

Bioethics of the care in the teaching clinic: learning with patients

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ABSTRACT

The study aimed to understand welcoming patients practices in a dentistry teaching clinic. It is a holistic single-case study with a qualitative approach. Twenty patients were interviewed following an open-ended script containing problematizing topics trying to connect bioethical principles to subjective devices of care: expanded concept of health and illness, intersubjectivity, co-responsibility, and quality of life. The discursive practices analyzed showed that the bond between students and patients of the teaching clinic is established in a construction mediated by the long training time. Co-responsibility is related with the intersubjective constructions in the care, being the actors of the process both the students and the patients. When claiming to feel free to give an opinion on their treatment, they also express a position of reduced autonomy, as they consider that it is not necessary to give it. As a reflection of the fragmentation of the care in the teaching clinics, much silencing emerges from these relations of power and care. It is believed that that the importance of practices that unlink themselves from strictly technical functions and invest in the speaking and listening processes is clear. In an untiring search for empathy and bond as the most powerful health technologies for the treatment, they reaffirm the autonomy of the people in the construction of their itineraries of care and human dignity as a core value of the practice of health.

Descriptors: Bioethics. Ethical Analysis. User Embracement. Education, Dental.

1 INTRODUCTION

In what extent the care to the patient in a dentistry teaching clinic is grounded on bioethical constructions? Is the dentistry teaching clinic is guided by welcoming, the

acknowledgement of life conditions, the development of processes of intersubjectivity, autonomy and co-responsibility of the patient? Or is it still founded on hierarchic paternalistic relations, with a minimal space of participation

and autonomy of the served people, disregarding ethical conflicts and prioritizing the learning needs rather than the patient's care?

The field of bioethical studies is based on the criticism to the facing of sickening by means of extremely technologized arrangements that act in detriment of the patients in their personal, social, and cultural context. In an approximation with Public Health, Bioethics tries to subvert the traditional sense of understanding health and disease – from the individual to the collective, from technification to humanization. Due to the emphasis on the analysis of values present in the way people relate to each other, bioethics contributes with theoretical-methodological references for the process of humanization in health^{1,2}. It becomes the central axis for the understanding of the dignity of living and the valuation of life as basic aspects. This is because it evidences the benefits of science in balance with humanization, overcoming health practices entrenched in the techno-scientific aspects, not in the bond with the patient³, the society and the environment.

The professional acting guided by bioethical practices is constructed transversally along the training of future health professionals. As structuring of the higher education in the health field, the understanding of the role of bioethics in the production of care in health is a challenge in the current context of medicalization of life. The teaching of ethics and bioethics in the undergraduate health degrees includes the process of training providers to deliver health care, problematizing the professional interventions in a way of recognizing the patients' rights. When the training assigns less value to bioethical education, it neglects the humanization of future professionals responsible for assisting

the population, who will receive technique without solidarity, assistance without empathy, and treatment without care⁴.

The distancing between disciplines from the Social and Human Sciences field and the professionalizing axis, added to the teaching clinic model, may result in situations of reduction of the patients' freedom of speech and, consequently, of their autonomy and therapeutical co-responsibility.

In health care practices, welcoming is an attitude that allows the qualified encounter between professional and patient/family. It is a scope for the bioethical listening, not always focused on health conditions, but on the mutual recognition of rights and duties in the process of ethically-based clinical decision making. In the care process, welcoming is conceived as the co-responsibility for the demands of a community or a person, when the subjectivity of the differences is merged into the decisions⁵. The recovery of values like solidarity, citizenship and respect for the patients will result in the promotion of autonomy and the co-responsibility for their treatment⁶. Both welcoming and bonding are associated with concepts of subjectivity and humanization. The production of bonds with the patients amplifies the health care and favors the participation along it. The bond with the patients is related with their recognition as participants in the decision process⁷.

Based on this assumptions, the study aimed to understand how bioethical principles and care concepts are correlated in the dentistry teaching clinic. By studying the discursive practices of patients in treatment, it was analyzed how dentistry students have developed welcoming processes in the care provided at the teaching clinic.

2 METHODOLOGY

It is a case study⁸ ascribed to the field of education and health, with a qualitative approach.

