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Conflicts in the practice of Dentistry: the autonomy in question

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ABSTRACT

The study aimed to arrive at an understanding of the dynamics and the changes faced by dentistry, using the professional autonomy category and its significance to professional discourse and the strategies that are used to preserve professional autonomy. The reflections are based on the sociology of professions, particularly the concepts of autonomy, expertise and service ideal. The research revealed that professional autonomy is still a strong element with an important role to play in shaping the identity of the group and that autonomy has not
been affected in spite of changes in the labor market.

Key words: Dentistry. Sociology. professional practice. professional autonomy. labor market.

INTRODUCTION

The definition of a profession has historically undergone the possession of a certain degree of autonomy legitimised and organised by control of its own work which means the exclusive right to determine who and how a person can exercise such profession. Some professions and among them Medical Doctors and Dentists were able to be the judges of their own performances under the justification that they are the only ones capable of evaluating their performances adequately furthermore guaranteeing basic standards. As a profession, they have the expertise and the ideology of an independent and quality service to society.

The insertion of Dentistry in the public service was constituted as health care for children on school age and to a great majority of the poor population, the most common practice was tooth pulling. Machado (1995) considers that if on the one hand, technological innovation produced solid knowledge which enhanced the competence and the action fields, on the other, it did not improve the

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enhancement in the quality of the services provided by dentists and in general, treatment of teeth problems has been restricted to the most privileged strata of our society. The success and consolidation of Dentistry as a profession refer to its liberal practice, thus, making questionable its benefits to society as a whole.

Medical profession studies on market questions (Donnangelo; 1975 Machado *et al.*, 1992) and of professional autonomy (Machado, 1997, 1996, 1995; Schraiber, 1993) in spite of different approaches, they point out that medical practice has undergone a transformation process from a liberal, individual practice which valued clinical experience to an institutionalised practice with a strong tendency to rationalization showing multiple forms of insertion and pinpointing the acting of group medicine.

As to the dentists practice, Machado *et al*, (1992) point out that among dentists, the autonomous group is rather large. The decrease in the number of autonomous professionals in the 70s of the 20th century was small. From a percentage of 69, 9% in 1970 to 54, 5% in 1980 of the total number of dentists. The research of Silva Filho and Eleutério (1977) made in Araraquara (SP) with surgeons that graduated from 1964 to 1974 showed that 61, 1% of these only worked as private surgeons.

Dentists work market suffers a lot of modification in the 1980s. Many studies show the tendency to wage receiving, a tendency of surgery practice combined with deed covenant and credentials and the association of both forms. The research of Pereira & Botelho (1997) made with 3,191 dentists in the State of Goiás shows that 51% were liberal workers, 48% worked as deed of covenant, 49% are common workers and receive salaries and 45% work in their private surgeries and receive salaries.

Jardim (1999) in a survey made in João Pessoa/PB noticed that 78, 4% of the dentists work in surgeries, 59% are civil servants and 9, 9% have a private job. Of the considered autonomous, 61, 6% work with deed covenants and the great majority (54%) for less than five years.

The survey carried out by the Regional Council of Dentistry of Minas Gerais State in 2000 with 1,199 surgeons of the state identified that 65,9% of the professionals are liberal workers exercising dentistry in surgeries, 56,2% of them work with deeds of covenant and credentials; those who are liberal workers and receive salaries are 25,2% and 8,7% are paid workers.

In a survey carried out by dentistry entities in 2002, 614 dentists were interviewed in Brazil. As to professional share, 26, 6% are civil servants, 11, 1% are private sector workers, and 89, 6% work on their own surgeries as liberal professionals. A percentage of these (56, 2%) work with deed covenants and credentials. Of the civil servants, 48, 5% are in the Family Health Programme or PSF (Ministry of Health, 2003).

Reflections about professional autonomy are based on the sociology of professions having as a basis concepts such as autonomy, expertise (Freidson, 1970; 1994) as well as the concept of ideal of service developed by Moore (1970).

