The Role of Brackets in Tooth Alignment

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Balancing Data and Clinical Judgment in Orthodontics

Understanding brackets: Types and functions in orthodontic treatment

Understanding brackets: Types and functions in orthodontic treatment

Early intervention in orthodontics plays a pivotal role in ensuring optimal dental health and development in children. This approach, often referred to as interceptive orthodontics, aims to address potential issues before they become more complex and difficult to treat. The significance of early intervention is underscored by data on childhood dental development and the prevalence of malocclusion.

Dental development during childhood follows predictable patterns marked by key milestones such eruptive timelines-first molars around six years old, incisors at seven or eight years old-which orthodontists use extensively during evaluations (Lew & Kornman). Malocclusion prevalence studies reveal significant figures; approximately fifty percent (Proffit et al.) highlight comprehensive issues necessitating early detection mechanisms beyond surface level corrections - ensuring alignment doesn't oversimplify broader skeletal growth considerations vital during adolescent periods extending profound impact later stages alignments correction potentialities diminished considerably post maturation ages typically fourteen plus affecting speech phonetics mastication functions esthetics detrimentally implicated long term contextually influencing overall guality life dimensions substantially holistically considered integrally essential elements interventional strategies preemptively addressing precursory conditions effectively mitigate ensuings complications establishing foundational basis corrective orthodontic interventions facilitating harmonious progressions oral health facets intrinsically aligned developmental milestones conducive balanced data clinical judgment paradigms optimally harnessed cohesive integrated framework fostering

enhanced outcomes sustainably achieved therapeutic timelines pragmatically managed comprehensively conceptualized orthodontic disciplinary perspectives efficaciously implemented individual patient needs dynamically addressed personalized treatment plans strategically devised ensuring long lasting beneficial impacts tangible sustained results incrementally realized continuum care philosophies underscored balanced data clinical judgment synergistically intertwined ultimately benefiting overall orthodontic treatment efficacies pragmatic real world applications nuanced patient centered approaches therapeutically groundbreaking advancements contemporarily evolving field orthodontics perpetually refined adaptable innovatively progressive methodologies continually striving excellence maximizing patient outcomes holistically envisioned systematically actualized through meticulous scientifically validated evidence based practices dynamically enriched robust multidisciplinary collaborative frameworks enduringly committed enhancing lives profoundly positively impacting societal wellbeing broadly encompassing therapeutic modalities inclusively embracing future forward thinking paradigms proactively championing innovative transformative orthodontic care excellence perpetually refined progressive integratively aligned balancing data clinical judgment symbiotically intertwined collectively fostering optimized patient outcomes sustainably achieved therapeutic timelines pragmatically managed comprehensively conceptualized orthodontic disciplinary perspectives efficaciously implemented individual patient needs dynamically addressed personalized treatment plans strategically devised ensuring long lasting beneficial impacts tangible sustained results incrementally realized continuum care philosophies underscored balanced data clinical judgment synergistically intertwined ultimately benefiting overall orthodontic treatment efficacies pragmatic real world applications nuanced patient centered approaches therapeutically groundbreaking advancements contemporarily evolving field orthodontics perpetually refined adaptable innovatively progressive methodologies continually striving

A child's bite can be improved with timely orthodontic intervention **Youth orthodontic correction** dentistry.

The process of fitting brackets on children's teeth —

- Understanding brackets: Types and functions in orthodontic treatment
- The process of fitting brackets on children's teeth
- How brackets contribute to the alignment and movement of teeth
- Benefits of early orthodontic intervention with brackets for kids
- <u>Common issues and solutions related to brackets in pediatric</u> orthodontics
- The role of parental support during orthodontic treatment with brackets
- Long-term effects and maintenance after bracket removal

In the realm of orthodontics, balancing data and clinical judgment is particularly crucial when addressing key issues specific to children, such as crowding teeth. This balance ensures not only optimal oral health but also considers the psychological well-being of young patients during their critical growth years.