The undergraduate dentistry degree, object of the study, had its pedagogical project⁹ structured in accordance with the National Curricular Guidelines in force¹⁰, searching for a professiographic profile that articulates the teaching-learning process by means of the acquisition of skills and competences. It is included in the curriculum a combination of basic disciplines, teaching clinics, and curricular traineeships. The syllabus is aimed to bring the professional training closer to the services, and the involvement with the services network must happen in the very first semester of the course. This commitment is gradual, being the higher number of planned credits offered in the two last semesters, when traineeships are developed as the major training activity¹¹.

In the curriculum of the undergraduate dentistry degree where this study was conducted,

teaching clinics are organized with the goal of integrating teaching and assistance in the scope of dentistry specialties. Professors (tutors) follow up the procedures carried through by the students along the clinic; dental procedures aimed to be achieved by the students form the assessment criteria of the students' teaching-learning.

The participants were 20 patients or guardians of underage patients being treated in the clinics of this public higher education institution in the south of Brazil participated, being 75% females, 40% were 60-years old or older, 45% were married, and 80% lived in [concealed text] and the metropolitan area.

It was used an interview for the data production based on a guiding script, correlating topics of the welcoming processes in the care with bioethical principles: expanded concept of health and disease – principle of justice; intersubjectivity and co-responsibility – principle of autonomy; and quality of life – principles of beneficence and nonmaleficence (chart 1).

Chart 1. Script of the open interview based on the preestablished analysis topics

Expanded concept of health and disease:

What do you think of the knowledge of the student who took care of you concerning the reality of your conditions of life, health, and disease? Please elaborate.

Intersubjectivity:

Considering the appointments for the development of your treatment, how was your relationship with the student established? Please tell us how your relationship with him/her is.

Autonomy:

Regarding to the course of treatment: how much freedom did you have to decide or give an opinion? Please elaborate. How much your decisions and opinions were respected or not?

Co-responsibility:

How did you participate in the treatment and the appointments? Please elaborate. What was your contribution in the treatment?

Quality of life:

How do you evaluate the treatment (the decision of the technical choices) that you were provided? Please speak about any possible problems (pain/discomfort/limitation of life).

The participants were invited for the interview while they waited for the appointment or it was finished, in the waiting rooms of the teaching clinic. The interviews lasted for about 40 minutes. Next, they were transcribed for analysis purposes. Saturation – the acknowledgement that the collected data is enough to explain the problem, was adopted as the criterion of evaluation to establish when to interrupt the gathering of new data¹².

The methodology of analysis of the discursive practices tried to focus on the understanding of historical, social, and cultural practices present in the live practices of the way how the discourses are presented. The meanings of the objects under study are not translated only by the subjects' speeches, but they articulate the linguistic with the social and the historical. Language is a political production and constituent of its own practices, not the mere reference or expression of situations. It was identified the intrinsic regularities of the conceptual networks present in the discursive practices, defining sets of enunciates that support discursive formations^{13,14}.

The research project was submitted for ethical analysis by the institutional Research Ethics Committee and is available in Plataforma Brasil under the CAAE 30459914.8.00005347, recommendation number 2.522.074. The Informed Consent was presented to those invited, having been considered participants the people who agreed to sign it.

3 RESULTS AND DISCUSSION

From the expanded concept of health and disease to the clinic in the practices of care

In the study's dentistry teaching clinic, anamnesis and physical examination are part of the opening guideline for the beginning of the patients' oral treatment. The record adopted by the teaching

clinics contains questions aimed to identify and describe the patient's social data. However, in the discursive practices analyzed, the interviewed patients claim that their first dental appointment in the teaching clinic as a moment in which general questions on their health are made, however like an interview disarticulated from the process of care and clinical interventions. According to the participants' answers, the students establish fragile relations between the universe (cultural, social aspects, and beliefs, among others) of the patients, their processes of sickening, and the production of care.

They make a survey on health. They ask about diseases and medications. I already passed by several [students] and they all do the same [...] they don't know anything regarding my personal life (E11).

When I come here, they ask me a thousand questions to know exactly what I have. I think that they are even well informed [...] (E03).

I believe that all of them always ask those same questions on disease, isn't it? I really have a problem, but I don't think that they are that interested, it's just for asking... [...] (E04).

Speaking of health as a whole, I don't know if she knows a lot, they only ask those questions. However, in relation to oral health, I think that she knows everything (E12).

They never asked me anything about my health, about any disease, nothing. They always spoke of teeth only (E14).

