresentados e discutidos em três momentos – suspensão das atividades, reconfiguração do trabalho do dentista durante a pandemia, processo de retomada dos atendimentos – e analisados à luz dos conceitos de saúde bucal coletiva, bucalidade, cuidado em saúde, processo de trabalho em saúde, interprofissionalidade, clínica ampliada, integralidade e processo instituído-instituinte. O contexto pandêmico emerge como um momento analisador para reorientação das práticas de cuidado em saúde bucal e permite refletir sobre a necessidade de se ampliar a clínica e a atuação dos cirurgiões-dentistas para além do consultório e dos procedimentos odontológicos.*

PALAVRAS-CHAVE *Saúde bucal. Assistência integral à saúde. Covid-19. Sistema Único de Saúde.*

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Introduction

Since 2004, there is a new state response to the oral health problems of the Brazilian population with the Política Nacional de Saúde Bucal (PNSB – National Oral Health Policy), called Brasil Sorridente, whose priority components were the expansion of the Oral Health Teams (OHT) in primary care and the organization of specialized care[1]. Thus, one can see a growing expansion of the offer and potential coverage of dental services in the Unified Health System (SUS), especially in the Family Health Strategy (FHS) and in the Dental Specialty Centers[2], reaching 40,839 OHT in Brazil in July 2024[3].

The expansion of access and coverage did not necessarily translate into transformations in oral health care practices, even though the FHS introduced modifications in care models and work processes adopted by Dentistry[4]. Recent studies demonstrate the maintenance of a hegemonic disease-centered conception of health for the oral health care model, despite advances in the understanding of the concepts of integrality of care[5,6] and buccality, understood as an expression of the social works that the human mouth performs—manducation, language, and erotic—which are its functioning, its own physiology and its permanently covered aspect[7].

The challenge becomes even greater from 2020, when the World Health Organization (WHO) declares an international health emergency due to the COVID-19 pandemic, an infection caused by the SARS-CoV-2 coronavirus, with rapid spread among humans in several countries[8]. The limitations imposed by social isolation measures and the need to meet a growing and unknown demand led to transformations in health practices during the pandemic period, with a special impact on oral health actions, which suffered restrictions to perform care and procedures, especially in the use of rotating instruments of high speed with sprays that generate aerosols[9]. Studies have identified contingencies and reduced access to oral health in the period[10-12], but not the impact on the work process of professionals. This research aims to analyze how the context of the COVID-19 pandemic affected oral health care in the SUS in the state of São Paulo.

Material and methods

The article was produced from a research developed with the purpose of analyzing the productions, inventions, and challenges in care management implemented by health care networks in the state of São Paulo to face the COVID-19 pandemic. This is a qualitative and quantitative study, characterized as a multiple case study, which involves more than one case and has the potential to provide a more in-depth study, as it uses multiple sources of evidence[13]. The research was developed in two stages.

In phase 1, we sought to identify the actions and strategies developed by the Municipal Health Departments (MHD) to face the COVID-19 pandemic via a questionnaire structured based on four axes: Management, Surveillance, Health Care, and Vulnerabilities. This questionnaire was directed to the 645 MHD of the state of São Paulo and contained 39 questions, with 38 closed- and one open-ended questions. They were answered by the head manager or by designated advisors, using an electronic form. The invitation sent by electronic message allowed access to the questionnaire via an internet address (link) generated by the platform itself, whose completion was preceded by the acceptance of the informed consent form. Multiple choice questions allowed for one or more answers. Data were collected from November 24, 2021, to February 1, 2022. The answers of the municipal managers were organized by the 63 Health Regions, and duplicate answers were excluded, considering the last one posted as valid. After statistical descriptive analysis of each axis, combined analysis was performed with the statistical software STATA.

To carry out phase 2 of the research, the study field consisted of two Health Regions selected from the results of the first stage, one located in the state's countryside and the other in the Metropolitan Region of Greater São Paulo. The choice took as a reference the perception of the group of researchers on the relevance, originality, and preliminary results of the experiences of these health regions in the previous phase of the investigation, especially the data on health care arrangements produced in the context of the pandemic. In each of the regions, three municipalities were selected by population size, from the same criteria: small (up to 10,000 inhabitants – MPP), medium (between 10,000 and 100,000 inhabitants – MMP) and large (MGP – above 100,000 inhabitants), whose characterization is presented in *table 1*.