Crowding teeth, a common orthodontic issue among children, can significantly impact overall health beyond just dental aesthetics or functionality concerns alone; appearance concerns during these formative years can lead adolescents to feel self-conscious or experience reduced self-esteem. Psychological well-being is intrinsically linked to physical health, and addressing these concerns early can prevent long-term negative effects on a child's emotional development. Clinical judgment plays a pivotal role in managing these issues effectively. Orthodontists must consider various factors, including facial growth patterns, which differ from child to child. Understanding these patterns helps practitioners predict how the face and jaws will develop over time and plan treatments accordingly. For instance, early intervention with palatal expanders or functional appliances can guide jaw growth and create space for crowded teeth, potentially avoiding more invasive treatments later on.

While clinical judgment is indispensable, it must be complemented by data-driven insights. Advances in digital dentistry provide valuable data through 3D imaging, digital scans, and software simulations that aid in precise diagnosis and treatment planning. This data helps orthodontists make informed decisions about the best course of action tailored specifically to each child's needs.

However, relying solely on data without clinical context can lead to misinterpretations or oversights. The art of orthodontics lies in integrating objective data with subjective assessments based on experience and knowledge of individual patient characteristics. For example, while data might suggest a particular treatment plan based on current dental alignment, an experienced orthodontist might adjust this plan considering the patient's unique facial growth pattern or emotional readiness for treatment.

Furthermore, involving parents and caregivers in decision-making processes is essential. Clear communication about treatment options, potential outcomes, and the importance of compliance can foster a collaborative environment where all parties feel informed and empowered. This approach not only enhances treatment success but also supports the child's overall well-being by ensuring they receive comprehensive care tailored to their specific needs and circumstances.

In conclusion, balancing data and clinical judgment in pediatric orthodontics is vital for addressing key issues like crowding teeth effectively. By integrating objective data with nuanced clinical insights, orthodontists can provide holistic care that addresses both physical health and psychological well-being during children's formative years. This balanced approach ensures that each child receives personalized treatment designed to optimize their oral health now and into adulthood-a goal that benefits both patient and practitioner alike

How brackets contribute to the alignment and movement of teeth

In the dynamic field of orthodontics, striking a balance between data-driven insights and clinical judgment is paramount, especially when treating young patients. The integration of diagnostic tools such as X-rays, 3D imaging, and bite assessments with clinical expertise allows for a comprehensive evaluation that goes beyond mere numbers and images.

Orthodontics has traditionally relied heavily on the clinical judgment of practitioners. Experienced orthodontists bring a wealth of knowledge and intuition to their diagnoses, understanding that each patient presents unique biological traits and growth patterns. However, the advent of advanced diagnostic technologies has introduced a new layer of precision and objectivity to treatment planning.

X-rays provide detailed views of dental structures and potential issues hidden beneath the surface, while 3D imaging offers a holistic perspective by creating digital models of the patient's mouth. Bite assessments further contribute by analyzing functional occlusion, ensuring that

treatment plans address both aesthetic and practical concerns. These tools generate vast amounts of data that can be analyzed to predict treatment outcomes and craft personalized strategies.

However, data alone cannot replace the nuanced decision-making capabilities of an experienced clinician. The art of orthodontics lies in interpreting this data within the context of each patient's individual needs and biological variability. For instance, while 3D imaging might suggest a particular course of action based on structural analysis, a clinician might adjust this plan considering factors like patient comfort, psychological well-being, and developmental stages specific to younger patients.

Moreover, young patients are still growing and developing, which adds another layer of complexity. Clinical judgment becomes even more critical here as orthodontists must anticipate future growth patterns and adapt treatments accordingly. This is where the combination of clinical expertise and data comes into play most effectively: diagnostic tools provide a snapshot in time, while clinical judgment helps project this snapshot into future scenarios.

In practice, this integration might look like using 3D imaging to map out initial tooth movements followed by regular clinical check-ups where adjustments are made based on observed growth and developmental changes. It involves constantly revisiting both quantitative data from diagnostic tools and qualitative insights from clinical observations to refine treatment plans dynamically.

Ultimately, balancing data-driven approaches with clinical judgment enhances the quality of care provided to young orthodontic patients. It ensures that treatments are not only scientifically grounded but also tailored to each patient's unique circumstances, leading to more effective and satisfying outcomes. This synergy represents the future of orthodontics-a blend of technological precision and human intuition that together can achieve optimal dental health for every patient.

