Clinic and oral health at SUS: innovating and (re)constructing care pathways

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ABSTRACT

The article provides analyses of work processes and the use of care technologies and competencies in interpersonal and bonding relationships. In a multicentric research on expanded clinic and oral health at SUS, we used the clinical method of the expanded clinic comprising users and the health team. This text aims to discuss the clinical practice in oral health and patient-centered health care, based on the theoretical frameworks of buccality, welcoming, and health care technologies. It brings reflections on one of the study settings, with the participation of four researchers and eight trainees (dentistry students), having as a locus the oral health clinic of a primary care service of São Paulo/SP. The activities took place along 13 months (2014 and 2015), serving 135 users. A total of 375 dental procedures were performed, with an average of 1.54 returns per patient and 6.38 interventions per user in 2014, and 7.25 in 2015. Most users had their oral health needs met in one single return. Researchers and trainees produced field diaries with impressions and perceptions about care, and this article brings analyses from a narrative within the scope of Discourse Analysis. By resignifying the practices, we assume new possibilities for care, within the singularity of each case and with light, communication and welcoming/bonding technologies, as well as processes that integrate the being, the thinking, the doing and the being. It is emphasized the potential of health practices constituted in the becoming, in the resumption of the clinic as a space for the production of subjectivities, of production of the self, pointing to the (re)construction of the field of signs and symptoms, appreciating differences and discontinuities, and inviting everyone to think and discuss the hegemonic clinical practices of Dentistry, from the training to the health services.

Descriptors: Oral Health. Biomedical Technology. Comprehensive Health Care. Health Human Resource Training.

1 INTRODUCTION

Health practices have been constituted of technosciences and unveil in their discourse a fusing between science and technology in an interrelationship that provides subsidies; also, it is a mediator between science and the real, in events that develop within an economy of power and that are characterized by interaction and mutual feedback of capitalism, science, and technology[1,2].

The work in health, mainly the oral health clinic, does without the legitimation of a doing/knowing in the daily life of the services that

values and prioritizes the intersubjective interaction of this action. The challenges to the dental clinical practice are the construction of proposals that articulate knowledges (not only technical/surgical ones) towards therapeutical projects legitimized by those involved; processes grounded on the perspective of collectively establishing a relationship with the subjective world of each one and with the way how health needs are constructed, permeated by relationships of welcoming and bonding, by an ethics of care.

One of the major theoretical cornerstones to analyze and understand the dimensions of the clinic practiced by the oral health teams is the concept of buccality[3-6]: a theoretical tool whose scientific basis is the collective health and that brings to the clinical practice the subjectivity of the human mouth, recognizing its social, cultural, emotional, and political role in all relationships of health care. It understands that both the mouth and the correlated oral experiences of the subjects are something other than tissues and organs and physiological functions perceived by dentistry as a science (and for which it produces knowledge and scientific evidence).

Considering these arguments, a collective of researchers led the multicentric project "*Innovation in the Production of Care in Oral Health. Possibilities of a new approach in the Dental Clinic for the Brazilian Unified Health System,"* developed in four distinct settings. The study assumed that the practice in oral health reproduces in a permanent way a model of care that is organized using hard technologies (equipment, tools, and materials), therefore constituting a practice centered on the injuries (markedly those related with dental caries processes) that dismisses the subject in the process of care[7,8].

It is desirable to rethink the oral health clinic and understand how programs and policies become actions in health in the daily life of the services. At this point, it matters to analyze a proposal for the clinic in which the social actors are protagonists of pathways that are "*more sensitive, critic, and responsive to the practical successes always aimed by means of, and beyond, any technical success in health care*" [9].

The research project was incorporated by oral health teams from Primary Care Services (UBS) in the conduction of the interventions, in new technological arrangements for the practice in oral health. Care was structured based on a qualified listening, understood as the possibility of the encounter with the individual's subjectivity, as the act of being sensitive to what is communicated and expressed by gestures and words, actions, and emotions, with sensitivity to understand what is concealed in the depths of the subject. It is understood that the listening is inscribed in the ability to grasp the sensations of the other, performing the listening-seeing-feeling integration[10].

