"I Should Have Been Able to Do at Least Something": Protocols, Frustrations, and Emotional Silencing in Dental Care for Patients with Disabilities

"Era pra Eu Ter Conseguido Fazer ao Menos Alguma Coisa": Protocolos, Frustrações e Silenciamentos Emocionais no Atendimento Odontológico a Pacientes com Deficiência

"Se Suponía que al Menos Debía Haber Logrado Hacer Algo": Protocolos, Frustraciones y Silenciamientos Emocionales en la Atención Odontológica a Pacientes con Discapacidad

RESUMO

Objetivo: Compreender a percepção dos cirurgiões-dentistas sobre o atendimento a PcDs. **Método:** Estudo qualitativo de abordagem fenomenológica, baseado no Método Clínico-Qualitativo, realizado com seis cirurgiões-dentistas do serviço privado de Piracicaba (SP), utilizando entrevistas semiestruturadas em profundidade analisadas por Análise de Conteúdo Clínico-Qualitativo. **Resultados:** Emergiram três categorias: "Os protocolos na formação odontológica e o manejo dos casos: caminhos que facilitam ou rigidez que limita?", "Entre o idealizado e o possível, surge a frustração" e "A angústia do profissional frente às próprias emoções durante o cuidado". **Conclusão:** O atendimento odontológico a PcDs envolve desafios que ultrapassam a técnica, expondo dificuldades emocionais pouco abordadas na formação. A rigidez dos protocolos limita a autonomia dos profissionais, gerando frustração e insegurança diante de casos complexos. Sem preparo para lidar com as próprias emoções, muitos acabam silenciando seu sofrimento durante o exercício da prática clínica.

DESCRITORES: Percepção. Dentistas. Pessoas com Deficiência. Clínicas Odontológicas.

ABSTRACT

Objective: To understand dentists' perceptions of dental care for people with disabilities. **Method:** A qualitative phenomenological study based on the Clinical-Qualitative Method, conducted with six dentists from the private sector in Piracicaba, São Paulo, using in-depth semi-structured interviews analyzed through Clinical-Qualitative Content Analysis. **Results:** Three categories emerged: "Protocols in dental education and case management: facilitating paths or limiting rigidity?", "Between the ideal and the possible, frustration emerges," and "Professional distress in facing one's own emotions during care." **Conclusion:** Dental care for people with disabilities involves challenges that go beyond technical aspects, revealing emotional difficulties rarely addressed in professional training; rigid protocols limit professional autonomy, generating frustration and insecurity in complex cases, and the lack of preparation to deal with one's own emotions leads many professionals to silence their suffering during clinical practice.

DESCRIPTORS: Perception. Dentists. People with Disabilities. Dental Clinics.

RESUMEN

Objetivo: Comprender la percepción de los cirujanos-dentistas sobre la atención odontológica a personas con discapacidad. Método: Estudio cualitativo de enfoque fenomenológico, basado en el Método Clínico-Cualitativo, realizado con seis cirujanos-dentistas del sector privado de Piracicaba, São Paulo, mediante entrevistas semiestructuradas en profundidad, analizadas a través del Análisis de Contenido Clínico-Cualitativo. Resultados: Emergieron tres categorías: "Los protocolos en la formación odontológica y el manejo de los casos: ¿caminos que facilitan o rigidez que limita?", "Entre lo idealizado y lo posible, surge la frustración" y "La angustia del profesional frente a sus propias emociones durante el cuidado". Conclusión: La atención odontológica a personas con discapacidad implica desafíos que superan la dimensión técnica, evidenciando dificultades emocionales poco abordadas en la formación profesional; la rigidez de los protocolos limita la autonomía del profesional, generando frustración e inseguridad ante casos complejos, y la falta de preparación para manejar las propias emociones lleva a muchos a silenciar su sufrimiento durante la práctica clínica.

DESCRIPTORES: Percepción. Odontólogos. Personas con Discapacidad. Clínicas Odontológicas.

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INTRODUCTION

It is estimated that there are approximately 1 billion people with some form of disability worldwide[1-3]. In Brazil, according to data from the Brazilian Institute of Geography and Statistics (IBGE) from 2022, this number corresponds to approximately 14.4 million individuals[4-6]. Law No. 13,146/2015, which establishes the Statute of Persons with Disabilities, provides in Article 2 that Persons with Disabilities (PwDs) are those who have long-term physical, mental, intellectual, or sensory impairments which, when encountering various barriers, may hinder their full and effective participation in society on an equal footing with others[7].