Table 1. Characteristics of Health Regions and Municipalities studied

Health Regions	Number of Municipalities per Health Region	Population per Health Region (2021)	Municipalities Research Field	Population per Municipality (2021)	HDI of the Municipality (2010)	Number of COVID-19 cases (2020-2023)	Number of Deaths by COVID-19 (2020-2023)
Countryside Health Region	8	328,335	Large Municipality	240,542	0.815	66,893	663
			Medium Size Municipality	41,545	0.751	7,630	113
			Small Municipality	1,752	0.722	459	5
Health Region of the Metropolitan Region of São Paulo	11	3,092,717	Large Municipality	1,404,694	0.763	102,475	5,586
			Medium Size Municipality	303,397	0.765	29,441	1,043
			Small Municipality	30,465	0.731	2,583	112

Source: Population estimated in 2021 and HDI calculated for 2010: IBGE[14,15]. COVID-19 cases and deaths: SEADE[16].

In this phase, 29 open interviews were carried out with managers, health service coordinators and SUS workers (*table 2*), addressing in-depth issues related to the four research axes used in the previous phase, using a script collectively formulated in research group meetings, based on the analysis of the results of the first phase. The interviews were conducted in two layers: in the first, with managers of the 'senior management' of MHD and Regional Departments (RD) of the State Department of Health; in the second, the coordinators, managers and workers of health sectors and services indicated by the senior management of MHS and RD were interviewed. The approach was individual or in groups[17], in person at the interviewees' workplaces and carried out by the researchers themselves, with an average duration of 90 minutes, and recorded after acceptance and signing of an informed consent form, with confidentiality and anonymity guaranteed.

Table 2. Interviewees in the Countryside Health Region (CHR) and in the Metropolitan Health Region (MHR) of São Paulo, 2022

Interview	Date	Field	Activity	Number of participants
E 1	06/08/22	Council of Municipal Secretaries of Health/ State Department of Health	Management Support	2
E 2	07/14/22	Large Municipality (CHR)	Municipal Management	1
E 3	07/14/22	Regional Department of the State Department of Health (CHR)	Regional Management	5
E 4	15/07/22	Small Municipality (CHR)	Municipal Management	1
E 5	07/13/22	Medium-Sized Municipality (CHR)	Municipal Management	4
E 6	08/23/22	Regional Department of the State Department of Health (CHR)	Regional Management	7
E 7	08/22/22	Small Municipality (CHR)	Health worker	1
E 8	08/22/22	Small Municipality (CHR)	Health workers	3
E 9	08/22/22	Small Municipality (CHR)	Health worker	1
E 10	08/22/22	Small Municipality (CHR)	Health worker	1
E 11	08/24/22	Medium-Sized Municipality (CHR)	Health Services Coordination	6
E 12	08/23/22	Large Municipality (CHR)	Health Services Coordination	2
E 13	08/23/22	Large Municipality (CHR)	Health Services Coordination	1
E 14	08/23/22	Large Municipality (CHR)	Health Services Coordination	2
E 15	08/23/22	Large Municipality (CHR)	Health Services Coordination	1
E 16	07/14/22	Medium-Sized Municipality (MHR)	Municipal Management	2
E 17	08/03/22	Small Municipality (MHR)	Municipal Management	1
E 18	08/24/22	Small Municipality (MHR)	Health Services Coordination	1
E 19	10/03/22	Small Municipality (MHR)	Health Services Coordination	2
E 20	07/19/22	Regional Department of the State Department of Health (MHR)	Regional Management	1
E 21	15/07/22	Regional Department of the State Department of Health (MHR)	Regional Management	1
E 22	07/06/22	Large Municipality (MHR)	Municipal Management	3
E 23	09/05/22	Large Municipality (MHR)	Municipal Management	1
E 24	09/05/22	Large Municipality (MHR)	Municipal Management	1
E 25	09/05/22	Large Municipality (MHR)	Municipal Management	1
E 26	05/31/22	Medium-Sized Municipality (MHR)	Health Services Coordination	3
E 27	06/07/22	Council of Municipal Secretaries of Health/ State Department of Health	Management Support	2
E 28	11/24/22	Regional Department of the State Department of Health (CHR)	Health worker	1
E 29	11/24/22	Small Municipality (CHR)	Health Services Coordination	1

Source: The authors.