Health and sickening are ways through which life manifests. The expanded concept of health, advocated in the legislation that grounds the Brazilian Unified Health System (SUS), recognizes that its biological dimension is integrated to social and political dimensions. In the still hegemonic biomedical model, there is a reduction of the human

body when focusing on the biological dimension, detaching it from the set of cultural relations and the actual contexts of social life. Reducing attitudes of the understanding of ways of life and sickening culminate in behaviors limiting the powers of care.

In its production, the health-illness process is understood as articulated to the ways of living of each person – their historical personal relations –, trying to include the uniqueness of the production of life. It is the skill of welcoming those who seek for care that allows the sharing or not of personal information^{6,15,16}. Life is produced in the daily routine of social, family and work relations. Often, this is a fact that is disregarded in the teaching-learning scope of the clinic, when health is addressed as an attribute exclusively defined from the conditions of psycho-biological normality and abnormality established by Biomedicine¹⁷.

The discursive practices demonstrate that the students master the technical and scientific knowledge valued by the biomedical models of care, also necessary for care. However, the patients do not understand the way how the student's knowledge regarding personal and social aspects of their life may be related to the construction of therapeutical courses in the teaching clinic.

The knowledge is specific, the treatment is specific, thus there is no need to know about my life, my family (E14).

I think that she doesn't know that much about my life, maybe this will improve with time. I don't think that it influences anything. The treatment is equal for all, rich or poor, everything must be equal (E09).

I believe that this more intimate knowledge depends on the person, wanting to know about the life of the patient. They never asked me any big question in this sense, but certainly it's important because you must know the context

where the patient lives, subjective aspects (E16).

Oh, I find it really important to share personal information, to really talk. Even because it's hard when two people don't get along well (E18).

I think that having this knowledge concerning personal life adds a lot. Being able to interact as a patient creates affinity. I find it quite positive, quite important. The one who takes care of you professionally only makes you to withdrawn and even not mention certain things. I think that the bigger the opening, the better the communication, the better the treatment (E11).

The historical processes of constitution of teaching in health can help to explain the students' difficulties bringing closer the knowledge on the patient's social contexts and the production of care in the clinical activities developed by them. The dentistry clinic, in its historical process, was (and still is) mixed up with dental technique, both in professionals practices and in education. Dentistry education (and practice) consolidated its organization and regulation by means of the separation from medicine¹⁸.

Dentistry education is a protagonist in the technification of the profession when it dissociates clinic and care from people's conditions of existence and life. Focused on teeth and surrounded by narratives circumscribed to the surface of the tooth crown, the professional practice has been drawn, shaped and assigning scientificity to the dental discourses – one of the functions of the discipline – and establishes the network of interests that links school, profession, and industry in the dentist's education¹⁹.

A bioethical look to the work in health brings to the focus of debate questions on care, trying to

surpass hygienist and prescriptive approaches, centered on the disease and the production of procedures, for more humanistic understandings, centered on people, intersubjective relations, and the social determination of health. In the concept of a territory that is existential, situational, and carrier of many senses, patients are co-responsible for the construction of their network of care. In this context, the construction and the strengthening of existential and therapeutical bonds is achieved by means of tools for care practices²⁰.

The discursive practices here analyzed problematize the professional training clinic in dentistry. How do students produce and use the patient's information on health and disease in the clinic and in which way do they construct the care?

Intersubjectivities: possibilities of welcoming production in the teaching clinic

The discursive practices indicate that the students are recognized both by the technical practices and the personal characteristics. The practices of interaction between the students and the patients are mediated by informational devices, emotional networks, social skills and, especially, communicative practices.

[...] This relation happens, first by their nice and interested way. They don't look at me as if I were only a person who is there so that they can carry through the task. I have always been incredibly lucky! I know details of their life as much as they know of mine, and this only adds to the treatment (E11).

I certainly have created a relationship. I always received an incredibly good care and ultimately, we create a bond. The bond was created gradually, intimacy increased gradually. The student was always quite open, very likeable and this collaborated a lot (E07).

It's a very good relationship, I have her WhatsApp contact. She's always available for any clarification that I need, and they also inform me, if I ask her something or in case that I won't come. Any clarification that I need. This is very good! (E12).

The subjectivities regarding the oral health topic expressed by the patients are linked with their own dentistry-related experiences, resulting from productions of power relations, not only understood as oppression or domination, but, mainly, in their processes of construction, as they result from an objectivation that transforms the human being in a productive subject¹³. Therefore, subjectivity is here understood as a power resource in the act of care: a biopower, that is, a power over the body. And the subject is, ultimately, a product of these processes called biopolitical^{3,21}.