PwD are defined as individuals who have some type of impairment, with causes of a biological, mental, social, behavioral, or physical nature, requiring, in most cases, specific care that differs from that of others, whether for a specific period or for life[8,9]. Depending on the diagnosis, these individuals can be classified into categories such as physical disorders, mental disorders, congenital anomalies, psychiatric disorders, behavioral disorders, infectious and contagious diseases, and sensory and communication disorders[10]. According to the Ministry of Health, a person with a disability is one who has one or more temporary or permanent limitations related to mental, physical, or emotional health, growth, or medical conditions, ranging from hereditary diseases and congenital defects to systemic diseases, behavioral changes, and aging. Factors that, collectively, may hinder or prevent the application of conventional approaches in dental care[6,11,12].

The terms used to describe this group of individuals have undergone several changes over time, ranging from "Exceptional Individual" to the current terminology "PcD," established by the 2009 Convention on the Rights of Persons with Disabilities. In the dental context, the Federal Council of Dentistry, recognizing that these individuals require a differentiated approach, adopted the term "Patients with Special Needs (PNE)"[13,14]. These patients often have limitations stemming from their underlying conditions, which hinders cooperation during treatment. This reality significantly compromises the maintenance of adequate oral hygiene, resulting in a higher incidence of dental caries, periodontal disease, edentulism, oral trauma, and poor oral hygiene[11]. Furthermore, poor oral hygiene negatively impacts the individual's general health, being influenced by factors such as difficulties with motor coor-

dination, reduced muscle tone in the cheeks and tongue, as well as the use of medications that cause side effects such as xerostomia[15] .

In this context, dentistry must focus its attention on people with disabilities, taking into account their specific characteristics and needs, especially given the limited access to dental care and the potential lack of training among dentists, which can lead to the inappropriate referral of these patients to hospital care[4,5,15] . Thus, it is essential to provide appropriate guidance to caregivers and/or guardians, contributing to the promotion of oral health and the reduction of preventable complications[16] . It is worth noting that responsibility for the oral health care of people with disabilities should be shared among all professionals in the Health Care Network (RAS), in both the public and private sectors. Within the Unified Health System (SUS), most cases can and should be managed in Primary Health Care (PHC), with referral to specialized care reserved only for situations of greater complexity or difficult management[17] . Given that a significant portion of patients are not covered by the SUS and therefore seek private care, private-practice dentists play a crucial role in the oral health care of these patients. In the public sector, dental surgeons work within multidisciplinary teams, with emotional support and access to referral services, such as Dental Specialty Centers (CEO). In private practice, however, they generally work in isolation, without emotional support or a referral structure. Given this, it is important to investigate these professionals' experiences in caring for people with disabilities (PwD).

Balint (1988)[18], in his theoretical and practical investigation of the doctor-patient relationship, highlights the role of the healthcare professional as a central element in clinical dynamics, emphasizing that the emotions involved in this relationship extend beyond the personal sphere and directly influence professional practice; recognition of this aspect can contribute to safer and more empathetic care. This perspective leads us to reflect on the importance of understanding dental surgeons' perceptions when caring for PwD, in order to deepen our understanding of the phenomena surrounding this practice. Given the social relevance of oral health for PwD and the difficulty—already widely described in the literature—regarding the care of this population by a significant portion of professionals, there is a justified need to explore their perceptions as a means of informing strategies that promote more qualified and inclusive care.

METHODS

Overview

The methodology of this study was designed based on phenomenology and elaborated using the Clinical-Qualitative Method (CQM)[19,20] , enabling the exploration of the perceptions of dental surgeons in the private sector of the city of Piracicaba, São Paulo, regarding dental care for patients with disabilities. In-depth interviews were conducted using open-ended questions to address the topic flexibly and gather information, perceptions, and experiences from the interviewees in their work environments[21] .

Sampling and Recruitment

The study population comprised 6 dental surgeons working in the private sector in a municipality of approximately 407,000 inhabitants in the southeastern region of Brazil. Four work in two different settings, that is, they provide services in more than one clinic, and two work in their own private practices. The inclusion criterion was: being a practicing dental surgeon in private dental clinics in the municipality of Piracicaba, São Paulo, who agreed to participate, with the respective authorizations via the Informed Consent Form (ICF) signed by them.