The material was transcribed, deposited on a digital platform with restricted access and processed in the Atlas.ti® software, through thematic content analysis, being coded by at least two researchers. Based on the reports issued, the results were organized considering three moments of coping with the COVID-19 pandemic: suspension of activities, work of the dentist during the pandemic, and the process of resuming care. The interviewees' statements in *verbatim* are presented between the results described and the discussions undertaken.

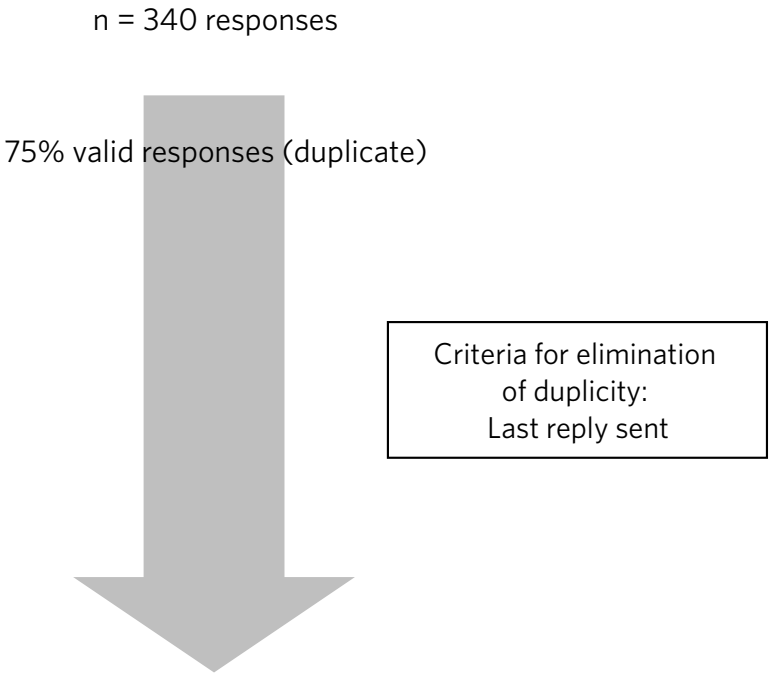
Analysis considered the theoretical pluralism proposed by Ball[18], with an inductive character, i.e., from the empirical material, different concepts, and referential aggregates from the field of collective health were researched, based on the literature researched on the theme of the study.

All research ethics principles were complied with in accordance with Resolution No. 466/2012[19] and Resolution No. 510/2016[20] of the National Health Council. The study was approved by the Research Ethics Committee under Certificate of Presentation of Ethical Appreciation (CAAE) No. 45679521.6.0000.5505 and Opinion No. 4.737.913.

Results and discussion

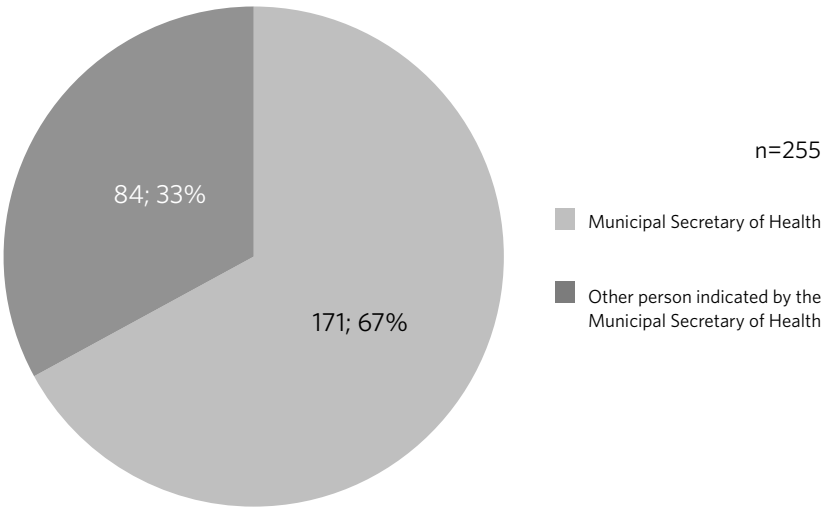
In phase 1 of the survey, 340 MHD responses to the questionnaire were obtained. From the application of the criteria for elimination of duplicity, 255 responses were considered valid, which corresponds to 39.5% of the municipalities of São Paulo (*figure 1*), and two thirds of the questionnaires were answered by head managers of the MHD, and one third by designated advisors (*figure 2*), covering all 63 health regions of the state.