The clinical method that guided the researchers and scholarship holders-trainees in the conduction of the care was grounded on singular approaches, in accordance with each person's needs when they attended the scheduled appointments. This clinical method was in line with the concepts of expanded clinic[11]. The patients were invited to participate in a conversation circle with other patients (according to the number of people scheduled for the period of internship/care). Such procedure was structured as a collective anamnesis, understood in the research as a device that assumes the group as a reference, reconnecting the patients with their personal and social process, making it possible the construction of narratives of life with the entering in scene of elements other than the oral-clinical aspects[12].

In other visits, it was prioritized the individual appointment, a moment of bigger deepening of the relationship with the patient, with privileged time and space for the listening, using as a basis the pathographic history, carried through

outside of the dental environment and without using the dental chart (considered as a light-hard tool or technology and that we have chosen not to use in this project).

The pathographic history, on which this project is conceptually supported, is thought from the fusing of clinical history and its factual and fictional dimensions with pathography, conceived as the description of the sick individual and their life other than the clinical aspects. That is, the clinical history is, simultaneously, life history[13,14].

In this way, the appointment can be considered as a system, involving structure, process, and outcomes[15]. In the practice developed by the study, several elements belonging to the structure entered the scene: architectural and furnishing elements of the UBS – like chairs and desks – the use of rooms attached to the dental office, and the dismissal of the dental equipment – dental chair, dentist chair, lighting, and dental desk, besides the suction unit. Also, regarding the structure, it is highlighted the organization of the waiting room and the welcoming process; the way of inviting the patients; the foreseen hours and the rules of scheduling and appointment scheduling[15].

In the structure for the appointment, it can be included the joint support for the clinical record: the single health record, in which the evolution of the appointments is made in joint with physicians, nurses, psychologists, social workers, and other possible providers who are members of the health teams. It is emphasized that the record of the appointments, anamnesis, and clinical history of the people served in the activities of the project were made by researchers and trainees, stored in files in the dental care sector of the UBS, and later attached to the record by the service oral health team. Initially, it was attempted to use the patients' single records, which were already used for all the clinical records by distinct professional categories in the institution (UBS Paula Souza, São Paulo /SP). However, the researchers were not allowed to access them.

The processes involved in a clinical appointment concern the communication between the team and the patient; the strategies for conducting the appointment (structured *versus* disorganized, linear, and non-linear, degree of directiveness); the clinical method; the involvement and bonding processes; the participation and negotiation with the person who is being served; the models of clinical records, among others[15].

The goal, when discussing some aspects of the research accomplished, was to point innovations for the oral health clinical practice. This was grounded on a clinical method that, simultaneously, would displace the centering on dental injury and surgical/rehabilitating procedures (characteristic of the hegemonic dental practice, historically supported by hard and light-hard technologies, structured by a semiotechnique of signs and symptoms that excludes, both for diagnosis and prognosis, the patient's social and cultural context, among other aspects), and cover other knowledges. This sets the dental science in line with social and human sciences, with health practices that are reconfigured, aiming to construct and conduct the appointments, in the settings of practice and research-intervention, from cornerstones that were structuring for the production of care in oral health[16,17].

This reconfiguration involved a qualified listening (aiming to create a pathway for the construction of the clinical case, beginning with spaces for talks and listening on the people, their needs, life history, perspectives, personal and social relationships, work and affective world); shared and unique therapeutical projects (processes of construction of care pathways which were drawn from the anamnesis and were imperatively supported on the desires and needs perceived by the patients and the technical resources available at PHC); conversation circles, or groups, that

constituted the moments of collective anamnesis. The distinct approaches highlighted are the major differences between dental practice and the expanded clinic of oral health.