Most authors in the field of sociology of professions consider that the main characteristic of the occupations considered professions is the esoteric knowledge acquired through a prolonged formation (Goode, 1969; Moore, 1970; Wilensky, 1970; Friedson 1970, 1994). By that, the monopoly of knowledge is defended, the control over work and, thus, the capacity of regulating itself as an activity and have independence in its development and practice.

The ideal of service or the collective orientation encompasses rules that have as aim to guide technical procedures which focus on the clients rather than professionals and are considered one of the key elements in the process of professionalization (Goode, 1969; Moore, 1970; Freidson, 1970). The professional's behaviour has to be based on the ethical code in relation to clients and other professionals.

The central object of this study is to comprehend the vision of the professional in relation to its working context, the pitfalls that professionals face in different spaces and types of practice as well as the strategies developed to overcome and preserve their work autonomy. The main foci are the technical and market autonomies as axis of the professionalization process taking into account reflections of professionals about their practice.

METHODOLOGY

This is a field survey of as qualitative approach. To obtain the data, it was necessary to combine life story with semi-structured interview (Becker, 1999). As Minayo (1994) points out, the qualitative survey has as its main characteristics: openness, flexibility and capacity of observation and the interaction with the social actors involved.

Semi-structured interviews were carried out with 12 dentists of João Pessoa County in the State of Paraiba, Brazil. Three of them are experts of dentistry health plans. Following the qualitative tradition to come to this number, the criteria of exhaustion and saturation were followed, that is, when the researcher verifies the formation of a whole and recognizes recurrences in the collected data (Blanchet & Gotman, 1992).

The research was approved by the ethics committee of Federal University of Paraiba (UFPB). To carry out the interviews, it was previous explained to interviewees the objective of the study and each signed a consent term observing the ethical and scientific demands of surveys with human beings as stated in the Resolution 196/96 of the National Health Council (Brazil, 1997).

The interviewees were randomly selected based on the list of specialists provided by the Regional Council of Dentistry – Paraiba Section and obeyed the following criteria: 1) professionals who were working in the period of the study; 2) professionals of different specializations; 3) professionals with different market insertions and different experience of work (more or less time) to characterize the undergoing of market transformation so as to reflect a degree of heterogeneity which exists in reality; 4) the interest of the professional in taking part in the study.

Interviews were carried out following a preliminary script evaluated through a pilot interview. The interview dealt with themes such as the choice of profession, daily practice, problems faced by professionals in daily practice that result from the job market transformation and what strategies professionals use to preserve their autonomy.

Based on the literature about sociology of professions, more specifically on the contributions of Freidson (1970, 1994), Goode (1969), Larson (1977), Moore (1970), Schraiber (1993) and Ribeiro & Schraiber (1994), we elected the following criteria for analysis which are inter related.

- Autonomy as a professional identity element: technical autonomy is related to the capacity of judgment and decision making in the work process and constitutes a theoretical category which makes it possible to articulate knowledge and power; market autonomy has to do with the capacity of the profession to sell itself in the service market.
- Expertise – knowledge as a fundamental element to characterise a profession.
- The ideal of service considering the social commitment of the professional so as to contribute to the improvement of health conditions of his or her patients.

RESULTS AND DISCUSSION

The interviewed professionals were eight female and four male, all graduated between 1979 and 1996 and ages varying from 29 to 45 years old. Nine of them are specialists; three are general practitioners and have made post graduate courses at updating and improvement levels. The three general practitioners work as experts in dental care enterprises.

The reasons that influenced in the choice of profession are related to individual and social questions. One common aspect to all is the choice of health area. Other aspects are important in the reports such as the interest for a profession that has liberal characteristics and the possibility of having a good income and be independent. This was the image that they had of the profession: a liberal profession, although the reports showed a discrepancy between what was real and the imaginary when it came to work market position. There were reports of professionals who arouse the interest and vocation to the profession.