Figure 1. Valid responses, phase 1. Municipal managers. State of São Paulo. 2022



Source: The authors.

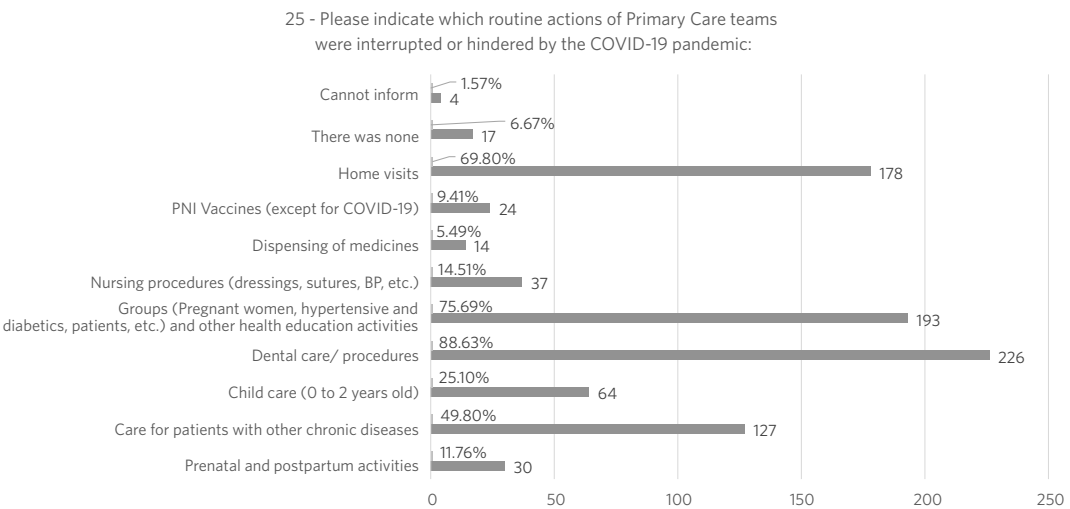
Figure 2. Respondents, phase 1. Municipal head managers and designated advisors. State of São Paulo. 2022



Source: The authors.

When provoked to indicate which routine actions of the teams were interrupted or impaired by the COVID-19 pandemic, based on a list of innate actions of primary care, the respondents identified dental care/procedures (n=226; 88.63%); groups of pregnant women, hypertensive and diabetics patients, and other health education activities (n=193; 75.69%); and home visits (n=178; 69.80%) as those most impacted, as shown in *figure 3*.

Figure 3. Answers to Question 25. Municipal Head Managers. State of São Paulo. 2022



Source: The authors.

The interruption of home visits, groups, and dental care, added to the losses of care for users with chronic diseases, expresses how much primary care was impacted and suffered losses and transformations. Although a significant number of Basic Health Units (BHUs) have maintained or increased operating hours, their routine actions have been hampered with a potential impact on the health conditions of the population, especially oral health care, an area with greater indication of suspension of activities by municipal managers.

In the analysis of interviews carried out in Phase 2 of the study, 20 mentions of oral health in the context of the pandemic were identified. This empirical data will be presented and discussed from the three analysis moments indicated above—suspension/restriction of activities, work during the pandemic, and the resumption of care—and analyzed in the light of the concepts of collective oral health, buccality, health care, health work process, interprofessionality, expanded clinic, integrality, and instituted-instituting process.

Why did it stop? What is the reason for stopping? Suspension of elective care, health risks and possible care

Most respondents report scenarios of interruption of dental care during the pandemic period:

> *it was a class that left the offices [...] there was no care, in any municipality [...] patients were medicated and released, no dental treatment was offered.* (E3).