The intersubjectivity is more than shared or mutual understanding, as it is closer to the notion of possibility of being in the place where the other one is. Moreover, the intersubjectivity is not necessarily something to be reached or negotiated by means of the oral communication or other means. Human and non-human aspects of the health environments lead the processes of intersubjectivity between professional and patient, mediated by health technologies. In this view, intersubjectivity is, in the first place, not a product or effect of communication, but a condition for its possibility²².

The service in the teaching-learning clinic takes place along two school semesters with a unique and complex dynamics. It becomes a longer period, considering skills, constant need of supervision, and the very evolution of the student in the curricular course, what delays the treatment conclusion. Students in training do not have the agility and dexterity of experienced professionals and depend on the presence of the teaching staff for approval of

the steps of the procedures.

[...] time doesn't exist here. Everything takes a long time. The person must start knowing that the treatment will be long, as I did. If the person does not start knowing that, he/she will be a little irritated with the delay (E07). [...] There is a lot of people and the staff ends up not being able to pay the due attention to everyone, they have little time. I believe that if they stayed more with the students, the treatments wouldn't be that long. This is my observation, as this is what happened to me (E11).

[...] one thing that takes too long is the treatment to make a temporary procedure, I've done it almost a year ago, it's not possible, right? (E04).

It was quite fast to get the spot, but now I'm here for over one year and I think that it still will take more time (E12).

The patients are assisted by different students; the functioning of the teaching clinic follows the semester flow of the students' progress in the curriculum, with changes in the teams of teaching staff and students, besides mandatory conclusions and restarts of treatments. Also, the levels of complexity of the clinics are organized in the semester curricular development. Unfortunately, those patients with health needs that involve more complex procedures pass through different clinics (e.g., child and youth clinic, clinic I, II, III and IV, outreach clinics, specialization clinics) and are cared by different students and teaching staff. This process can result in fragilities in the communication and bond with the patients. In this context, data presented by the study and that deserves to be evaluated is that around 30% of the interviewed patients do not identify in which teaching clinic they are receiving the provided care.

There were a lot of students who took care of me, sometimes it is this one, then it changes, but all were always very considerate (E01).

The students change every year. It is a pair every six months. We are already used with this process, but all the girls who worked with me were always very kind and concerned (E17).

These (im)possibilities define the production of care. Welcoming the patient's demands and needs assumes the recognition of the patient's conditions to generate information on treatment proposals and autonomy of decision. Within health care, welcoming depends on the intersubjectivity. When this process is degraded, silencing zones are formed²³. Welcoming provides interaction between professional and patient, favors the interpretation of uniqueness and the construction of relationships. Welcoming and bond are concepts that complement each other in the construction of care. Welcoming favors the creation of bond. Intersubjectivity produces communication with the other and creation of bond^{2,6,24,25}.

From autonomy to co-responsibility: the clinic as a producer of silencing

The discursive practices on freedom of expression during the clinical treatment are presented in an intricate of variations, and even contradictions, of how the opinion making in the clinic and the treatment happens. The participants say that they do not have freedom for such, or they say that they feel free, but they do not consider it necessary to do so, for believing that they do not have enough knowledge, trusting the decisions of the students and the professors. In this sense, the interviewed patients find a 'place' in this process and remain distant from their treatment and care.

[...] I think that I didn't have complete

freedom, because they didn't give me complete information so that I could make my decisions [...] (E11).

I didn't feel free, as I didn't understand the case. Nobody explained everything in full detail to me, so that I would have a choice [...] (E20).

I have freedom, but I try not to give an opinion, since they know what they are doing; but they ask me, but I always leave it to them. I believe that it's not necessary (E03).

I had full freedom if I wanted to say anything, but I never had to. If it were necessary, I would express my opinion (E19).

[...] I don't know anything about this, so I don't have the right to give an opinion. I can ask, but not give an opinion. I already made commentaries, but I didn't give any opinion. Also, there is a professor, right? Opinions are for the professors only (E06).

Did I feel any opening for this? I believe I did. But we are not dentists, thus there are things that I cannot speak because I don't fully understand. But I didn't have anything to say, I think everything is fine. But sure, I would say something (E12).