Benefits of early orthodontic intervention with brackets for kids

In the realm of orthodontics, particularly when treating pediatric patients, balancing data-driven insights with seasoned clinical judgment is a delicate yet essential art form-one where success can lead towards improved outcomes while failure might result misaligned smiles or protracted treatment durations far exceeding expectations initially set forth during consultation phase . Historically clinicians relied heavily upon subjective experience honed over years spent meticulously examining each patient's unique dental structure ; however , advancements within technology coupled alongside robust research findings have ushered forth an era where empirical evidence plays increasingly pivotal roles informing treatment protocols .

Case studies highlighting successful integration between these two paradigms reveal compelling narratives . For instance , one notable example involves comparing traditional methods employing cephalometric analysis against advanced 3D imaging techniques enhanced via machine learning algorithms . The former , while tried-and-true , often fell short due its inherent limitations : two dimensional representations unable fully encapsulate complex craniofacial anatomy leading potentially misinterpretations influencing subsequent intervention strategies adversely affecting efficacy overall treatment plans whereas latter leveraging comprehensive volumetric data alongside sophisticated statistical models yielded markedly superior predictive accuracy thereby enabling clinicians tailor bespoke therapeutic approaches yielding tangible improvements both aesthetically functionally speaking.

Moreover , another compelling illustration showcases how big data analytics fostered personalized medicine through genomic profiling identifying genetic markers predisposing individuals towards certain malocclusions hence allowing preemptive measures be implemented early mitigating severity future complications arising thereof . Conversely , relying solely upon intuition sans quantitative backing could lead overlook critical underlying factors contributing suboptimal results despite best intentions otherwise well-intentioned practitioner might harbor .

However, it would remiss neglect mention drawbacks associated overreliance pure quantitative methodologies devoid contextual nuances derived experiential wisdom accrued decades handson practice. Overemphasis metrics might risk reducing intricate biological systems mere numerical values thereby losing sight holistic patient care encompassing psychological social dimensions integral achieving truly satisfactory conclusions beyond mere technical proficiency alone. Thus striking equilibrium wherein both schools thought complement rather contradict each other remains paramount aspiration continually refined amidst ever evolving landscape contemporary orthodontic science.

In conclusion, balancing data analytics with clinical judgment offers profound advantages within pediatric orthodontics provided harmonious synergy achieved between them . By leveraging strengths inherent each approach whilst mitigating respective weaknesses practitioners stand poised deliver unprecedented levels care marked improvements across myriad facets encompassing aesthetic functionality longevity ultimately culminating radiant confident smiles cherished lifelong memories alike . As technology continues advance apace so too must our commitment fostering symbiotic relationship empirical evidence intuitive acumen ensuring bright futures await tomorrow's generation young patients today!

Common issues and solutions related to brackets in pediatric orthodontics

In the contemporary practice of orthodontics, the integration of extensive data usage with clinical judgment presents a complex landscape filled with ethical considerations and practical limitations. This delicate balance is crucial for delivering optimal patient care, particularly when dealing with sensitive medical information, such as that pertaining to minors.

One of the foremost ethical concerns is privacy. Medical information, especially concerning minors, requires stringent safeguards to ensure confidentiality and compliance with legal standards like parental consent. Practitioners must navigate these waters carefully, ensuring that data is collected, stored, and analyzed in a manner that respects privacy rights. This involves using secure systems, obtaining proper consent from parents or guardians, and maintaining transparency about how data will be used.

Another significant challenge is addressing potential biases that can influence decision-making processes. Purely data-driven conclusions may lack context sensitivity, overlooking nuances specific to individual patients. Conversely, subjectively biased intuitive clinical decisions might not always have robust empirical substantiation. Striking a balance between these two approaches is essential for accurate diagnostics and effective treatment plans.

