

Perceptions of Primary Health Care Dentists on Oral Cancer Care in Alagoas: from “Islands” to Encounter

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Percepções de Cirurgiões-Dentistas da Atenção Primária sobre o Cuidado no Câncer de Boca em Alagoas: das “Ilhas” ao Encontro
Percepciones de Cirujanos Dentistas de la Atención Primaria sobre el Cuidado del Cáncer Bucal en Alagoas: de las “Islas” al Encuentro

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ABSTRACT

Introduction: Oral cancer, a serious condition that compromises patients’ quality of life, requires an approach that goes beyond conventional clinical treatments. **Objective:** To understand the perspectives and practices of primary care dentists regarding the management of oral cancer within the public health system in Alagoas, identifying barriers, opportunities, and strategies to strengthen the integration of the healthcare network and improve the quality of cancer treatment within the National Health System. **Method:** The qualitative design enabled the researchers to better understand the complexity of professional experiences and everyday work contexts. Data were collected through questionnaires, individual and in-depth interviews, and field notes, allowing for a situated analysis of the phenomenon. **Results:** Findings revealed challenges related to work management, interprofessional communication, training, and organizational structures within Primary Health Care. Diagnostic uncertainties, limited familiarity with preventive actions, and fragile communication flows indicated that oral cancer is still not a priority in routine practice. **Conclusion:** Despite structural and organizational barriers, the bonds established between dentists and users emerged as a strength for more integrated care practices. Strengthening continuing education, consolidating communication pathways, and enhancing coordination between primary care and specialized services are essential strategies to improve the management of oral cancer.

Key words: Mouth Neoplasms; Dentists; Organization and Administration; Primary Health Care; Qualitative Research.

RESUMO

Introdução: O câncer de boca, uma condição grave que compromete a qualidade de vida, exige uma abordagem que ultrapasse os tratamentos clínicos convencionais. **Objetivo:** Compreender os sentidos e práticas de cirurgiões-dentistas da atenção primária sobre a gestão do trabalho e o cuidado ao câncer de boca na rede pública de Alagoas, identificando barreiras, potencialidades e caminhos para fortalecer a integração da rede de atenção e qualificar o cuidado oncológico no Sistema Único de Saúde. **Método:** Pesquisa qualitativa que possibilitou compreender melhor a complexidade das experiências e práticas profissionais, considerando os efeitos da doença no cotidiano e nos microcontextos de trabalho. Foram utilizados questionário, entrevistas individuais e em profundidade, além de diário de campo, permitindo uma análise situada do fenômeno. **Resultados:** Os dados revelaram desafios que atravessam a gestão do trabalho, a comunicação interprofissional, a formação e a organização dos serviços na Atenção Primária à Saúde. As inseguranças diagnósticas, a baixa familiaridade com ações preventivas e a fragilidade dos fluxos formais de comunicação indicam que o câncer de boca ainda não constitui prioridade na rotina da atenção primária. **Conclusão:** Apesar das dificuldades estruturais e organizacionais, os vínculos estabelecidos pelos cirurgiões-dentistas com os usuários surgem como potência para práticas mais integradas. Fortalecer a formação contínua, consolidar fluxos comunicativos e ampliar a articulação entre a atenção primária e a atenção especializada são caminhos essenciais para aprimorar o cuidado ao câncer de boca.

Palavras-chave: Neoplasias Bucais; Odontólogos; Organização e Administração; Atenção Primária à Saúde; Pesquisa Qualitativa.

RESUMEN

Introducción: El cáncer bucal, una condición grave que afecta la calidad de vida de los pacientes, requiere un enfoque que supere los tratamientos clínicos convencionales. **Objetivo:** Comprender las percepciones y prácticas de los profesionales de la odontología de la atención primaria en relación con la gestión del trabajo y la atención del cáncer oral en la red pública de Alagoas, identificando obstáculos, potencialidades y vías para reforzar la integración de la red de atención y mejorar la calidad de la atención oncológica en el Sistema Unificado de Salud. **Método:** El enfoque cualitativo permitió comprender mejor la complejidad de las experiencias y prácticas profesionales considerando los efectos de la enfermedad en los contextos cotidianos y laborales. Los datos se recopilaban mediante cuestionarios, entrevistas individuales y en profundidad, y notas de campo, lo que permitió un análisis situado del fenómeno. **Resultados:** Los datos revelaron desafíos relacionados con la gestión del trabajo, la comunicación interprofesional, la formación y la organización de los servicios en la Atención Primaria de la Salud. Las inseguridades diagnósticas, la limitada familiaridad con acciones preventivas y la fragilidad de los flujos formales comunicacionales indican que el cáncer bucal aún no constituye una prioridad en la práctica cotidiana de la atención primaria. **Conclusión:** A pesar de las barreras estructurales y organizacionales, los vínculos establecidos entre los odontólogos y los usuarios emergen como una fortaleza para prácticas de cuidado más integradas. Fortalecer la educación continua, consolidar los canales de comunicación y mejorar la articulación entre la Atención Primaria y los servicios especializados son estrategias esenciales para perfeccionar el manejo del cáncer bucal.