No, I'm not like that, I think that he's doing his job and that's fine, I will not speak and get in his way. He's focused on something. [...] They must be professional [...] (E14).

They do everything right; I don't need to do anything [...] (E01).

The idea of professional trust that emerged in the discursive practices analyzed assumes a model of therapeutical, including (or mainly) moral authority. The participants do not exert, at least overtly, the power of choices regarding the treatments. It is like professional knowledge would overlap the freedom of choice of the subjects, reduced to supporting

actors in a process where the central figure of care is not the patient. Their opinions are considered less important than the technical-scientific knowledge. Cooperating consists of following guidance, not missing appointments, and answering the questions accurately, collaborating with the student's training.

I'm trying to do everything that he asked me: brushing better, eating less sweets.

I have a 29-year-old son and he encourages me a lot and I'm passing the information to everybody. I understood and accepted everything that [the student] told me. It's not because I'm 70 years old that I will not understand what is wrong (E05).

My contribution was to do everything right at home and never miss the appointments, precisely because of the delay (E07).

My part was always to organize myself to attend the appointments, and everything is right. I always talked with her when I needed to change my schedule and she always understood [...] (E10).

[...] but I collaborated a lot with him. He did things in my mouth that he had never done (E06).

The patients do not want or cannot disturb the correct technical-scientific decisions delivered by the teaching staff and repeated by the students, risking losing the possibility, or the spot, of treatment. The patients construct themselves in passivity to consume the therapy that will be presented to them. They are assumed as learning objects, as silenced bodies, split from their conceptions of health, their speeches, and desires, neglecting themselves.

In the epistemological field of the Public Health, one of the basic elements of the concept of health promotion is to encourage and to fortify the autonomy of the subjects²⁶, with a valuation of the

bioethical principle that promotes the right of the person to decide on the questions related to his/her life. Promoting co-responsibility in the patients' health care is prioritizing the patient's right to autonomy.

In the profession's deontological code, the professional duty of providing information necessary for the sensible decision-making stems from the principle of autonomy. It is an ethical infraction not to clarify intentions, risks, costs, and alternatives of treatment, or "not keeping the users informed on the available resources for the service and not answering to their complaints"²⁷.

The co-responsibility in health is an exercise of power on attitudes and decisions in face of the therapeutical possibilities. This exercise is related with the competence to have expanded attitudes of health. An exercise linked to the processes through which people master decisions and actions that affect their health and strengthen the construction of their own capacities of choice²⁶. Co-responsibility defines subjects who assume a role of protagonists in their processes of health⁷.

When somebody decides to analyze a discursive practice, he/she must understand the silence that follows the words. However, how to analyze it? In which way the non-saying is presented in the daily life of the health practices? Silencing is a representation of power relations. In every speech, in every human encounter, there are non-spoken sayings that can be named as silencing²⁸.

Silence makes all meaning possible, it identifies the saying that implies in not saying. It is the not expressing due to some conjuncture. The censorship is presented in what cannot be said due to the intervention of relations of forces at the moment of the enunciation²⁸.

The person who does not communicate what he/she needs to communicate, silences. A silence

that is produced to not express, not harm. One runs from questionings, answers without deepening. Silence can seem to be of easy identification, however its interpretation is complex, as it explores dimensions of the human that are produced in the interfaces of the teaching clinic practices of care.

In the critical theory, the "culture of silence" cannot be understood outside of the context of the analyzed situation. To understand the "culture of silence", it is essential to promote an analysis of how the subjection in a relation can generate different forms of thinking, speaking, and doing. "To be silent it is not lacking an authentic word, but to follow the prescriptions of those who speak and impose their voices"²⁹.

In which way are we subjected to the determinations of our own practices and we subject, in the intersubjectivities produced by and in us, our ways of welcoming in the ordinary wander of a teaching clinic – a clinic that even considers listening, but is not able to relate glances between the social and the clinical?

Quality of life: who defines the criteria?

It becomes a difficult exercise to use the code of ethics as a foundation in texts of bioethical analyses, as the codes of ethics are normative and prescriptive, besides fostering an ethical problematization. Also, what is seen quite often is that the anguish generated by the situations of doubt in bioethical conflicts leads to appealing to guiding deontological documents, giving up the need to reflect to make decisions in situations of uncertainty. This is a context that strengthens deontological questions and reduces the space or the visibility for the bioethical debate. Thus, it is strategic to show that deontology needs the input and deepening from the social and human sciences to grow and to be analyzed.