To mitigate these biases, orthodontists should adopt a hybrid approach that combines empirical data with clinical intuition developed through experience and education. Advanced analytics can provide valuable insights into patterns and trends, but these insights should complement rather than replace clinical judgment based on patient history and examination findings tailored specifically through human expertise which cannot easily replicate via algorithms alone.. Regular peer reviews along side continuous professional development can help practitioners stay updated on both technological advances alongside maintaining ethical integrity during practice.. Additionally fostering open communication channels between clinicians themselves patients besides caregivers ensures all perspectives contribute effectively towards informed decision making process thus enhancing overall quality health outcomes delivered sustainably overtime amidst evolving healthcare landscape dynamics.. In conclusion balancing data analytics alongside subjective intuition guided by ethical standards forms cornerstone contemporary orthodontic practices striving deliver personalized optimal patient centric care responsibly harnessing best both worlds proactively addressing challenges posed therein thereby ensuring holistic wellbeing individuals entrusting their health professionals committed pursuit excellence field..

About thumb sucking

For other uses, see Thumbsucker (disambiguation).



Infants may use pacifiers or their thumb or fingers to soothe themselves

Newborn baby thumb sucking



A bonnet macaque thumb sucking

Thumb sucking is a behavior found in humans, chimpanzees, captive ring-tailed lemurs, [¹] and other primates. [²] It usually involves placing the thumb into the mouth and rhythmically repeating sucking contact for a prolonged duration. It can also be accomplished with any organ within reach (such as other fingers and toes) and is considered to be soothing and therapeutic for the person. As a child develops the habit, it will usually develop a "favourite" finger to suck on.

At birth, a baby will reflexively suck any object placed in its mouth; this is the sucking reflex responsible for breastfeeding. From the first time they engage in nutritive feeding, infants learn that the habit can not only provide valuable nourishment, but also a great deal of pleasure, comfort, and warmth. Whether from a mother, bottle, or pacifier, this behavior, over time, begins to become associated with a very strong, self-soothing, and pleasurable oral sensation. As the child grows older, and is eventually weaned off the nutritional sucking, they can either develop alternative means for receiving those same feelings of physical and emotional fulfillment, or they can continue experiencing those pleasantly soothing experiences by beginning to suck their thumbs or fingers.^{[3}] This reflex disappears at about 4 months of age; thumb sucking is not purely an instinctive behavior and therefore can last much longer.^{[4}] Moreover, ultrasound scans have revealed that thumb sucking can start before birth, as early as 15 weeks from conception; whether this behavior is voluntary or due to random movements of the fetus in the womb is not conclusively known.

Thumb sucking generally stops by the age of 4 years. Some older children will retain the habit, which can cause severe dental problems.^[5] While most dentists would recommend breaking the habit as early as possible, it has been shown that as long as the habit is broken before the onset of permanent teeth, at around 5 years old, the damage is reversible.^[6] Thumb sucking is sometimes retained into adulthood and may be due to simply habit continuation. Using anatomical and neurophysiological data a study has found that sucking the thumb is said to stimulate receptors within the brain which cause the release of mental and physical tension.^[7]

Dental problems and prevention

[edit]



Alveolar prognathism, caused by thumb sucking and tongue thrusting in a 7year-old girl.

Percentage of children who suck their thumbs (data from two researchers)

Age	Kantorowicz[⁴	Brückl[⁸]	
0–1	92%	660/	
1–2	93%	00 %	
2–3	87%	_	
3–4	86%		
4–5	85%	25%	
5–6	76%		
Over 6	—	9%	

Most children stop sucking on thumbs, pacifiers or other objects on their own between 2 and 4 years of age. No harm is done to their teeth or jaws until permanent teeth start to erupt. The only time it might cause concern is if it goes on beyond 6 to 8 years of age. At this time, it may affect the shape of the oral cavity or dentition.[⁹] During thumbsucking the tongue sits in a lowered position and so no longer balances the forces from the buccal group of musculature. This results in narrowing of the upper arch and a posterior crossbite. Thumbsucking can also cause the maxillary central incisors to tip labially and the mandibular incisors to tip lingually, resulting in an increased overjet and anterior open bite malocclusion, as the thumb rests on them during the course of sucking. In addition to proclination of the maxillary incisors, mandibular incisors retrusion will also happen. Transverse maxillary deficiency gives rise to posterior crossbite, ultimately leading to a Class II malocclusion.[¹⁰]

Children may experience difficulty in swallowing and speech patterns due to the adverse changes. Aside from the damaging physical aspects of thumb sucking, there are also additional risks, which unfortunately, are present at all ages. These include increased risk of infection from communicable diseases, due to the simple fact that non-sterile thumbs are covered with infectious agents, as well as many social implications. Some children experience social difficulties, as often children are taunted by their peers for engaging in what they can consider to be an "immature" habit. This taunting often results the child being rejected by the group or being subjected to ridicule by their peers, which can cause understandable psychological stress.^{[11}]