The sampling termination criterion was based on saturation, in which all participants in the study population were interviewed. The sample was selected by convenience, taking into account access to participants, that is, transportation and distance to the dental offices visited in the city. Initially, a pilot study was conducted to test the suitability of the interview guide with two professionals from the study population who met the inclusion criteria. The purpose of the acculturation was to deeply understand the participants' perspectives, values, norms, and behaviors by directly observing and experiencing their cultural practices[22] . Five dental surgeons refused to participate in the study, ceasing to respond to the researcher's contact attempts.

The researcher made initial contact with the dental surgeons who practice in private clinics via *Google Meet* and at the interviewee's office interviewee's office. After explaining the interview and receiving acceptance of the invitation to participate, the informed consent form was provided, discussed, and signed.

Ethical Approval

This study was conducted in accordance with the latest revision of the Declaration of Helsinki, which establishes ethical standards, following the guidelines of the Research Ethics Committee of the Piracicaba School of Dentistry, University of Campinas (FOP/Unicamp). The project was approved under number 75470923.2.0000.5418 in the Certificate of Submission for Ethical Review of the Brazil Platform[23] .

Qualitative data collection

Interviews began only after obtain-

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ing the signed informed consent form. Regarding the data collection method, a semi-structured interview was employed, characterized by including fundamental questions grounded in theories and hypotheses related to the research topic. This format, in turn, facilitates the emergence of new theories and questions arising from the participants' responses. Furthermore, it is distinguished by the researcher's active and conscious presence in the information-gathering process[24] .

The interview script was designed with the following trigger question: "*What does a patient with a disability mean to you?*" This question guided the beginning of the interview, along with supplementary questions added throughout the interview to address the research question. At the end of each interview, each participant was asked about their emotional state and whether they wished to share any additional information. All details of the interview setting, such as tone of voice, posture, and description of the environment, were carefully recorded in a field notebook. The data underwent processing and validation through peer discussions with researchers from the Qualitative Research Study Group (GEPEQ) at FOP/Unicamp. This group, consisting of a multidisciplinary team comprising a nurse and four dental surgeons with interview experience, analyzed the performance and offered suggestions regarding the content of the interview guide and the interviewer's demeanor.

The principal investigator conducted the interviews via *Google Meet* and at the interviewee's dental office, without the presence of observers, with an average duration of 50 minutes per interview. The interviews were audio-recorded and subsequently transcribed in full by the interviewer, preserving the accuracy of the statements for subsequent categorization and systematization. To ensure the anonymity of the participants in the transcripts, their names were replaced with fictitious names.

Data Analysis

The data were collected and analyzed using Clinical-Qualitative Content Analysis (CQCA)[20] . This analysis is part of the MCQ, which is particularly applied in the health field. This analytical approach involves a process of organizing, understanding, and interpreting the material obtained through the transcription of the interviews and comprises seven stages to be carried out sequentially or simultaneously[25] .

RESULTS

Six dental surgeons working in the private sector in the city of Piracicaba, São Paulo, Brazil, were interviewed. The interviews were conducted between April and May 2025; three took place at the dental offices where these dentists practice, and three were conducted remotely via *Google Meet*, according to the preference and convenience indicated by each interviewee. The main characteristics, such as age, gender, years of training, and specialty practice of each interviewee are presented in Table 1.

Table 1. Key characteristics of the respondents Source:

	Age	Gender	Years of training	Specialty
E1	28	Female	4 years	Generalist
E2	31	Male	9 years	Implantologist
E3	27	Female	4 years	pediatric dentist
E4	32	Male	7 years	Generalist
E5	31	Female	7 years	orthodontist and generalist
E6	28	Female	4 years	General practitioner

Source: author's own work, 2026.

The analysis clinical-qualitative of statements originating the interviews revealed the emergence of three thematic categories:

1. Protocols in dental education and case management: paths that facilitate or rigidity that limits?
2. Between the ideal and the possible, frustration arises
3. The professional's distress in the face of their own emotions during care

1) Protocols in dental education and case management: pathways that facilitate or rigidity that limits?

The participants' statements demonstrated that the emphasis on protocol-based care—a hallmark of dental education—while necessary, can potentially strip students of their autonomy and freedom to act, generating insecurity during patient management; protocols constrain clinical reasoning to such an extent that any need for improvisation or actions that deviate from these protocols generate insecurity and even self-doubt among professionals regarding their technical competence.