In the case of the study, when attending the clinic to receive a health treatment (a clinic that is also a teaching institution), the patients bring with them (more or less explicit) demands, their bodies, and their unique subjectivity. The clinical relation is created in an encounter of people with interests and subjectivities in production, and with an object in common: the body of the patient and, in the case of the study, the mouth, or, even more specifically, their teeth.

The decision of a person to look for health care in a teaching institution does not grant the unrestricted access to his/her body. It is an ethical infraction in the Code of Ethics in Dentistry to use the patient and/or the student in an abusive way in class or research, as well as to overlap the interest of science to the one of the human person²⁷.

The health provider must act in benefit of the person and favor ways of comfort and well-being. The patient's quality of life is based on the conciliation of his/her preferences and the clinical indications³⁰. It is related to the bioethical principles of beneficence and nonmaleficence, which complement each other, with decisions that may affect the quality of life of the patient. The Code of Ethics in Dentistry establishes as the professional's basic duty the zeal for the health and dignity of the patient²⁷. However, how to establish quality of life? Would the professional indication be causing the good, as it is advocated by the principle of beneficence, when it is distant from what the person understands as feeling well?

The decisions in a therapeutical process must be based not only on professional objectives and scientifically based therapeutical indications, but also on affective investment, on the daily possibilities, and the unique ways of life of the patients, approximating therapeutics with personal and subjective realities. The benefits and harms must

be confronted with the ideal of quality of life of the person under care. After all, will the person commit to a treatment in which he/she does not believe?

In the discursive practices analyzed, the decisions made during the treatment are considered correct by the patients.

The treatment has always been quite good. The choices made have always been the right ones. I don't have any complaints. She always explained everything to me, I was always aware of everything. I never felt badly, this anesthesia here is very good. Before, I always felt a lot of pain (E10).

It is pain – transitory, chronic, temporary, clinical, post operatory, that affects the quality of life of the dental patient. When the professional practice works for the pain relief, the treatment is understood as a reward for a personal effort or more likely to be endured.

When I had an implant, I was quite afraid, I thought I was going to die. I had never done it in my life and I'm weak for pain, but I was advised, I took the medication, I used the mouth wash and soon I was fine, I felt good (E02).

I already had pain, but it was only at the time of the surgery. Then, I sent a WhatsApp message, he explained everything to me, and this helped me [...] (E06).

I already felt a lot of pain when I had my wisdom teeth removed, but later it was over, it didn't last long. I think that everybody who had a wisdom tooth removed felt it (E20).

[...] It aches, it's suffering, but I won't give up [...] Oh, you don't know how worth it is. I know that I'm going to feel pain at the time or the other day, but it will disappear, and my mouth will be better. Thus, it's great to me. I will go on! (E03).

Regarding access (or its difficulty) to the

service, the competition to receive care is great and there is a long wait for the dental services offered in the teaching clinic, considered of low cost when compared with the dental private market.

[...] I pay 5 Reals, young lady. I cannot complain about anything! (E16).

I wanted to treat the teeth, but I never had a chance, I never had money to do it. Here they are doing it, then I cannot say anything, I only must thank [...] (E12).

I try not to give any opinion to not disturb anything. [...] In my reality, it's quite hard, then having the spot here was great. Being able to enter here and being cared for, being treated was the best. I don't give up. I skip my job if it's necessary, but I cannot lose this here [...] (E03).

There are things that I don't like in the system here at the dental school, but there are issues that one must accept when you pay 5 Reals for the appointment (E20).

These are points that can affect the quality of life of the patients, who in face of the appreciation of the access to the spot reduce the value of their own wills and opinions e of the proper wills and opinions reduce, perhaps for considering it as a favor, not as a right.

4 FINAL REMARKS

In the teaching clinic, the students master technical-scientific knowledge and produce information on the patients' life conditions, but they do not relate this knowledge in the construction of therapeutical itineraries.

For considering that they do not have enough knowledge for such or for trusting the decisions of students and professors, the patients limit their participation during the clinical treatment, creating a distancing from the process of care. Cooperating is

understood as being patient in its literal meaning: following advices, not missing appointments, and answering questions accurately, submitting themselves to the time of treatment due to the student's training need.