Methods to stop sucking habits are divided into 2 categories: Preventive Therapy and Appliance Therapy.[¹⁰]

Examples to prevent their children from sucking their thumbs include the use of bitterants or piquant substances on their child's hands—although this is not a procedure encouraged by the American Dental Association[⁹] or the Association of Pediatric Dentists. Some suggest that positive reinforcements or calendar rewards be given to encourage the child to stop sucking their thumb.

The American Dental Association recommends:

- \circ Praise children for not sucking, instead of scolding them when they do.
- If a child is sucking their thumb when feeling insecure or needing comfort, focus instead on correcting the cause of the anxiety and provide comfort to your child.
- If a child is sucking on their thumb because of boredom, try getting the child's attention with a fun activity.
- Involve older children in the selection of a means to cease thumb sucking.
- The pediatric dentist can offer encouragement to the child and explain what could happen to the child's teeth if he/she does not stop sucking.

- Only if these tips are ineffective, remind the child of the habit by bandaging the thumb or putting a sock/glove on the hand at night.
- Other orthodontics[¹²] for appliances are available.

The British Orthodontic Society recommends the same advice as ADA.^{[13}]

A Cochrane review was conducted to review the effectiveness of a variety of clinical interventions for stopping thumb-sucking. The study showed that orthodontic appliances and psychological interventions (positive and negative reinforcement) were successful at preventing thumb sucking in both the short and long term, compared to no treatment.[¹⁴] Psychological interventions such as habit reversal training and decoupling have also proven useful in body focused repetitive behaviors.[¹⁵]

Clinical studies have shown that appliances such as TGuards can be 90% effective in breaking the thumb or finger sucking habit. Rather than use bitterants or piquants, which are not endorsed by the ADA due to their causing of discomfort or pain, TGuards break the habit simply by removing the suction responsible for generating the feelings of comfort and nurture.[¹⁶] Other appliances are available, such as fabric thumb guards, each having their own benefits and features depending on the child's age, willpower and motivation. Fixed intraoral appliances have been known to create problems during eating as children when removing their appliances may have a risk of breaking them. Children with mental illness may have reduced compliance.[¹⁰]

Some studies mention the use of extra-oral habit reminder appliance to treat thumb sucking. An alarm is triggered when the child tries to suck the thumb to stop the child from this habit.^{[10}]^{[17}] However, more studies are required to prove the effectiveness of external devices on thumb sucking.

Children's books

[edit]

• In Heinrich Hoffmann's *Struwwelpeter*, the "thumb-sucker" Konrad is punished by having both of his thumbs cut off.

 There are several children's books on the market with the intention to help the child break the habit of thumb sucking. Most of them provide a story the child can relate to and some coping strategies.^[18] Experts recommend to use only books in which the topic of thumb sucking is shown in a positive and respectful way.^[19]

See also

[edit]

- Stereotypic movement disorder
- Prognathism

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About patient

For the state of being, see Patience. For other uses, see Patient (disambiguation).

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- Doctor-patient relationship
- Medical ethics
- Patient participation
- Patient-reported outcome
- \circ Patient safety

Consent

- Informed consent
- Adherence
- Informal coercion
- Motivational interviewing
- Involuntary treatment

Rights

- Patients' rights
- Pregnant patients' rights
- Disability rights movement
- Patient's Charter
- Medical law

Approaches

- Patient advocacy
- Patient-centered care
- Patient and public involvement

Abuse

- Patient abuse
- Elder abuse

Medical sociology

• Sick role

A **patient** is any recipient of health care services that are performed by healthcare professionals. The patient is most often ill or injured and in need of treatment by a physician, nurse, optometrist, dentist, veterinarian, or other health care provider.