"[...] because in college, when it comes to patient management—even with children—you know, when the situation calls for it, I feel unprepared, and we say things like: 'Geez, I'm a healthcare professional; I have to discharge a patient who needed care, and I wasn't able to fulfill my role in their life,' *so, like, that... makes me... feel disappointed in myself and...*

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and... disappointed to think, maybe not the patient, maybe the patient doesn't. doesn't

realize it, but for example the mother, who comes expecting the patient to be seen and isn't, so... we... think: I embarrassed myself in front of the mother, whom I couldn't see; sometimes we're hard on ourselves too, right? What will the mother think of me as a professional? What will the clinic director think of me as a professional? That's right. It causes a lot of disappointment." (E1)

"It causes anxiety because you have to think fast; you have to figure out what I can change here (regarding the protocol established in medical school*) to make the patient more comfortable. So, yes, it does create a sense of anxiety, you know, about... the issue of having little time for planning and preparation, you know, more..."* (E6)

"It wasn't an act of desperation, but it was. the only thing left, or it was that

or the child would leave with an abscess and... and face an infinitely more dangerous situation, [...] but I, I felt as if I had taken a desperate approach, right..." (E6)

2) Between the ideal and the possible, frustration arises

The interviewees' comments highlighted the complexity of dealing with situations in which the results obtained in practice do not match the professional's expectations:

"You think: wow, I was supposed to have managed to do at least something, but I couldn't do absolutely anything, so you feel incapable, you feel distressed, you leave, and you spend the day thinking about it." (E1)

"Look... in a way it's frustrating, right, because you tried in all sorts of ways (laughs) *and couldn't desensitize them* (laughs), *and then you stayed there for ages talking... and... couldn't get anything done"* (E2)

The professional's distress in the face of their own emotions during care

There is a clear concern on the part of the professional regarding the technical management of the patient; however, there is no observable concern on the part of the professional regarding managing their own emotions in the face of situations that clearly affect them. On the contrary, what can be perceived is a concern with "suppressing" their feelings.

"It's like... suppressing that feeling... (long pause) *I don't really know how to explain it to you in words, you know, what it's like to suppress this feeling, it's more, it's... you... knowing... that your personal emotions there, your human emotions, they, no, they shouldn't... they shouldn't surface at a moment when you need to be serious, right? So the professional has to speak up and maintain personal confidence"* (E6)

"I try to suppress, yeah, like, stifle that... that anxiety, to, to show confidence so the patient ends up trusting us, right? But it's always there—I think that with any procedure, no matter how used to it the person is, there's always... that little bit of anxiety left..." (E6)

DISCUSSION

This study adds a new perspective to the discussion on dental care for patients with disabilities by highlighting the dentist's subjective experience in providing such care, whereas most studies in the literature focus solely on the technical aspects involved in this context. And understanding the symbolic content inherent in this care is important, as it can reveal the complexities of this care. By understanding them, it is possible to address them and create strategies to cope with them, thereby making this care feasible and improving its quality.

Thus, when listening to the dental surgeons' perspectives on care for people with disabilities, certain aspects stood out. Their statements highlighted tensions between the standardization of clinical care through protocols and the need for more flexible and creative responses in light of the uniqueness of each case. During dental training, clinical protocols serve as guides for clinical practice. They shape the training process, and their importance is undeniable. However, when the application of protocols is too rigid, the professional risks having their autonomy and creativity limited. In situations requiring improvisation and adaptation, responses may not occur in a timely manner or to the extent necessary[26].

Dental education, by prioritizing technical and procedural mastery within strict parameters, may compromise the development of more creative and responsive clinical reasoning. The focus on rigid protocols seems to be adequate only for needs visible during patient care. This rigidity translates into insecurity and self-doubt, especially when the professional faces contexts that demand strategies outside the scope of protocols. In this sense, clinical practice ceases to be a field for constructing unique solutions and comes to be experienced as a space of pressure and inadequacy. The training of health professionals has been undergoing transformations, with the aim of developing a more comprehensive practice focused on promoting social change. In this scenario, healthcare for people with disabilities assumes a relevant role, considering the multiple barriers that hinder their access to services, such as communication limitations, a lack of empathy on the part of professionals, architectural obstacles, and inadequate equipment[27].