The dentistry teaching clinics are structured by a hierarchized order and basically concerned with train students for a professional practice guided toward technical excellence and manual dexterity in the clinical procedures.

The study brings to the surface the bioethical skills of a teaching clinic. The results point to a training that persists in strengthening the centrality of the doing in dentistry on disease and a patient who participates without acting in the process of care. The understanding of the clinic as a micro space producer of subjectivities, as a process for subjects and not for diseases or functional and aesthetic repairs can displace the historical practice of Dentistry. This can create space for subjects who produce health, who exerts their autonomy and co-responsibility, making the act of caring an expression of values and a production of life.

Regarding silencing, power relations and care, it must be constituted practices that are unlinked from strictly technical functions and invest in intersubjective production and processes of speaking and listening. Relentlessly searching for empathy and bond as the most powerful technologies of health for the treatment reaffirms the autonomy of the people in the construction of their itineraries of care and the human dignity as central value of the practice of health.

RESUMO

Bioética do cuidado na clínica de ensino: aprendendo com pacientes

O estudo buscou compreender práticas de acolhimento de pacientes em uma clínica de ensino

odontológico. Trata-se de um estudo de caso único e holístico, com abordagem qualitativa. Foram realizadas entrevistas abertas com 20 pacientes, guiadas por um roteiro com temas problematizadores que procuram ligar princípios bioéticos a dispositivos subjetivos do cuidado: conceito ampliado de saúde e doença, intersubjetividade, corresponsabilidade e qualidade de vida. As práticas discursivas analisadas mostraram que o vínculo entre estudantes e pacientes da clínica de ensino se estabelece em uma construção mediada pelo longo tempo da formação. A corresponsabilidade está relacionada às construções intersubjetivas no cuidado e tem como atores do processo os estudantes e os pacientes. Ao afirmarem sentirem-se livres para opinar sobre seu tratamento também expressam uma postura de reduzida autonomia, pois consideram que não seja necessário fazê-lo. Como reflexo da fragmentação do cuidado nas clínicas de ensino, muitos silenciamentos emergem destas relações de poder e cuidado. Acredita-se que é clara a importância de práticas que se desvinculem de funções estritamente técnicas e invistam nos processos de fala e escuta, incansavelmente buscando empatia e vínculo como as tecnologias de saúde mais potentes para o tratamento, pois reafirmam a autonomia das pessoas na construção de seus itinerários de cuidado e a dignidade humana como valor central da prática de saúde.

Descritores: Bioética. Análise Ética. Acolhimento. Educação em Odontologia.

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REFERENCES

1. Diniz D, Guilhem D. O que é bioética? São Paulo: Brasiliense; 2002.
2. Cotta RMM, Reis RS, Campos AADO, Gomes AP, Antonio VE, Siqueira-Batista R. Debates atuais em humanização e saúde: quem somos nós? *Ciênc Saúde Coletiva*, 2013; 18:171-9.
3. Junges JR. Direito à saúde, biopoder e bioética. *Interface Comum Saúde Educ*. 2009; 13(29):285-95.
4. Finkler M, Negreiros DP. Formação x Educação, Deontologia x Ética: repensando conceitos, reposicionando docentes. *Rev ABENO* 2018; 18(2): 37-44.
5. Warmling CM, Baldisserotto J, Rocha ET. Acolhimento & acesso de necessidades de saúde bucal e o agir profissional na Atenção Primária à Saúde. *Interface*. 2019; 23:1-15.
6. Garuzi M, Achitti MCDO, Sato CA, Rocha SA, Spagnuolo RS. Acolhimento na Estratégia Saúde da Família: revisão integrativa. *Rev Panam Salud Publica*. 2014; 35:144-9.
7. Nora CRD, Junges JR. Política de humanização na atenção básica: revisão sistemática. *Rev Saúde Públ* 2013; 47(6):1186-200.
8. Yin, RK. Estudo de Caso: planejamentos e métodos. Porto Alegre: Bookman; 2015.
9. Universidade Federal do Rio Grande do Sul. Faculdade de Odontologia. Projeto Político Pedagógico. Porto Alegre; 2005. [Cited: June 16, 2020]. Available from: http://www.ufrgs.br/odonto/projeto_politico.pdf.
10. Ministério da Educação. Conselho Nacional de Educação. Câmara de Educação Superior. Resolução CNE-CES n.º 3. 2002. Institui as Diretrizes Curriculares Nacionais do Curso de Graduação em Odontologia. *Diário Oficial da União, Brasília*, 4 mar. 2002. Seção 1, p. 10. [Cited: June 16, 2020]. Available from: http://portal.mec.gov.br/cne/arquivos/pdf/CES_032002.pdf.
11. Universidade Federal do Rio Grande do Sul. Faculdade de Odontologia. Resumo do pró-