It was possible to notice the various forms of insertion of dentists in the work market: five of them are paid workers and work in their surgeries under the “liberal” flag working with deed covenant and credentials; two are paid workers and work in their surgeries under the “pure” liberal form without deed covenants or credentials; four of them work only in their surgeries accepting deed covenant and credentials and only one of them is purely a wage worker, working as a teacher.

The first years after graduation are for an effective insertion in the work market followed by a search for a specialization. The main interest is to improve clinic experience once trainee jobs are not enough to give professionals the required experience they need in practice. A common trait among all interviewed is that they started their professional lives under a dentistry that no longer liberal, that is,

they put together experience in private surgeries in the outskirts of cities as underemployed with no working rights, as private or public paid workers and the work in surgeries under the liberal flag either individually or sharing a surgery with colleagues.

LIBERAL PRACTICE: THE FEELING OF CHANGE

Almost all interviewed referred to the association between professional autonomy and the concept of a liberal profession. In a study by Machado (1996), doctors also associate autonomy to the liberal profession concept. The concept of liberal practice means the way in which the professional markets his or her services in the market determining how he is paid for that and the bonds of clients—how the patients freely choose them.

It was possible to identify many forms of insertion of dentists in the market as paid work and work in surgeries with health plans as pointed out in studies about medical profession made by Donnangelo (1975), Machado (1996, 1997), Schraiber (1993).

> When I graduated (1986), the idea of a liberal professional was still around. This was the philosophy of professors at University, of graduating and working in a private surgery. We had the idea of finishing the course and to be free to work in a surgery but reality is not like that. To be a liberal professional was the objective in life but when you start working you really see this aim even more distant. I never had the chance of being a pure liberal professional mainly to depend exclusively of my surgery. I worked in the surgery but I was also a paid worker. (Teacher)

> I did not know the liberal dentistry. I started my professional life in the late 1980s as a civil servant and in surgery working with deed of covenants […] the percentage of private clients is too small especially when you are beginning and has no specialization. I did not live this situation of liberal dentistry. I think this is the image that they have of the profession which is reinforced by schools and entities. (Children dentist)

> When I started studying dentistry in 1987, everybody told me it was the best profession, which was the only liberal, that there were no health plans or deeds of covenants but I started working within this framework in my surgery and as a specialist. (Specialist 2)

The new forms of insertion of the professional in the work market made changes in work relationships and with clients. The production of services does not depend exclusively of the professional, the clients are institutionalized, there are distinct forms of getting new clients, redefining kind, quantity and access of clients to professionals and the main point is the re-directing of professional-patient relationship. The institutionalization of such model in what regards technique and the organization of work and distribution of services in society represents changes. As Schraiber (1993) points out, the professional who works in a surgery is related to the ways in which clients

come to him through deeds of covenant and credentials. Besides loosing control over the clients, the professional looses control over how he is paid because it is subordinated to market conditions and the difference in the amount of payment that the professional has no control of.

AUTONOMY: AN ELEMENT OF PROFESSIONAL IDENTITY

All the interviewed professionals referred to autonomy as an essential question to the daily practice. According to Schraiber (1993) practice is considered adequate and technically qualified when the professional is in conditions of acting on the basis in technical knowledge, his own judgement and power to decide. In a first moment, in practice, professional give high value to technical element represented by the act of receiving the patient which is considered he basis of the work. Thus, the step of producing the technical act, the diagnosis and therapeutics are considered essential to the preservation of autonomy. The implicit questions are seen through a technical perspective making the autonomy at work a priori only a technical act. The question of preservation of technical autonomy is common in the interviews in spite of restrictions of autonomy through the market.