The collective anamnesis was a group activity with a maximum of 12 patients and no longer than 90 minutes. As a group activity, it is related with group practices in dynamic, operative groups or, as it can occasionally happen, with psychodrama. Thus, it does not resemble the anamnesis that is usually practiced (questionnaires on illnesses and health conditions), but rather is developed to provide welcoming, to process the bonding, and to allow the patients to speak on their discomfort, symptoms, expectations, and life. At the same time, they listen to the stories from the other members of the group and thus reaffirm or they reconsider their own health pathways. There was no *a priori* definition of any topic and those patients who did not agree with the group proposal were served by the oral health team from the health service, outside of the research scope. The provider conducted the conversation, allowing the patients to express themselves freely, asking questions or making comments in order to allow or to facilitate the offer of the subjective matter.

People's itinerary through the care network in the city happened by means of referrals (municipal protocols) from the team's dentists, under regulation from the corresponding spheres.

Thus, it was established a flow for the care that respected the centrality and the protagonism of each patient in the construction of their own demands, therefore grounding the oral health actions of the collective of researchers and scholarship holders-trainees along the study.

The dominant explanatory models to define the demands reduce the subject by the objectivation of the illness, disregarding the contexts where they are inserted. The constituent elements of the health demands "*emerge from interactions of the subjects (patients, providers, and managers) in their relationship with the provision in the health services, in face of a certain institutional political project*"[18].

According to Pinheiro *et al.* (2005)[18], the demand and provision of health services should not be seen as two non-related concepts, as this view places user and worker in "opposing sides", moving away the possibility of joint construction of care. For Stotz (1991)[19], demands result from the relationship between actors who have distinct needs, desires, and institutional projects, which must be considered.

2 METHOD

The material used for the analysis was an account from one of the field diaries of the researchers. The diary as a research device has been considered as part of the empirical material and integrates the inquiry. It allows the researchers to record impressions from the field work, the events, and the happenings, as well as inaccuracies and correctness. It allows the exploring of what was experienced by the researchers; also, it facilitates and articulates, among them, the analysis of the field findings and the respective implications with the inquiry work, reducing or flattening the idea of neutrality in the scientific production[20].

The study was structured as a research-intervention in an experimental activity of oral health expanded clinic in a UBS in the city of São Paulo/SP. It was used the field or research diary for recording data, impressions, discoveries, difficulties, and accomplishments of each researcher involved. At several moments, the diary reported not only the perceptions and senses or meanings of each researcher's acts, but also narratives on the observations and pathways in the clinic. From the exercise of rethinking the practice of each researcher in the production of care, in the work that was carried through at each meeting, and also by the systematic use of the diaries, the recovery of some stories contributed for the

resignifying of the affections that emerged in this process, as if they were discursive products.

For the analysis of the produced material, it was used inputs from authors[21-23] that converge on the apprehension of the discourse at the very moment of its emergence or in the positiveness of its existence. It is like things were grasped at the particular moment of their flowing amidst their determinants and circumstances. These would be the methodical conditions for its analysis by analysis of discourse. Thus, what matters is the way how it is perceived, that is, its overt content. From this, it shall be signified, and not for some concealed meaning that perhaps can keep with realities foreign to the practical conditions of its production and emergence. In these analyses, the study's object of appreciation is not the sentence or each word individually; it became the whole discourse, escaping from a sequence enclosed in itself. It is important to remember that the concept of discursive formation reminds the one of totality. All discourse can only be under the condition that it expresses the possible set of the utterable regarding a certain object, fact, or occurrence. It is not only the scientific discourses that matter, but also the documents, the legislation, the political commentaries, the literary texts, the images, the metaphor figures, the semantic games, the artworks, parts of the scientific discourses themselves, the sayings, and the daily and usual practices. What is assigned to the analysis of discourse is to make explicit the relationships between what is said and not said, while it explores in the analyses the relationships of intertextuality[21-23].