However, this narrative that 'care was stopped' is relativized in other statements in which the maintenance of urgent care is reported: "*oral health was in emergency care, doing only emergency care*" (E2). "*It stopped. It only served urgency*" (E18). In fact, what happened was the suspension of elective treatments, a measure adopted in several countries[11]. In Brazil, Cunha et al.[12] observed a 92.3% reduction in non-urgent dental procedures by the SUS in 2020, compared to the previous year.

In addition, in all situations, there were restrictions on procedures: "*during the pandemic, there were restrictions on some procedures, some things I could not do*" (E12). Specifically, dental procedures that generate aerosols have been limited:

> *[...] these services generate aerosols due to the high-speed handpieces. We also stopped these procedures.* (E23).

> *[...] in the peaks, we restricted the use of high-speed handpieces in dental care due to aerosol generation.* (E4).

These measures were regulated in May 2020 by the National Health Surveillance Agency, which issued a technical note restricting dental procedures to urgent and emergency care and indicating the priority use of manual devices when attending, to avoid the generation of aerosols[21].

Such decisions were guided by the risk of spreading COVID-19, a respiratory transmission disease that occurs by the emission of contaminated aerosol from the oral cavity during the procedures in which *spray* is used: "*we had to restrict it, because the mouth was the biggest transmitter*" (E8). In addition to protecting the users served, such restrictions are also justified for the specific protection of oral health professionals: "*I had to ensure, in this scenario, that workers were protected from what we did not know*" (E17). Dentists and their team are among the professionals who are most exposed to aerosols[11], the main route of transmission of the virus, also because they are invariably in contact with saliva, responsible for most infections by SARS-CoV-2[22,23]. In practice, these restrictions promoted transformations, even if temporary, in oral health actions: fewer interventions meant fewer procedures and less invasive care.

Oral health practices in SUS are known to still reproduce the mercantilist, curative,

biological, and poorly resolutive character of the private sector or pre-SUS public services[6]. Authors report that Brazilian public dental services mechanically and uncritically reproduce core elements of the private sector model of service provision: a practice centered on dental care to the sick individual and performed exclusively by an individual in the restricted clinical-surgical environment[24,25]. This situation is not specific to oral health. It is also present in the FHS and in primary care as a whole, which, despite having promoted the expansion of access and incorporation of reception and humanization of practices, still maintains a certain centrality in the treatment of pathologies and care for the biological body[26]. In addition, the hegemonic conception of dentistry, disease-centered and liberal-private, has also contributed to the relatively low insertion of oral health care in family health teams in the country[5].

The constitution of collective oral health aims to make an epistemological break with (market) dentistry, which implies developing a praxis that dialectically breaks with the hegemonic dental practice: it seeks to 'deodontologize' oral health and ensure everyone has access to the necessary resources so that dental care is effectively a human right[24]. Thus, the pandemic context, by imposing limitations on the performance of traditional dental procedures, especially the 'use of the rotary motor,' constitutes a moment of analysis for the reorientation—even if temporary—of oral health practices in the SUS and, perhaps, even to 'deodontologize' them.

For Pires and Botazzo[27], oral health has historically been confused with Dentistry, as it is still centered on procedures and takes the mouth as a fragmented and disembodied organ. In addition, when planning its actions, it prioritizes the epidemiological data of the two most prevalent diseases—dental caries and periodontal disease—disregarding other oral diseases or even the subjectivities produced in the condition of illness as a source of information to organize clinical care.

For decades, dental clinical practice, too interventional and focused on invasive procedures, has been questioned as a potential producer of iatrogenesis and overtreatment. Expressions such as 'repetitive restorative cycle' and 'spiral of tooth death' are theoretical and figurative constructions of these processes. For authors such as Elderton[28] and Fejerskov[29], dental restorations have a limited duration, and once the tooth has been restored, it is likely that they will be replaced several times in a lifetime in a repetitive restorative cycle that can eventually lead to their destruction: the spiral of tooth death. So we have a paradox: if excessive dental care can cause iatrogenesis, the reduction of care in the period of high transmissibility of COVID-19 may have produced lack of care and contributed to worse oral health conditions of the population? Could the limitations for dental procedures in this period have reoriented oral health practices in SUS?