> I think that the professional is the one who has to decide the plan of treatment independent of anything. You have to decide according to ethics. From the moment that you have the knowledge, it is your call; you are responsible; we cannot depend on the analysis of an auditor. This autonomy the professional has to have and a person who is not doing the treatment cannot say what you have to do. (Endodontist 1)

> My practice in my surgery is according to my knowledge, my conscience and my principles. I admit that we have an economical dependency, that is, we need deeds of covenant to work but I do not give up my technical autonomy in the treatment with the patient even when I have financial deficit. (Children dentist)

We showed that the transformation in the organization of work demonstrate a new perspective in the way how autonomy is perceived by professionals. There is a displacement of autonomy as the essence of work to an exterior plan, the social plan. Thus, working conditions are identified as conditions of work autonomy. In spite of considering the work in surgeries as the main activity—which in fact symbolizes professional work because it is the situation which gives the best profit and prestige—the work space is considered as a “free space” in which professionals live work autonomy. The situation of employment, public or private, leads to a concern with preservation of autonomy in relation to the quality of the assistance given.

Nowadays practice proposes new obstacles which reduces the capacity of professionals to do their daily jobs in a way that satisfies them and this satisfaction is not only related to economic

compensation. To professionals, the ideal of service appears as an element as important as the ideal of autonomy, that is, they are interdependent.

> We suffer interference in your job everywhere you work. In the public service you have no work conditions and is limited in what you can do. In your surgery when you work with deeds of covenant, you undergo the scrutiny of experts […] I have always worked according to my conscience and what was possible to do according to work conditions and what I learned in my trade […] Treat well and give the best assistance within the work conditions. Not to do anything which was contrary to my principles. Not to do anything wrong due to lack of work conditions. (Endodontist 1)

The experience and meaning that each professional attributed to their practice represent their individuality while a social subject in a given historical context. Schraiber (1993) considers that in the space of autonomy, choices would not be exclusively technical but expression of ethical values which gives the actions a moral sense. This is the position of Castro Santos (2002) to whom the very concept of profession is undergoing a revision when assimilating elements of an ethical nature to the professional project and to the strategic dimension of how professional associations act. This would be the case of the nurses' profession which is traditionally considered a "semi-profession" when sharing an altruist orientation and moral expectations about the notion of duty, as well as services to society and patterns of performance. This means that values are present as part of the action guiding them. The stories we collected show this concern with ethical order.

Besides the problems with working conditions, the interference in technical autonomy (for example, not being able to do a job technically well), dissatisfaction with paid work, be it public or private, is directly associated to the incompatibility between worked hours and salary consequently leading to personal and economic dissatisfaction. The association between low salaries, long work hours, bad working conditions and the feeling of under value and lack of prestige lead to a disenchantment with the profession. Such situation was also seen in other studies such as Araújo (2002, 2003); Machado (1996, 1997); Machado & Souza (1999). Of the people interviewed six (50%) stated that nowadays they would not choose Dentistry as a profession.

If, on the one hand, autonomy defence conjures altruistic arguments such as the defence of a quality assistance and good working conditions to a good technical performance, on the other hand, arguments of private interests; the search for economic reward and status. It is a strategy of maintenance of the old professional identity: liberal professionals, different which are preserving individually or by their personal efforts, the quality of assistance and this is because of preserved autonomy.

ESPECIALISATION/EXPERTISE

Specialisation is one of the arguments in defence of autonomy. This should always be preserved while an independent form through which professionals articulate to their main mean of work: knowledge. The defence of technical autonomy gains support in the technical demands imposed by the instrumental difficulties, the manual and intellectual dealing with the scientific which is becoming more and more complex.

> Experts think that when you do a treatment plan you want some financial advantage. He looks and many times has no competence. It is not an attempt to diminish your colleagues' worth but he is not a specialist. We all have our limitations and we cannot want to know everything. […] Dentistry has a wide spectrum; there are new techniques, materials, studies. Can he follow all that in all areas? (Periodontist)

The strategy of trying to maintain technical autonomy as a work tool is only one of the meanings of such changes. This also shows the search to maintain the monopoly over knowledge and practice once such autonomy is threatened because of transformations in work organisations, this monopoly is equally threatened. So, the expectancy for professionals is to maintain to their profession the position or situation previously conquered. The monopoly of knowledge and practice grants social benefits or as Bourdieu (1989) says, confer social benefits, that is, status, power and prestige.