Palabras clave: Neoplasias de la Boca; Odontólogos; Organización y Administración; Atención Primaria de Salud; Investigación Cualitativa.

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INTRODUCTION

Oral cavity cancer is a relevant public health problem in Brazil, but its epidemiological expression is especially critical in contexts of socioeconomic inequalities, as is the case in the State of Alagoas. For each year of the 2026-2028 triennium, 210 new cases are estimated in Alagoas, an expressive number when considering population size, unequal distribution of services, and concentration of specialized care in the State capital^{1,2}. In addition to incidence, the proportionally high mortality in the State is also concerning, frequently attributed to late diagnosis, restricted access to oncological services, and structural fragilities across the care network^{3,4}.

The social and territorial vulnerabilities of Alagoas, which has presented one of the lowest Human Development Index values in the country, directly influence the healthcare system's capacity to ensure care continuity and integrity. The precariousness of assistance workflows, reliance on a few reference centers, and persistence of geographic and organizational barriers produce fragmented itineraries and long waiting times for diagnosis and treatment⁵. In this context, the journey of people with suspected or diagnosed oral cancer is often marked by disarticulated care levels and a lack of effective mechanisms to return information to their point of origin⁵.

Primary Health Care (PHC) has a strategic position in coping with this problem. According to the National Oral Health Policy (PNSB), it is up to the PHC to conduct active surveillance of suspicious lesions, develop systematic prevention actions, ensure coordination of care, follow up with referred cases, and articulate specialized services⁶. However, evidence shows that, in Alagoas, as in most States, fragilities in record-keeping, follow-up, and communication between the PHC and specialized care persist, revealing a gap between what is dictated by policy and what actually happens in the services' routine^{5,7}.

The literature also indicates that the effectiveness of Health Care Networks (HCN) depends on horizontal and vertical articulation between their components, which requires active communication, clear roles, and shared responsibility⁷. However, professional practices, perceptions of the work process, organizational conditions, and structural limitations influence how PHC performs its attributions in oral cancer care, especially in vulnerable regions⁸.

Given this scenario, it is fundamental to understand how professionals who work in the front line interpret and organize care for people with suspected or diagnosed oral cancer. The objective of this study is to understand the perspectives and practices of primary care dentists

regarding the management of oral cancer within the public health system in Alagoas, identifying barriers, opportunities, and strategies to strengthen the integration of the healthcare network and improve the quality of cancer care within the National Health System (SUS).

METHOD

Qualitative, observational, exploratory study. The choice of a qualitative approach is justified by the need for an analytical perspective that investigates the meanings and practices of primary care dentists regarding the care of patients with oral cavity cancer⁹.

By adopting an interpretive-understanding perspective, the study analyzes phenomena and complex social relations within healthcare, addressing less visible issues such as management, organization of work, public policies, relationships, and the symbolic relationship with cancer¹⁰.

The research was conducted with dentists who work in primary care in several Alagoas municipalities, who assessed patients with suspicious oral cancer lesions, later confirmed by a histopathological test from a stomatology reference center of the State, during 2020.

The participants were identified through a survey of records from the stomatology reference center, a facility within the Maceió Municipal Health Department, which serves all State demands, located in the Medical Ambulatory (MA) Salgadinho, which has 19 professionals. These professionals were invited by phone and presented with the study's objectives, procedures, schedule, risks, and benefits. All participants signed an electronic Free and Informed Consent Form (FICF) via Google Forms[®].

The final sample number was defined by the saturation criteria, interrupting recruitment when new interviews stopped adding significant information¹¹. That is, the researchers considered that enough participants were reached, which facilitated the recurrence and complementarity of information. Thus, the final sample was composed of ten dentists, identified by the D acronym, and numbered from one to ten, to maintain their anonymity.