For Narvaz *et al.* (2006)[24], in the analysis of discourse, the production of knowledge happens when subject and object interact to produce meanings. In these approaches, there is not the split claimed by the positivism between the subject that knows and the reality (object) to be investigated. What is produced is a relationship of interdependence and recovery of the researcher's (who analyzes the discourse) subjectivity in the process of knowledge.

Considering that the analyses of utterances is made through things that are said, without asking what they hide, what has been said in them, or the non-said that they cover, the thoughts, the images or whatever they bring with them, the analysis of discourse operates as a question, an inquiry on the ways how something is said by whom and with which interests. The analysis of discourse tries to understand the marks left by what was said and the possibilities of its emergence, identifying the pathway through which the utterances emerge[24].

Guided by these lines, the researchers present narrative sets produced by the experience lived, by the interior of the process, at the moment when it was a real, felt, experience and with power to produce new signs. From the records, a discursive formation composes the empirical material of analysis of this article, because not only we have produced diaries, but we have also talked the whole time. Each day we have seen, interacted, and produced new experiencing and new collective ways of saying and doing. It was produced a total of eight field diaries (from researchers and scholarship holders).

3 RESULTS AND DISCUSSION

Reproduced as a result, the narrative that follows (with the fictitious names to preserve the anonymity of the research participants) potentializes the discussion on subjects and clinic, on the clinical method that was the study's theoretical ground, and illustrates the relationships drawn along the research between patients and researchers, as a practice of care in health:

"It was a hot, end of summer afternoon in São Paulo… I arrived to work at the healthcare service, and the trainees and two researchers of the project were already there. That day, my activity was to conduct the individual appointments with

the students/trainees from the last year of the dental course. In the hallway that takes to the dental clinic, six women were waiting to be seen. None was actually young, all between 40 and 70 years of age. The eldest ones were talking about the weather, the heat, the lack of rain… soon I noticed the distancing of the youngest… oblivious to the topic of conversation of the other ones. Quiet, an air of fatigue and little patience for that waiting, a waiting that did not make sense yet, as the scheduling for the "dentistry" as proposed by the project team was previously explained to the interested parties: an initial conversation, often in a group, but that would be made individually that day…. my eyes ran through all of them while I walked along the hallway. I said loudly, "Good afternoon, ladies! How are you?" The conversation stopped and everyone looked at me excited, except Maria das Graças. Her tired look called my attention and, I confess, I hoped that this would not be the first patient to be seen, as I guessed how to conduct a good anamnesis and an appointment rich in details concerning her life history, so that this would be didactic to the eyes of the students who would follow the individual appointment. Also, starting with somebody so much not in the mood – my first impression – would be a little disheartening. Her name was the first one I called; the single health record of each patient registered in that service. I looked at the trainee and we came back to the hallway:

- Maria das Graças, please.

She got up slowly… Maria das Graças had no grace in her look, no grace when walking… as I already mentioned, her tired look came with a misaligned, sweaty bun, eye bags, walking bending and slowly. The youngest of the ladies sitting in the hallway was also the most discouraged one. Let's go, I thought, with a mix of challenge and even concern: what could we propose in this conversation/appointment for somebody so "down"?

The room that the health service offered to the project for the individual appointments was the gynecologist office, who did not work in the afternoon. Between the gynecological stretcher, an old room divider, and a glass door closet with a few free medicine samples, a small desk and three chairs tight in a cramped space waited for us.

The sweat ran along Maria das Graças face. I did the initial introduction, commented on the project, and proposed a wide, without restraints scrip, for our conversation. I left aside the classic questions on the mouth, some possible tooth ache, or broken teeth.

I could not help noticing the lack of some teeth and the bad breath when Maria das Graças started to speak. Shyly, she began to say that she never had time to take care of her mouth, that she had been to the dentist very few times... a mix of excuse and shame. But now she had decided to take care of it. And then, in an eloquent and surprising way, Maria das Graças told in many details the financial hardships she had experienced in the recent years, since she was fired from a multinational company and opened a small candy shop in the region. She spoke about the bohemian life of her husband, a musician, her only teen daughter, her widower and sick father that she was caring for. And she spoke of her life with such a clarity, without complaining, without resignation… She spoke with force, with courage, as a fighter of life and for life. She indicated the difficult moments through which she has been going and also clarified how she was facing each of them.