The polarisation between the more technical specializations and the general specializations undergo a myriad of situations in which the professional has varying degrees of control over the technique and also over the market position. It is the case of specialists in ortodontics, surgery, prosthetics and implants who have a bigger market autonomy. The question of paid work, the dependency of surgery income of covenants and credentials is still seen as external to their practice, different from professionals of more general specialities.

> The work with covenants today is a reality but you need to choose with which ones you are going to work. […] Health plans exploit professionals. It is a very big investment to professionals in terms of study and maintenance of the clinic (materials, instruments, workers, everything). […] Covenants do not interfere in treatment plans; the only one which has limitations is Petrobrás. It determines that children up to the age of eleven we cannot put a fixed device. But there are cases in which a 10-11 year-old has all the permanent teeth. This is a major drawback once chronological age does not mean bone and dental ages, it depends on each case. That's the only problem but I never had any problems with forensics, of interference in my treatment plan. (Orthodontist)

> I work in my surgery for more than twenty years and I only accept private customers […] I was once invited to take part in a cooperative but I almost never get clients from them, one or another every 2-3 months […] I have a clinic of specialties where professionals work for me and there I accept covenant treatment but you have to

> choose with which ones you are going to work with; I only accept those which pay according to the National Table or over. It is too much professional and financial investment for you to submit to those plans. (Surgeon and Prosthetics)

There is no such thing as homogeneity within the category once social positions of the various agents vary. Specialization is one of the components to differ and qualify professional practice and it is one of the ways for the professionals to establish himself and compete in the job market. For those who are not specialists, working is important to qualify their professional development and to follow technical-scientific development.

> Dentistry is a wide spectrum profession […] There is no condition of dominating all knowledge , technological advances. Specialization is essential; it is necessary to exercise adequately your practice. […] In the market, only the specialist is praised, there is only space for the specialist. (Surgeon and Prosthetic)

> The professional that makes the treatment is a specialist and I am not. I have to be updated to discuss with professional; I have to know the techniques, materials because when he arguments he used such and such material and this is going to happen, I have to know if it is true or not. I have to know if his reasoning has coherence or not; I need to reason to. That's why I am always doing courses and reading a lot. (Forensics 2)

IDEAL OF SERVICE

Among the questions that can be identified as restrictive to the idea of service, we point out the interference of enterprises over the work of forensics and the interference of the forensic expert in the professional-patient relationship.

Professionals consider that forensic experts extrapolate their functions and end up acting in a non-ethical way because they put pressure so that cheaper procedures are carried out to benefit companies. Besides, they "gloss" the made procedures which results in non payment of jobs already done. The non-acceptance of professionals of forensics interference even though it is made by a peer professional shows the conflict of interests. As stated by Bahia (1999), it is clear that the relationship between service providers and companies of health care is a conflicting one.

The interference of managers of dentistry enterprises is common in auditing practices. They implement explicit controls in relation to forensic experts as well as in relation to accredited professionals and patients to reduce costs rather than promoting access to services and care. Thus, professionals and patients alike face situations in which their interests are not respected.

> When I arrived in the company they came to talk to me to guide me on how to fill forms, to tell what the rules of the company were and that I should authorize only the

> necessary. Prevention for children up to 12 years old, resin restoration only prior and aesthetics. These norms have as their aim to reduce costs and these were the recommendations I received. […] They also recommend that accredited professionals do few procedures a week so that treatment takes longer and users do not leave the heath plan because lots of them give up. In the business clinic it is even more restrict because of the number of patients and they want to shorten the waiting time to attend more people. (Forensic expert 3)

In what concerns the relationship professional-patient, it is compromised when there is divergence between the diagnostics and the treatment plan. Mainly if the forensic expert does not find an ethical way of convincing the patient to return to the surgery.