Data collection involved more than one instrument, organized in sequential steps. The first instrument was a questionnaire with ten objective and discursive questions on their sociodemographic and professional profiles (age, gender, qualifications, years of experience, among others). The questionnaire was sent electronically through a link generated on Google Forms[®]. Next, individual videoconference interviews were conducted (*Teams*[®]), a technique that enables accessing particular discourses and their relations with community knowledge structures¹².

A semi-structured script was used, encompassing themes that ranged from the first contact with the patient to clinical follow-up and network articulation, composed of the following research questions, as shown in Chart 1.

Chart 1. Semi-structured interview script

N#	Research questions
1	How was the first contact with the patient with suspected oral cancer lesion established?
2	What are the easy aspects of referring these patients to diagnostic confirmation and oncological treatment start?
3	What are the difficulties in the same processes?
4	How were the assessment, diagnostic confirmation, clinical follow-up, and treatment procedures conducted?
5	Did the patient return to their original unit for clinical follow-up? If yes, how was the process conducted?
6	What is the importance of the care network for your work coping with oral cancer?

Although the script guided all the interviews, it was not applied strictly, allowing for adjustments to the order of questions and inclusion of additional questions as needed to deepen the understanding of emerging themes during the interaction with the participants.

The interviews, which lasted on average 30 to 50 minutes, were conducted by the main researcher with support from their advisor and co-advisor, with no technical incidents or interruptions. At first, the researchers aligned their objectives, conduct, and use of the script, seeking greater consistency in data production. Although they shared the same professional field, there was no direct hierarchical connection between researchers and participants, which opened space for conversation.

The interviews were recorded with due authorization and later submitted to evenly suspended attention, which, according to Campos¹³, consists of an initial, open, non-directive approach to the empirical content, allowing researchers to have a first broad contact with the *corpus*. This step is characterized by repeatedly listening to interviews without immediately imposing previous analytical categories, favoring the overall understanding of discourses, their nuances, recurrences, silences, and contradictions.

Evenly suspended attention enables us to go from a descriptive posture to an interpretive approach, articulating the empirical material to the theoretical framework. In this process, units of meaning and

analytical clues are identified to guide systematization and progressive construction of analytical categories, favoring a denser understanding of the investigated phenomenon and respecting the complexity of discourses.

Next, an in-depth interview was conducted with two dentists (a man and a woman), selected for demonstrating greater closeness with the theme and problematizing relevant issues during the initial interviews. The interview occurred at a single moment, using the *Teams*[®] video-conference platform, with the participation of two selected dentists, the main researcher (head and neck surgeon), and the advisor professor (dentist/stomatologist). Both interviewers functioned as conversationalists, not just question formulators¹⁴. This dialogical dynamic favored a collective discussion of the thematic categories, considering the strategic position of each professional in the care network.

The in-depth interview followed a semi-structured script, built from preliminary categories identified in the evenly suspended attention of previous interviews. The script approached the network articulation, referral and counter-referral workflows, longitudinal care, communication between services, and challenges in the coordination of care, maintaining a flexible character to deepen emerging questions and incorporate new themes. The interview was manually recorded and transcribed in full by the main researcher.

For the analyses, the Discursive Practices and the Production of Meaning in Everyday Life methodological-theoretical framework was used, considering the linguistic repertoire present in the interviews¹⁵. A fluctuating reading was conducted, with repeated and open readings aimed at familiarization with the contents and overall understanding of discourses. After the exploratory step, two researchers experienced in qualitative research conducted the initial manual data encoding. There was a prior theoretical-methodological alignment with the analytical assumptions, study objectives, and criteria for identifying units of meaning.

These categories emerged from articulating recurring content in the speeches with the research objectives and did not exclusively derive from fluctuating reading but from a progressive interpretation and systematization process. They are: technical knowledge of oral cancer; structure of the Oral Cancer Care Network; role of the dentist in managing oral cancer; communication in the care process; fragmentation of care; role of the undergraduate course; cancer invisibility; and affections mobilized in cancer management.

After this step, the researchers identified the repertoire present in the interviewees' speeches, with support from dialogical maps¹⁶. Dialogical maps consist of a strategy that



organizes the speech of interviewed people by identifying voices, positioning, and linguistic repertoire, allowing researchers to visualize the discursive dynamic and meanings produced in everyday life, that is, recognizing “what is being talked about” in each category, as illustrated in Chart 2.