Particularly with regard to academic training in dentistry, significant gaps still exist in the care of people with disabilities, which often results in unnecessary referrals to secondary care services and a consequent increase in demand at that level of care. This reality highlights the importance of including, in undergraduate

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curricula, specific content focused on dentistry for people with disabilities, in order to train professionals to properly manage these patients, both from a technical and behavioral standpoint. Considering that dentistry is still heavily marked by a technical approach, which tends to depersonalize the patient, care for people with disabilities becomes an even greater challenge, reinforcing the urgency of training that promotes a more humanized and preventive approach, capable of ensuring a better quality of life for this population[28] .

In this context, there remains a persistent difficulty in prioritizing the human dimension of care over the excessive emphasis on dental technique. Technical expertise, widely reinforced and demanded in clinical practice, continues to be viewed as the primary determinant of therapeutic success. There is also a tendency to distinguish between patients considered easier and those seen as more difficult, revealing a preference for treating people who fit a passive and predictable profile, similar to the controlled environment of undergraduate clinical training. This stance indicates a valuing of uninterrupted technical application, as if the ideal were the execution of the procedure without the complexity of human interactions[29] .

Although the results of the technicist scientific method are widely recognized as valid, it is possible to observe that science, by adopting an objective and technical perspective on the world, ends up distancing itself from the subjective and existential experiences of human beings. Reality comes to be treated as a set of measurable facts, subject to verification and experimentation, according to the criteria established by each field of knowledge. However, this type of approach does not adequately address the dimensions of personal and everyday life. Scientific research, even when complex and refined, tends to follow a theoretical path that fails to capture the richness of lived experience, leaving aside fundamental aspects of human existence[29] .

The technical ideal, often reinforced during training, does not hold up in the face of the complexities of clinical reality, generating intense frustration among professionals. This discrepancy between what is projected as the expected outcome and what is actually achieved triggers feelings of inadequacy and frustration, indicating that the training process, by failing to sufficiently address the unpredictable aspects of care, contributes to a practice model marked by emotional fractures. In this context, the impossibility of achieving the idealized goals is not only technical but also subjective, as it directly affects the professional's identity and self-esteem.

Although there is an evident concern with the technical management of the patient, there is a systematic silencing of the emotions that emerge during care. Instead of dealing with their own emotions in a conscious and thoughtful manner, professionals tend to suppress them, attempting to project an air of control and confidence. This attempt to "stifle" feelings such as anxiety, fear, or frustration not only reveals a neglected emotional dimension in dental education but also lays bare the psychological burden involved in clinical practice. The absence of educational and institutional spaces for acknowledging and discussing healthcare professionals' emotions contributes to a model of practice that prioritizes technical rationality at the expense of the subjective dimension of care. As a result, the clinical setting becomes a space of silent emotional overload, where the professional's suffering is rendered invisible and, at times, normalized.

From the statements related to this phenomenon emerged the category *"The professional's distress regarding their own emotions during care,"* which leads us to reflect on the burden of emotional repression at work. Garcia *et al.* [30], in their study of the strategies used by nursing technicians to cope with occupational distress in an emergency room in 2016, found, among other strategies, the separation of personal and professional life. Clearly, if the worker can accept that there is a world of work and another world where the rest of their life is spent, this will be healthy for them. Better yet, if, in addition, they can move between these two worlds daily and distance themselves from the world of work at the end of each shift, in order to alleviate the wear and tear resulting from the daily work routine. However, as the authors point out, there is no formula for this. And, as is well known, such separation is neither a simple nor an easy strategy. In the present study, although no statements regarding this separation emerged, the lack of coping with one's own suffering, which emanates from these consultations, was clear.

It follows, therefore, that dental care for people with disabilities (PwD) requires not only technical mastery on the part of the professional but also sensitivity to address the emotional and subjective complexities that arise during clinical practice, whether from patients or the professionals themselves. Training, still heavily focused on technical aspects, does little to prepare the dental surgeon to face challenges that go beyond protocols and require flexibility in management. The absence of institutional and educational spaces that consider the emotional dimension of care contributes to a scenario of silent and repeated suffering among these professionals.

CONCLUSION

Dental care for people with dis-

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abilities reveals a reality marked by challenges that go beyond technique, highlighting subjective implications in clinical practice. Dental training limits autonomy and the ability to adapt to the complexity of real cases, generating feelings of frustration and insecurity. The gap between the projected ideal and the concrete possibilities of care leads to experiences of distress that are often silenced or repressed in professional practice. The lack of preparation for managing one's own emotions reinforces this silent suffering.

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