At the end of our conversation, she stared seriously at me and, in a very affectionate way, advised me:

"– Take better care of yourself too…. Our life, as women, is not made only of work, children, and husband. Rest more and try to do things that you really like."

We headed to the clinical examination (in the dental chair) like two people who meet each other

in this life, who share experiences, who establish an important bonding so that some care can be produced. That day, the dental chairs were in maintenance and few surgical or restoring procedures of the classic dental practice could be performed. I explained that we would examine her mouth, her teeth, we would measure the saliva flow and we would write down in her record to start the treatment in the next appointment. This is when Maria das Graças surprised us again and provided the most valuable contribution that one could expect for a project that thinks the innovation of care and new processes of work:

"– Doctor, I'm already being treated… I trust you all and what you are doing for me."

And she opened a wide and sincere smile, a smile that had no shame and didn't even need to apologize, as the relationship that we had established did not fix hierarchic positions of knowledge nor contained patient/professional relationship protocols. And the following appointments were like that, more focused on the resolution of oral problems that Maria das Graças reported as making sense for her way of walking life, but her look and our look were not the same anymore… like accomplices for the care, with a trust bonding and mainly in a relationship centered on the subjects of the whole process, building an exchange that each day was less prescriptive or controlling, less thought on the role that the oral health team must have in relation to the mouth of the patients (remembering here those health promotion actions that, in many cases, ground the whole relationship between professional and patient and leave to the edge of any relationship the power of the daily life of patients and health teams).

The narrative here exposed made it possible to analyze crucial points for the discussion of work processes in oral health at SUS and on innovation in the production of care within the context of a UBS. The narrative, as an empirical matter of analysis, represents the construction of an existential territory, of intersubjectivities that are inherent to the relationships of the clinic and that, however, is intended to be concealed by the technoscience, by the hardness of the long-time structuring technologies and that are mediators of the relationships decurrent from professional practices.

The discussion is guided considering this empirical data as representative of many other moments of encounter, of alterity and production of subjectivity in the oral health clinic that is the object of this research. The selection of this excerpt, among others produced by the male and female researchers throughout the months of development of the project, is legitimate because the discourse contained in this specific diary is legitimate in itself. Of course, everyone could compose the empirical matter of this paper, as the analysis of the material produced (field diaries) in the distinct settings of the study indicates the construction of care technologies, over all welcoming and bonding, as the major inputs for the patient-centered clinical method. Thus, this text is about a clinic of oral health, displaying empirical matter (in a narrative form) to illuminate the discussion to produce knowledge on oral health practices, questioning some prerogatives of the dental practice and its activities, and redesigning pathways for the clinic: care and health production pathways from desires, knowledge, cultural, social, and affective contexts. A clinic of oral health does not exclude the technique, the skills nor the dental science, but it absorbs other knowledge and proposes the construction of care from the approach of the patients and their multiple possibilities, bringing their experiences to the center of the process. It is proposed to overcome the "treatment plan," while it invites the health team and the patient for the common construction of 'projects of care in health'.

Amongst the crucial points, the design of what the health needs are is necessary for the discussion. In this way, we were guided by the

notion that the needs pointed by the people are translated by demands that result from the organization of the daily life, the sociability, the affectivity, the subjectivity, the culture and the leisure, anyway, of the relationships[23-25].

Health is produced from the set of social experience, individualized in each feeling, and lived in a body that is, also, biological, produced in its social, cultural, political, affective contexts, and that call for the mobilization of multiple knowledges and doings for the confrontation of the complexity of the health problems and needs of the people, of the collectives. Recognizing health needs of the population is related to the permanence of an expanded view, one that identifies the diverse subjects and their position in the "power structure" in health[26].