The final analytical categories, built in the interpretive process and sustained by analyzing the linguistic repertoire, were articulated in three axes that express different modes of production of meaning regarding oral cancer care: (1) the care network and the role of the dentist; (2) interprofessional communication and “islands” of care; and (3) the disease no one can see. These axes not only organize empirical content but also highlight tensions, discontinuities, and disputes of meaning present in care practices.

The repertoire¹⁷, understood as “building blocks of discursive practices”, enabled us to analyze how the participants produce and negotiate meanings through terms, descriptions, and commonplaces, evidencing both regularities and displacements in the ways of talking about oral cancer and its management within the routine of services.

No formal validation of the findings was conducted with the participants. However, the in-depth interview conducted in the final step of the research contributed to deepening, tensioning, and refining the constructed

analytical categories, working as an internal validation strategy for the findings.

The present study has been approved by the Research Ethics Committee of the *Centro Universitário Cesmac*, report number 5034842 (CAAE (submission for ethical review): 48270821.6.0000.0039), in compliance with Resolution 466/2012¹⁸ of the National Health Council.

RESULTS AND DISCUSSION

Ten dentists were interviewed between February and March 2022, identified by the acronym D, followed by numbers from 1 to 10, as shown in Table 1, with the professional profile of the interviewed people.

Most participants were female (60%), a finding that follows the feminization of dentistry trend described in the literature¹⁹. Regarding race/skin color, 60% of professionals self-declared as white.

All the participants worked at PHC in Alagoas’ municipalities. The minimum time working at this care level was three years, and most of the professionals (80%) had been part of oral healthcare teams for over ten years, suggesting a more consolidated professional journey and more experience in the field. This finding is in line with a study conducted in Ceará, which also identified professionals with longer tenure in the service²⁰.

Chart 2. Analysis strategy (example)

Thematic category	Repertoire (what is being talked about?)	Produced meanings/ Analytical axis
1. Technical knowledge of oral cancer	“I am not prepared to deal with cancer” (D10)	Confidence at diagnosis
2. Oral Cancer Care Network structure	“If you don’t have this more integral approach, you can’t overcome difficulties” (D1)	Integral conception of the network
3. Role of the dentist in managing oral cancer	“I’ve always leaned towards this issue, because I like to make it my job. I’ve always had a unique perspective” (D9)	Adopting an attentive perspective
4. Communication of the care process	“There must be more interaction between professionals in every instance. A closer relationship” (D2)	Difficult access to other professionals
5. Fragmentation of care	“What I can do on my own, I do it. I prefer that way” (D8)	Isolation
6. Role of the undergraduate course	“I had no contact in the university, only in courses” (D7)	The absence of the theme in undergraduate courses
7. Cancer invisibility	“The family did not want him to know what it was” (D1)	The weight and the escape from the word cancer
8. Affections mobilized in cancer management	“I feel like I’m going through this alone” (D9)	Loneliness



Table 1. Identification of the professional role of participants

ID	Sex	Time working (years)	Post-graduate education	Other professional ties	Training courses (<5 years)	Knowledge of referral workflows
D1	Female	16	Public Healthcare	No	Yes	Yes
D2	Male	18	Master's in Health Sciences***	Yes	Yes	No
D3	Male	15	Public Healthcare	No	Yes	Would rather not answer
D4	Female	10	Oral Surgery and Hospital Dentistry**	No	No	No
D5	Male	18	Family Healthcare and Prosthetics	No	Yes	Yes
D6	Male	27	Family Healthcare	No	Yes	Yes
D7	Female	6	Aesthetic Dentistry	Yes	Yes	Yes
D8	Female	22	Family Healthcare	No	Yes	Yes
D9	Female	18	Pediatric dentistry	No	Yes	No
D10	Female	3	Endodontics***	No	Yes	No

Captions: D = Dentist; ****Stricto sensu* postgraduate; ***Lato sensu* specialization.

On the other hand, it diverges from studies that point to a predominance of dentists with less time since graduation, recent entry into the Family Health Strategy, and high turnover in primary care^{21,22}. Such differences can reflect regional specificities, local conditions of work provision and ties, aspects that influence team stability and continuity of care.