> You give a certain diagnostic; make a treatment plan and the expert questions it. For example, you could have a periodonty without the presence of tartar and he doubts your diagnostics saying that it is not periodontitis but gingivitis. We know that the procedure for gingivitis is cheaper. He questions in front of the patient. The client then is in doubt; who is right? The professional or the expert? It is embarrassing and anti ethical basically because it interferes in the relationship professional-patient. The patient goes for you by indication, trusting your work. (Periodontist)

> You make the treatment plan and when it comes down to forensics, they do not authorize following procedures using resin, they only authorize to do in amalgam […] And you do not have anyone to recur to; the reason is to reduce costs […] they put pressure on you to perform only the cheapest procedures. […] Even when this happens, I do the way I planned, even losing money. I do it based on my autonomy and my conscience. (General practitioner)

We noticed that paid workers in their daily practice face many ethical conflicts. According to Castro Santos (2002) and Schraiber (1993) in the autonomy space, choices would not be solely technical but would express ethical values giving a certain action a moral sense. Dilemmas by auditors of following or not the company “rules” and acting only on a cost-benefit bias—where the patient’s welfare should be the main point to be considered—are a daily feature of their work.

> Sometimes I feel embarrassed not to authorize a procedure. I put myself on the professional shoes and I know that certain things don’t make sense but are company rules and if I act differently, I am the one who is going to answer to that. We are evaluated also. We have periodical auditing and they evaluate everything we are authorising , if there is favouring, which criteria I am using, if it is uniform, if we are applying the rules that they are determining. […] The company wants the client satisfied, the professional as a partner and you saving for the company. And you are in the middle of the three. There are days you wish everything is gone. It’s a very difficult job. (Forensic expert 2)

According to Schraiber, paid jobs respond to company rules and norms and this could produce compromising procedures which conform professional exercise limiting autonomy and endangering the ideal of work. The ideal of work and autonomy are “tensioned” or “conditioned” to external facts. If we confront the interviews of professionals and forensic experts, we notice that the main criteria used by companies when performing forensic evaluations is the reduction of costs, independent from the patient’s welfare. Their argumentation is permeated by a cost-benefit rationale.

CONCLUSION

The changes that happened in the health system during the 80sand 90s had reflected in the work market. Supplementary medicine composed by enterprises of group Medicine and Dentistry, cooperatives, health insurance companies and the State started to intermediate the professional practice. Professionals who are inserted in daily practice suffer many restrictions which were not commonplace in their routines and see themselves limited in their autonomy, in their liberal practice and in their ideal of service. There is a lot of work with low salaries and the working conditions are not ideal for a good practice. Thus, the ideal of service is subdued to the ideal of the market; the quantitative aspect superimposes the quality of assistance.

The position of professionals is not to submit them to this new “world of work” but to reinforce the values of the profession. Control over practice, the dominion of knowledge and specific skills are questions over which professionals do not give up and they look for strategies to soften the reduction of autonomy. It is the search for conciliation between professional interests and the interests of the community.

In what concerns autonomy, as the main characteristic of a profession, it calls our attention the fact that autonomy as a value which conforms identity is not shaken, identity stands still. It is possible to build a professional identity, that is, it is clear to professionals, their cognitive basis is solid. What we noticed from the interviews that there are practices which pinpoint a problem in the service market. There is systematic attempt to conciliate the ideal with objective work conditions in an effort to preserve autonomy even at the expense of the transformation of the professional exercise.

The arguments of those who are in the daily practice is that autonomy is the pillar to guarantee the quality of assistance, of the prestige and respect to the profession. Professional use “altruistic” arguments such as the collective good—and we report to the importance given to the ideal of service or collective orientation pointed out by authors such as Freidson (1970) and Moore (1970)—and at the same time they use the collective to build up arguments to defend the profession which I call arguments of “private interest”. The status and social prestige of the profession are defended with arguments that are distant from the social or the collective and very close to the gaining of professional advantage such as a good salary and practice based on professional autonomy.

It is important that professional organisations and among them the Federal Council of Dentistry (CFO) “show” reality. The ideological elements of practice and teaching should be shown and this should be done with a certain criticism to the profession to overcome the fragmented view of their members. The University exercising the role of the formative part of professionals should break this guidance so that the obvious should not be obscure.

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