- saúde faculdade de odontologia da Ufrgs 2009. [Cited: June 16, 2020]. Available from: http://www.prosaude.org/odo/resumo/UFRGS_ODO.pdf.
12. Minayo MCS. Sampling and saturation in qualitative research: consensuses and controversies. *Rev Pesqui Qualitat.* 2017; 5(7): 01-12.
 13. Fischer RMB. Foucault e a análise do discurso em educação. *Cad Pesqui.* 2001; 114:197-223.
 14. Caregnato RCA, Mutti R. Pesquisa qualitativa: análise de discurso versus análise de conteúdo. *Texto Contexto Enferm.* 2006;14(4): 679-84.
 15. Backes DS, Lunardi VL, Lunardi WDA. humanização hospitalar como expressão da ética. *Rev Latinoam Enferm.* 2006; 14(1):132-5.
 16. Martins AA, Franco TB, Merhy EE, Feuerwerker LCM. A produção do cuidado no Programa de Atenção Domiciliar de uma Cooperativa Médica. *Physis.* 2009; 19(2): 457-74.
 17. Nogueira RP. Determinação Social da Saúde e Reforma Sanitária. Coleção Pensar em Saúde. Rio de Janeiro: CEBES; 2010.
 18. Warmling CM, Schneider Pires F, Baldisserotto J, Levesque M. Ensino da bioética: avaliação de um objeto virtual de aprendizagem. *Rev Bioét.* 2016; 24(3): 503-17.
 19. Botazzo C. O conhecimento pelas mãos. *Rev ABENO* 2017; 17(4): 2-19.
 20. Marques VRS. O acolhimento como vertente de humanização na atenção à saúde do homem. *Rev Científ Inst Ideia* 2019; 1(8): 191-9.
 21. Lancetti A. Notas sobre humanização e biopoder. *Interface Comun Saúde Educ.* 2009; 13 (Supl.1):797-9.
 22. Ayres JRCM. Sujeito, intersubjetividade e práticas de saúde. *Ciênc Saúde Colet.* 2001; 6(1): 63-72.
 23. Castiel LD. Dédalo e os Dédalos: identidade cultural, subjetividade e os riscos à saúde. In: Czeresnia D, Freitas CM. Editores. *Promoção da Saúde: conceitos, reflexões, tendências.* Rio de Janeiro: Fiocruz; 2009. p. 83-99.
 24. Lopes GVDO, Menezes TMDO, Miranda AC, Araújo KLD, Guimarães ELP. Acolhimento: quando o usuário bate à porta. *Rev Bras Enferm.* 2014; 67(1): 104-10.
 25. Vasconcelos FN, Vasconcelos EM, Duarte SJH. O acolhimento na perspectiva das Equipes de Saúde Bucal inseridas na Estratégia Saúde da Família: uma revisão bibliográfica da literatura brasileira. *Tempus* 2011; 5 (3): 115-22.
 26. Czeresnia D. O Conceito de Saúde e a Diferença entre Prevenção e Promoção. In: Czeresnia D, Freitas CM. Editores. *Promoção da Saúde: conceitos, reflexões, tendências.* Rio de Janeiro: Fiocruz; 2009. p. 43-57.
 27. Conselho Federal de Odontologia. Código de ética odontológica: Resolução nº118 de 11 de maio de 2012. Rio de Janeiro, 2012. [Cited: June 16, 2020]. Available from: <http://www.cropr.org.br/uploads/arquivo/724571448d7a83c915ebc18e218042a3.pdf>.
 28. Orlandi EP. *As formas de silêncio: no movimento dos sentidos.* Campinas: editora da UNICAMP; 1992.
 29. Freire P. *Conscientização: teoria e prática da libertação: uma introdução ao pensamento de Paulo Freire.* São Paulo: Moraes; 1980.
 30. Moreira LAC. Ética e aspectos psicossociais em crianças e adolescentes candidatos a cirurgia bariátrica. *Bioética.* 2017; 25(1): 101-10.

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