THE ORAL CANCER CARE NETWORK AND THE ROLE OF THE DENTIST

The work of dentists in tackling oral cancer exposes a tension between the PNSB^{9,23} guidelines and the practices actually carried out in PHC. Although the HCN attributes care coordination to primary care, including screening, early diagnosis, continuity of care, and interprofessional articulation²⁴, the participants' discourses reveal diagnostic insecurity, fragmented practices, and avoidance of the responsibilities expected at this level of care.

Despite that, although the interviewed dentists have acknowledged the importance of active search and detailed examination, they admit they are not systematically conducting them among at-risk patients. Clinical assessment generally occurs reactively, motivated by spontaneous complaints:

I have to cover three teams; it's hard. I end up advising the agents to bring only people with complaints to the unit (D7).

The lack of a structurally organized practice contrasts with studies that record greater adherence to detailed examination in PHC^{25,26}, although international findings indicate that the underperformance of this procedure is a global problem²⁷.

Diagnostic insecurity emerges as a key element. Even without formal instruments to quantify knowledge, the narratives express poor familiarity with neoplastic lesions and difficulties recognizing suspicious signs. This can be observed in the following speeches:

I don't have much experience with cancerous lesions, so I thought it was best to call a colleague (D2).

I was chill because I thought it was something else; I didn't think of cancer. I was very surprised with the diagnosis (D3).

This education gap is described in the literature²⁸⁻³⁰, and studies suggest that recently graduated professionals, an under-represented group in this research, tend to know more about the theme^{31,32}.

Another relevant dimension is the difficulty of managing referral and counter-referral workflows. Although dentists acknowledge the need for referral after identifying suspicious lesions, they lack confidence



regarding formal network protocols. Therefore, they usually resort to personal connections to anticipate the access of patients to other care levels, creating parallel networks that, in practice, replace the institutionalized HCN. This strategy is seen clearly in speeches, such as:

When we walk through the referral and counter-referral sector, I find it too impersonal. It's so much better if you have direct access (D2).

If I had no connection (referring to a colleague), it would be much harder (D3).

The first thing I did was call a colleague, because they don't have a DSC here (D4).

The resource I have is my connections, and I send the patient to whoever picks up the call faster (D6).

From the interviewees' perspectives, the actions of dentists in oral cancer care are almost exclusively restricted to identifying suspicious lesions and referring patients to secondary and tertiary levels. This understanding appears explicitly in the following reports:

Oh, we have a lot of attributions, so we can't follow up with the whole process (D2).

What happens after the diagnosis is not up to me; I can't act any further (D5).

The overload and perception of operational limits are also shown in speeches such as:

Regulation is extremely important because I reach my limit (D8).

Furthermore, some participants acknowledge that this restricted work is related to the lack of understanding of the responsibilities of PHC in the scope of SUS:

You need to understand what care is in the public sector, within primary care. You have to be clear on what this role is. You can be a great professional, but you can't lack this knowledge of the role (D1).

These testimonies reinforce that, despite guidelines that attribute centrality to PHC in coordinating care, the perception of the dentist as a peripheral actor, conditioned by structural barriers, education gaps, and work overload, persists.

To the interviewees, this work, which is predominantly centered on diagnosis and referral, is not explained

solely by individual limitations, but also by fragilities in interprofessional communication, translated into a fragmented workflow, in which each professional category works in isolation, with few opportunities for systematic information exchange and co-accountability for the cases.

INTERPROFESSIONAL COMMUNICATION AND "ISLANDS" OF CARE

Dentists are unanimous in suggesting that one of the main obstacles to the continuity of care is the difficult access to other levels of the HCN, highlighting structural and relational fragilities in the coordination process. Interprofessional communication emerges as a critical severance point:

I approached the social worker because when the patient returned, they only brought the exam request, but nothing that spoke about their case. I didn't have this response; it was pretty empty (D10).

This situation reveals that although formal instruments for communication between care levels exist, such as referral and counter-referral forms, they are underutilized or undervalued, as shown in the literature³³. This disuse reinforces the predominance of isolated and disconnected practices that weaken the principle of integrity.

The referral and counter-referral system should ensure continuity of care through circulation of information and efficient articulation of services³⁴. Its fragility reverberates directly in the configuration of care as something fragmented, as described by Lacerda³³, resulting both from professionals' knowledge gaps about the system and a lack of management that promotes permanent education, supervision, and integration. The reports from dentists in this study illustrate this fragmentation through the "islands of care" metaphor:

There are many interruptions in the work processes; the professional ends up leaving it for later (D1).

There must be more interaction between professionals in every instance; a closer relationship (D2).