In the field of epistemological (re)formulation of oral health, the concept of buccality stands out. According to Couto and Botazzo[30], in addition to teeth, one must broaden the view in an understanding that the human mouth is inserted in a process of production and reproduction: it works, produces, and consumes, it is socially produced and socially determined. The challenge is the implications of this concept for the organization of dental practice and reorientation of the work process in oral health services within the scope of SUS[24]. Thus, the problematization of the conception of care disseminated by the biomedical discourse is proposed, which refers to a certain technicity aimed at healing, investing in care in its ontological dimension, as an intrinsic characteristic of the human being, from which the subjects are constituted and realized in the world[30].

After all, during the restrictions of the pandemic period, was oral health care offered? Or rather: what care was offered to the population? Here, it is worth recovering the concept: health care is configured as an encounter that

produces subjectivities, a dialectical relationship capable of managing those involved and transforming them, a powerful encounter—a true becoming inherent in social relations, a possibility of change[31,32]. For Ayres[33,34], the production of health care takes place from the encounter, considering that subjectivity is ipseity, and, for this reason, it is built in the experience of the encounter with otherness, crossed by affections, with a rupture in the instituted subject-object relationship, enabling subjects to constitute themselves together in act, crossed by their existential territories, their histories, and desires. For this reason, the 'odontologized' idea of care cannot grasp oral health care in its complexity, making it necessary to renounce the 'Dentistry a priori,' understanding that it is in the mouth that the historical-social realities and experiences of the subjects materialize, opening space for care as an intersubjective encounter[30].

In addition, in the primordial issue of the link that a reorganization of the care model presupposes, the perspective of subjectivity in the practice of the dental clinic must be worked on, often separated by the essentially and historically programmatic bias of health policies. Subjectivity overlaps when in fact the subject of clinical action (the user) is placed at the center of the work[24]. Thus, would it be possible to have produced oral health care during the confrontation of the COVID-19 pandemic? One advocates that yes, but, for this, the predominance of light technologies would be necessary in the encounter between the worker and the user, based on dialogue and listening, generating complicity, bonding, acceptance, and responsibility, stimulating the autonomy of the subjects[35].

Anything goes: Other activities, fears, and insecurities

In the effort to face the pandemic, there were reports of 'breaks' in the classic attributions of professionals, especially in oral health:

> *[...] many of the dental surgeons were inserted in the surveillance teams to monitor cases.* (E2).

> *How do we organize screenings? So, the dentist came in, the physical therapist came in, everyone came in to do the screening, to take the temperature. We even had a scale.* (E17).

> *[...] some dentists agreed to learn how to apply the covid test, left the comfort zone and went to the front to help, to test.* (E12).

> *[...] I learned and went to screen for covid: we know the mouth, right? But the nose? I was dying of fear of getting sick and taking it to the family, but there was no other way.* (E7).

Despite the fear and insecurity, there was even participation in immunization actions:

> *Dentist did not vaccinate... everything stopped, it was only for urgency. I trained to aspirate; I trained to vaccinate:*
> *'Oh, so you're not working? So I'm going to teach you how to aspirate the vaccine, I'm going to teach you how to assemble the thermal box, dentist, I'm going to teach you...'*
> *'I know how to apply mouth anesthesia.'*
> *'Then I'll teach you how to apply vaccines.'*
> *We tried to use everyone and, little by little, the fear was conquered, because there were people who were very scared to die, to take it home.* (E19).

These 'blurs' between the activities of the different professional nuclei were motivated by a certain common goal: to overcome the pandemic! For Pires and Botazzo[27], one must rethink the technology of oral health care as a possibility of comprehensive care and its legitimation as one of the components of health in an expanded expression: quality of life. This unique moment, of exceptionality, brought opportunities for advances in the greatest challenge of oral health in the SUS: the integration of dentists with primary care teams and the interrelationship with FHS professionals[36].

As a matter of health responsibility in the face of the pandemic scenario, in many places, dentists have taken strategic positions in the fight against COVID-19, in contrast to the eventual emptying of oral health actions. In the literature, there are reports of these professionals working during the pandemic period to improve care skills that go beyond the oral cavity, especially with regard to dealing with spontaneous demand[37], training for the use of personal protective equipment, testing for COVID-19, diagnosis and drug prescription for cases of flu syndrome, in addition to direct action in monitoring the taste sensitivity of positive cases under monitoring[38]. In a literature review, Stralen et al.[39] also identified international strategies to make the regulation of the practice of health professionals more flexible in response to the COVID-19 pandemic, with situations of redistribution of activities among the health workforce—task-shifting—including the assumption of new assignments by dental surgeons.