Like cornerstones of a (re)construction of the clinic, inserted in a background for actions like the processes of saying and listening, the relationship with the "world of the patient," and how they construct their health needs, the study experienced new technological arrangements for the production of care, searching to establish bonding relationships, from an ethical positioning. When restructuring the actions in the space of the clinic, with articulation of knowledge, it was possible to construct therapeutical projects from the singularity of each one.

In the discussion on technoscientific arrangements that can deal with needs in health that are not framed in hegemonic, biomedical, and historically constructed references, it is highlighted the perception on the subjective components of the users, or, in other words, what is people's needs for them. Cecílio (2006)[27], grounded on the discussion proposed by Stotz (1991)[19], recognizes that, if the health needs are socially and historically determined or constructed, they can only be grasped and worked in their individual dimension, as "the way how one lives is 'translated' in distinct needs of health"[27], consubstantiated in the body of the subject.

It is indispensable to recognize the bonding not only as patient ascription to a health service or action, but as the process that affects those involved in a continuous relationship, as it is real and experienced in time, is nontransferable, is an encounter of subjevtivities[28]. The health needs are wide and unique, they cover distinct fields, they can have different translations and they range from good conditions of life to the right of being welcomed and listened, of having access to the necessary services and technologies to the bonding with a team that is accountable for the care, in a continuous way[28-30].

Feuerwerker (2011)[31] brings some basic premises for the processes of care in health: the user makes choices and is the manager of his/her own life; the expansion of the subjects' autonomy is desirable to configure the ways of conducting their own life, facing its conditions[28-32].

In this sense, the closeness of collective health with the clinic could overcome a narrowing of relationships when highlighting the listening, by means of an availability to the others, to their suffering; not only in the dimension of pains or understanding of their illnesses but, mainly, in the contact with more essential senses of another clinic, "of a conceptual and operative requalification, in the health field"[33].

Models, knowledges, doings

When thinking about new work processes in the clinic of oral health, innovating technologies for the production of care, this collective of researchers found situations in the research-intervention setting that pointed to the construction of possibilities from the precepts of the expanded clinic[11].

While we were trying to understand the clinic in a powerful plan of listening, which allowed a cartography and the construction of new forms of intervention, we tried to innovate in the construction of shared and unique therapeutical

projects with the people. We have focused on their desires, their expectations, not on programmatic actions of the public dental practice anymore, innovating and incorporating relational technologies, creating new flows in the network, also proposing other arrangements for work and management.

The result points to a new semiotics: moments of relationship with listening, welcoming, and bonding as technologies of care for the clinic of oral health. When understanding the subject at the moment where they bring accounts of illness and life stories, it is desirable that the workers develop competences to provide an attentive listening and that qualifies the experience of the user. From dialogues not verticalized by knowledge, and redefining the power relationships that support clinical practices[34], the study restructured the anamnesis in distinct dimensions, making it possible another relationship with the people. The clinical intervention was developed at a second moment, from the demands and not only by the mechanical identification of signs[35-38].

The analyses point to a desirable collective (re)construction of the clinic, grounded on the needs of each user (seen as the subject and not the object of the clinic), which is the major challenge for the process of production of care in oral health.

Understanding the clinic from an interlocutor space for the care is to reconsider its solid theoretical anchorage, besides adding to its technical dimension a production of welcoming and of deviation. The clinic and the science: knowledge when applied to the care of people incorporates a moral and interpretative knowledge, that is, a practical reason[39].

At this point, the power and the knowledge invested in this clinic support, in a dense way, a practice that brings the imperatives of excellence and technical quality, what is not good or bad in itself, as it may boost "creative processes, open to the diversity, welcoming of the difference; or function as a prescriptive prescription, a defensive umbrella against what threaten us in the other"[40]. Therefore, it is understood that the useful value of the technique lies in being a value for the other, not for health programs, neither for the fulfilment of productivity goals that the guidelines of a health policy may induce.