If I didn't have a colleague in secondary care, I'd be lost (D3).

I even made a report to refer the patient, but I don't know to whom it was addressed (D4).

This distance between network points is translated into concrete flaws in the return to the primary level, producing insecurity and discontinuity:

We get no answers on anything (D5).

I don't know what happened in the appointment with the specialist (D6).

I don't receive news from these patients (D7).

What I can do on my own, I do it (D8).

I often feel like I'm going through this alone (D9).

Such testimonies illustrate a scenario of professional isolation in which the PHC, instead of coordinating care, remains disarticulated from other services, operating on the margins of the institutional HCN workflows.

In the specific case of oral cancer, whose management requires multiprofessional articulation and continuity of care, this isolation becomes even more critical. The act of referral, which should imply shared accountability, is frequently interpreted as a transfer of responsibility. This perception appears in reports such as:

We want to help, but there's not much we can do (D4).

The patient was already in the hands of the Oncology team (D5).

That's all we can do (D7).

These narratives demonstrate an understanding of the dentist's role as limited to diagnosis and referral, with no active participation in the follow-up steps, prevention of complications, and rehabilitation, despite scientific recommendations that point to the central role of dentists in managing treatment complications³⁵.

Once more, education gaps and the idea of a care model strongly centered on a specialist emerge. Such a model operates through hierarchical levels, not through collaborative networks, reinforcing the distance between PHC and tertiary care. The lack of structured communication increases the risk of treatment interruption, worse prognoses, and inappropriate return of the patient to PHC, compromising the integrity of care and operational governance of HCN.

In this scenario, the bond emerges as a light technology with the potential to mitigate, albeit partially, the fragmentation of care. The narratives demonstrate how interpersonal bonding works as a bridge between "islands of care", boosting coordination actions based on ethical and affectionate commitment on the part of professionals, and not on formal network structures:

I didn't let him out of my sight. We created a trust bond (D1).

I treated this case as if I were the one with cancer (D3).

He saw me as a safety net (D4).

The family always gets in touch. I don't go three months without seeing them (D6).

I call them myself to know about the patient (D8).

They now are people I care so much about (D9).

Such practices reinforce the subjective and relational role of PHC, but also highlight that continuity of care, in many cases, depends more on the professional's individual initiative than on the HCN's institutional strength.

The lack of integrated information systems, clear protocols, and structured interprofessional communication mechanisms dislocates the responsibility of care coordination to the micro, individual sphere, and not to the meso and macro levels of network management. This produces inequalities, emotional overload, and professional insecurity, in addition to compromising the effectiveness of PHC as a care coordinator. In summary, the set of narratives highlights a scenario in which care is fragmented, communication is fragile, articulation between levels is incipient, and the role of dentists remains limited in relation to the potential attributed by health policies, revealing the existing distance between the prescribed model and the model experienced by the professionals.

THE DISEASE NO ONE CAN SEE

All the interviewees reported having diagnosed fewer than five oral cancer cases throughout their journeys, which, in 90% of cases, surpasses ten years of work. These data pose a key question: if oral cancer professionals perceive oral cancer as an uncommon event, where are the cases that do not reach the PHC? This perception emerges strongly in the reports:

In 15 years of my profession, I had never experienced this. This was my only case (D3).

What reaches us is minimal. In three years in this service, I have only seen one case. I can't believe this number is right (D4).

I graduated six years ago, and I only saw three cases in this period (D6).



It's not common to talk about cancer; it's a rare disease. In over 20 years, I cared for only 4 patients (D7).

The D2 speech synthesizes this perception by describing oral cancer as a "tumor that hides". This concept, however, opens space to a reflection on the factors that impair the diagnosis of this neoplasm.

In theory, the clinical examination of the oral cavity would allow for early detection of oral cancer. However, the literature is clear in affirming that delays in diagnosis involve multiple dimensions: patient, professional, and system factors⁵. In the interviewees' testimonies, there was a predominance of holding users accountable:

He was a street vendor and neglected his own health (D2).

The patients have no idea about oral cancer (D4).

The patient didn't complain about a thing (D6).

After six months, the patient still hadn't returned. I went after him (D9).

In fact, studies show that patient-related factors, such as ignorance, fear, lack of knowledge, and delay in seeking care, are associated with late diagnosis^{36,37}. However, research also shows that the responsibility does not lie solely with the user.