For Merhy[40], there is a work potential of all health professionals that can be used for direct care with the user, thus increasing the resolutive capacity of the services, restructuring the work processes and enhancing the 'live work in action' and relationships, as sources of creative energy and creators of a new moment in the configuration of the health care model. However, the technical and social division of health work[41], including the specialization of practices, often brings fragmented care processes.

For Campos[42], the institutionalization of knowledge and its organization in practices would take place through the conformation of nuclei and fields: the nucleus would demarcate the identity of an area of knowledge and professional practice; the field would be a space of imprecise limits where each discipline and profession would seek other's support to fulfill their theoretical and practical tasks. Routinely, dental surgeons tend to isolate themselves in their professional core, demarcating their identity to an area of knowledge and professional practice, not opening themselves to the field of knowledge and practices of collective health and to interprofessionality.

Interprofessional teamwork is a form of collective work that is configured in the reciprocal relationship between technical interventions and the interactions of the multiple agents involved, since it requires, on the one hand, the articulation of the actions of the various professional areas, based on the recognition of their interdependence, and, on the other, the complementarity between 'instrumental acting' and 'communicative acting'[43]. More than interprofessional work, what was observed in the pandemic was the assumption by dental surgeons of practices previously attributed to other health professionals or even those of the 'common clinic,' constituted in the 'interprofessional' work operated in the interstices of the borders of areas, through actions that are not claimed as specific prerogatives and that are invented in each situation[44].

Thus, in the 'war effort' against the pandemic, everything goes to save lives! These movements generated displacements in the practices of oral health professionals, allowing the discovery of new conceptual territories and the exploration of innovative practices to overcome the still hegemonic paradigm of dental care restricted to clinical procedures and care centered on the dentist's chair[38].

Starting again: Resumption, resistances, and the instituted

By reducing the frequency and/or attenuating the severity of COVID-19 cases, a slow and careful process of resumption of elective oral health care was initiated[45]:

> *[...] then we resumed the issue of assistance, where we had many discussions of the needs, because the cases of covid came, but also the worsening of other diseases. You can't prioritize, you had to work on both things. Then, we began to talk about the resumption, maintaining the care of covid, but with the resumption of oral health.* (E3).

> *[...] we started to come back, more or less, the specialty came back, oral health came back. It was one every hour.* (E18).

The question that arises is: how did these elective oral health care return? Did the pandemic moment, the suspension of elective care, the limitation of invasive procedures, the integration with the health team and the assumption of other activities besides the professional nucleus have the potential to usurp the dentist from his established practices? What the professionals say: "*under pressure, slowly, the consultations were returning*" (E7); "*soon, we started doing the restorations again and using the high-speed instruments*" (E10).

The conservation of market dentistry practices[24] is an important force vector for oral health actions in the SUS. Although the PNSB represents a milestone in the construction of public policies in Brazil and has brought proposals for various innovations, which include overcoming the traditional clinic[1], the micropolitics of work has changed little in relation to previous models[6]. For Lorau[46], in the institutions, there are two aspects that interchange: the so-called instituting aspect and its instituted part. The instituting aspect consists of processes that carry dynamic, transformative, creative, and changing characteristics. On the other hand, the instituted is based on static processes, naturalized as a set of rules of action and socially dictated behaviors linked to order, norms, the expected, the known, the immutable. Thus, it could be inferred that dentistry is an institution, with its ways of acting, operating, and thinking as a conservation vector in the face of the instituting and transforming movements of collective oral health.

This resumption of post-pandemic oral health actions could have been an opportunity to do things differently, producing health care, including oral care, with a view to integrality. Understood sometimes as an integrating axis of services, sometimes as a holistic view of the subject of care, or even as actions of integral care to demands and needs, the definitions of integrality express the feasibility of access to different spaces of care, the articulation of different health services and is based on welcoming and bonding between users and teams[47,48]. For Couto and Botazzo[30], to renounce the 'dentistry *a priori*' is to make room for multiple possibilities that the encounter can produce, 'rocking' instituted and betting on the possibility of summoning more powerful affections, producers of transformative care.