Likewise, the innovation of and in the work in health pointed to the relevance of rethinking the settings of practice. While some shapes offer more time and several possibilities of encounter, other settings are harder and provide punctual encounters, with little depth and, quite often, tensioned. It is understood in the live work that it is always possible to recreate spaces and, mainly, to reformulate our doings towards a recovery of the life of the user with their desires, possibilities, betting and projects as an agenda of these encounters, just like Campos (2005)[40] emphasized in his work.

The encounter as product and producer in this clinic of subjects contradicts a model practiced by the economy of the contemporary, a model that conditions a disease to an intervention and then produces prescriptions, symptoms, deaths, treatments, and "healings."

4 FINAL REMARKS

After revisiting the theory and the narrative displayed and discussed by the text, we can conclude that the journey along the conduction of the project, as a joint construction of concepts, practices, and new subjects for the clinic was one of the most expressive results.

This construction led the researchers to rethink the clinic towards another one, expanded, with the preparation of unique therapeutical projects, in a shared way with the individuals served, as a routine in the daily doing; with a qualified listening of users, providers, and students, as a daily doing. Both clinic and oral health interlace in a complex network of care whose

center needs to turn itself to the subject, not only toward "their" illness. It is necessary to rethink pathways that value the assumption of subjects, their possibilities, and needs other than what the clinical semiotics used to value: physiological rhythms, normality, and illnesses and their signs and symptoms. The study pointed the urgency of a clinic for oral health that has unconditional value and technical dental input, but that, above this technical-scientific knowing-doing, opens spaces for the listening, appreciates unique pathways, finds points of articulation between need, production of life, and of health. Innovating in this path is to invest in practices of health that are constituted in the becoming, in the resumption of the clinic as a space of production of subjectivities, of production of the self, pointing to the (re)construction of the field of signs and symptoms, valuing differences and discontinuities.

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RESUMO

A clínica e a saúde bucal no SUS: inovar e (re)construir percursos de cuidado

O artigo traz análises dos processos de trabalho e uso de tecnologias de cuidado e competências nas relações interpessoais e de vínculo. Em pesquisa multicêntrica sobre clínica ampliada e saúde bucal no Sistema Único de Saúde (SUS), utilizou-se o método clínico da clínica ampliada envolvendo pacientes e equipe de saúde. Este texto tem o objetivo de discutir a prática clínica em saúde bucal e o cuidado em saúde centrado no paciente, tendo por base os referenciais teóricos da bucalidade, do acolhimento e das tecnologias de cuidado em saúde. Traz reflexões sobre um dos cenários do estudo com a participação de quatro pesquisadores e oito estagiários (alunos de Odontologia), tendo como lócus a clínica de saúde bucal de uma UBS de São Paulo/SP As atividades ocorreram por 13 meses (2014 e 2015), atendendo 135 pessoas. Foram realizados 375 procedimentos odontológicos no escopo da APS, com média de 1,54 retornos e de 6,38 intervenções por paciente, em 2014, e 7,25 em 2015. A maior parte das pessoas teve suas necessidades de saúde bucal atendidas em único retorno. Os pesquisadores e estagiários produziram diários de campo com impressões e percepções sobre atendimentos e este artigo traz análises a partir de uma narrativa à luz da Análise do Discurso. Ao ressignificar as práticas, assume-se novas possibilidades para o cuidar, dentro da singularidade de cada caso e com tecnologias leves, de comunicação e acolhimento/vínculo e de processos que integrem o ser, o pensar, o fazer e o estar. Destaca-se a potencialidade de práticas de saúde que se constituem no devir, na retomada da clínica como espaço de produção de subjetividades, da produção de si, apontando para a (re)construção do campo de sinais e sintomas, valorizando diferenças e descontinuidades, convidando a todos para pensar e discutir as práticas clínicas hegemônicas da Odontologia, desde a formação até os serviços de saúde.

Descritores: Saúde Bucal. Tecnologia Biomédica. Assistência Integral à Saúde.

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