Among the professionals, the delay is also associated with technical insecurity. In this sample, composed mostly of dentists with over ten years of experience, all participants reported uncertainty in identifying suspicious lesions and a lack of preparedness for diagnostic procedures. The speeches are forceful:

I've had a degree for 30 years, but only three years ago did I have access to practical knowledge on cancer management (D1).

I had no contact with cancer in my undergraduate course (D7).

I never learned about it in my undergraduate course, no way (D8).

I feel underprepared. This experience blocked me a little (D10).

Studies corroborate this reality and point to the need for curriculum reform to strengthen preventive and

diagnostic competencies, especially in the oral cancer field^{38,39}.

The fears, stigmas, and affections mobilized in this context appear repeatedly in the testimonies:

The patient didn't come back. He was very scared (D1).

The family did not want the patient to know about it (D2).

The patient was terrified (D3).

They get scared (D4).

The patient even cried (D7).

They say "that bad disease" (D8).

Cancer here in the back country is very close to death (D10).

I fear this miserable disease (D5).

Cancer management involves dimensions beyond the technical: it sheds a light on finiteness, suffering, and the need to reorganize one's own life. As recalled by the National Cancer Institute (INCA)⁴⁰, there is always a subject living in that sick body, with fear, weaknesses, and stories. The interviewees recognize this human dimension:

The emotional side weighs a lot. You are putting your existence on the line (D5).

We don't see sick people, we see people (D10).

Despite difficulties, the speeches reveal an openness movement. The professionals show a disposition to improve their repertoire, acknowledge limitations, and strengthen their role in the care pathway. There are efforts to face fears, seek information, and follow up on cases, sharing more responsibility, as exemplified by D9, who, when the patient didn't return, "went after him". These gestures highlight an ethical commitment to supporting care, even in the face of stigmas that surround this illness.

Oral cancer care requires professionals capable of integrating technical and sensitive aspects, acknowledging limitations without losing sight of their commitment to care. This process requires resilience, institutional support, collaborative networks, interprofessional communication, and continuing education. Even though cancer often "hides", its management becomes clearer when the work is shared,

and fears are named, avoiding professional isolation. The empirical material points to a positive movement: even in the face of fragilities, there is a wish to learn, an appreciation of the human dimension, and a disposition to seek the patient, indicating new possibilities of communication, cooperation, and joint construction of care.

CONCLUSION

Oral cancer management in PHC in Alagoas is marked by diagnostic uncertainties, weak educational background, and difficulties in articulating with the other HCN levels. Despite PHC being normatively responsible for early detection, care coordination, and case follow-up, dentists restrict their work to diagnosis and referral, avoiding preventive actions, longitudinal follow-up, and integral practices.

Limited interprofessional communication, disarticulated formal referral and counterreferral workflows, and dependence on informal networks highlight that the challenges go beyond the technical dimension and reflect the structural conditions of the territory. Yet, bonds established between professionals and users emerge as an important strength of care, mainly compensating for institutional gaps. By giving visibility to meanings, practices, and limitations experienced within PHC, this study contributed to guiding actions that promote the integrity and effectiveness of oncological care in SUS in Alagoas, mainly in the qualification of education in oral health, strengthening care coordination, and improving care workflows in SUS.

By valuing the qualitative data produced from the participants' narratives, this study adds to the literature elements that are often little explored in studies about oral cancer: the affections mobilized in care, feelings of loneliness and professional responsibility, daily strategies to cope with diagnostic uncertainties, and the subjective impacts of insecurity in clinical management. In addition to mapping structural barriers, the findings highlight how emotions, interpersonal relationships, and concrete work experiences influence clinical decisions, referrals, and continuity of care. In a Northeastern context still underexplored, the study offers relevant support for qualifying education in oral health, strengthening care coordination, and building care networks that are more integral and sensitive to the human dimensions of healthcare work.

Finally, this study focused on dentists. We therefore acknowledge the need to include other perspectives, from healthcare professionals, managers, and people diagnosed with oral cancer. Thus, despite being a limitation, this choice opens possibilities for further investigations that

more broadly consider the different actors involved in managing primary healthcare.

CONTRIBUTIONS

All the authors have substantially contributed to the study design and planning, acquisition, analysis, and interpretation of the data, wording, and critical review. They approved the final version for publication.

DECLARATION OF CONFLICT OF INTERESTS

There is no conflict of interest to declare.

DATA AVAILABILITY STATEMENT

The data should be requested to the corresponding author due to containing sensitive information.

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