One of the possibilities for transforming practices would be the expansion of the clinic of oral health professionals. The expanded clinic is the redefinition of the object, objective, and means of work of health care, being characterized by a singular look at the other, by overcoming the fragmentation of care, accountability, and bonding with users of health services, increasing the degree of autonomy of the subject, valuing intersectorality and recognizing the limits of medicine and the technologies used[49]. For Graff and Toassi[50], oral health care practices need to advance from the perspective of an expanded clinic based on light, relational technologies, characterized by listening and producing dialogue, bonding, and subjectivities, through the sharing and reconstruction of the therapeutic plan. In this clinic, the initial dialogue and the identification of the reason that brought the person to the health service must be carried out before thinking about any strategy that involves the 'dental treatment' itself. Has the pandemic period evidenced other possible clinical practices to the dental surgeon other than dental interventions and procedures in the oral cavity? What did he do, or rather, how did the 'dentist without the high-speed instrument' do? "*We only medicated, sometimes, a bandage only with a manual instrument. Using the high-speed instruments was a crime...*" (E10).

For Cecílio[51], the degree of freedom and autonomy health professionals have in the micropolitic spaces of health care is strange for managers. In the case under study, these are expressed by the reports of some resistance from professionals regarding the return to elective oral health care:

> *[...] later, also in an arduous struggle, they returned to their services. They're very difficult people*. (E2).

> *[...]* [with] *oral health, I have a little difficulty: often because I think they should do more*. (E12).

This autonomy of dentists in their micro space of action can both conserve instituted dental actions and produce transformative instituting practices of oral health care.

The limitations of this research are in the scope and method of collecting qualitative data, as its emphasis is not on the potential for generalization, but on the understanding of experiences, which is strongly linked to intentionality and expansion of the experience. This study also did not show new oral health practices in the post-pandemic SUS. However, the literature points to two possibilities that emerged in the pandemic context that can remain as legacies: minimally invasive dentistry and teleodontology.

Minimal intervention dentistry, or minimally invasive dentistry, is a clinical operative domain critical to traditional dental practice, which should be seen as one of the pillars of minimal intervention in oral health care, applied in all disciplines of dentistry and not only in the treatment of caries[52], having been disseminated with some prominence during the pandemic period[53]. Likewise, virtual oral health care (teleodontology) has emerged as a possibility in the pandemic context of COVID-19 for the care of oral health problems, especially in the establishment of priority criteria in urgent and emergency cases and in the diagnosis and care of people infected by SARS-CoV-2 without putting the team of professionals at risk of infection[54]. Despite emerging in the contingency period, the institutionalization of these practices in the SUS will depend on investments in incentive policies and professional training to rebuild oral health care under other references. Cecilio[55], when studying the challenges of not doing 'more of the same,' proposes the idea of 'chimera of primary care': the promise that never becomes reality of a primary care network that is resolutive, qualified, that cares for and promotes life in all dimensions, in addition to being a gateway to the national health system. Would we be facing a 'chimera of oral health in SUS'?

Final considerations

The transformations in oral health care practices during the COVID-19 pandemic revealed the difficulties that dentists have in using light technologies. In some situations, the standstill, in others, the restrictions: what can a 'dentist without a high-speed instrument' do?

This analytic and unique moment could have been an opportunity to reorient the oral health work process in SUS through the incorporation of other practices, other actions, other knowledge, and a new model of care. It is impossible to affirm that concepts such as collective oral health, buccality, expanded clinic, and integrality have re-signified oral health care in the pandemic period, or after it. But could the dentist who offered welcoming patients, testing for COVID-19, measure temperatures, conduct epidemiological telemonitoring, and vaccinate not be able to expand his clinic beyond the office, the dental chair, and the 'high-speed instruments'?

Collaborators

Tofani LFN (0000-0002-1092-2450)*, Andreazza R (0000-0002-3332-2183)* and Chioro A (0000-0001-7184-2342)* contributed to the conception and design of the work; data collection, analysis, and interpretation; writing and final approval of the manuscript. Bigal AL (0000-0003-1020-2629)* and Tureck F (0000-0001-5583-1088)* contributed to data collection, analysis, and interpretation; writing and critical review; and final approval of the manuscript. ■

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