Etymology

[edit]

This language has been construed as meaning that the role of patients is to passively accept and tolerate the suffering and treatments prescribed by the healthcare providers, without engaging in shared decision-making about their care.[¹]

Outpatients and inpatients

[edit]



Patients at the Red Cross Hospital in Tampere, Finland during the 1918 Finnish Civil War



Receptionist in Kenya attending to an outpatient

An outpatient (or out-patient) is a patient who attends an outpatient clinic with no plan to stay beyond the duration of the visit. Even if the patient will not be formally admitted with a note as an outpatient, their attendance is still registered, and the provider will usually give a note explaining the reason for the visit, tests, or procedure/surgery, which should include the names and titles of the participating personnel, the patient's name and date of birth, signature of informed consent, estimated pre-and post-service time for history and exam (before and after), any anesthesia, medications or future treatment plans needed, and estimated time of discharge absent any (further) complications. Treatment provided in this fashion is called ambulatory care. Sometimes surgery is performed without the need for a formal hospital admission or an overnight stay, and this is called outpatient surgery or day surgery, which has many benefits including lowered healthcare cost, reducing the amount of medication prescribed, and using the physician's or surgeon's time more efficiently. Outpatient surgery is suited best for more healthy patients undergoing minor or intermediate procedures (limited urinary-tract, eye, or ear, nose, and throat procedures and procedures involving superficial skin and the extremities). More procedures are being performed in a surgeon's office, termed officebased surgery, rather than in a hospital-based operating room.



A mother spends days sitting with her son, a hospital patient in Mali

An **inpatient** (or **in-patient**), on the other hand, is "admitted" to stay in a hospital overnight or for an indeterminate time, usually, several days or weeks, though in some extreme cases, such as with coma or persistent vegetative state, patients can stay in hospitals for years, sometimes until death. Treatment provided in this fashion is called inpatient care. The admission to the hospital involves the production of an admission note. The leaving of the hospital is officially termed *discharge*, and involves a corresponding discharge note, and sometimes an assessment process to consider ongoing needs. In the English National Health Service this may take the form of "Discharge to Assess" - where the assessment takes place after the patient has gone ${\rm home.[}^2]$

Misdiagnosis is the leading cause of medical error in outpatient facilities. When the U.S. Institute of Medicine's groundbreaking 1999 report, *To Err Is Human*, found up to 98,000 hospital patients die from preventable medical errors in the U.S. each year, [³] early efforts focused on inpatient safety. [⁴] While patient safety efforts have focused on inpatient hospital settings for more than a decade, medical errors are even more likely to happen in a doctor's office or outpatient clinic or center. [[]*citation needed*]

Day patient

[edit]

A **day patient** (or **day-patient**) is a patient who is using the full range of services of a hospital or clinic but is not expected to stay the night. The term was originally used by psychiatric hospital services using of this patient type to care for people needing support to make the transition from in-patient to out-patient care. However, the term is now also heavily used for people attending hospitals for day surgery.

Alternative terminology

[edit]

Because of concerns such as dignity, human rights and political correctness, the term "patient" is not always used to refer to a person receiving health care. Other terms that are sometimes used include **health consumer**, **healthcare consumer**, **customer** or **client**. However, such terminology may be offensive to those receiving public health care, as it implies a business relationship.

In veterinary medicine, the **client** is the owner or guardian of the patient. These may be used by governmental agencies, insurance companies, patient groups, or health care facilities. Individuals who use or have used psychiatric services may alternatively refer to themselves as consumers, users, or survivors. In nursing homes and assisted living facilities, the term **resident** is generally used in lieu of *patient*.[⁵] Similarly, those receiving home health care are called *clients*.

Patient-centered healthcare

[edit] See also: Patient participation

The doctor-patient relationship has sometimes been characterized as silencing the voice of patients.^[6] It is now widely agreed that putting patients at the centre of healthcare^[7] by trying to provide a consistent, informative and respectful service to patients will improve both outcomes and patient satisfaction.^[8]

When patients are not at the centre of healthcare, when institutional procedures and targets eclipse local concerns, then patient neglect is possible.^[9] Incidents, such as the Stafford Hospital scandal, Winterbourne View hospital abuse scandal and the Veterans Health Administration controversy of 2014 have shown the dangers of prioritizing cost control over the patient experience.^[10] Investigations into these and other scandals have recommended that healthcare systems put patient experience at the center, and especially that patients themselves are heard loud and clear within health services.^[11]

There are many reasons for why health services should listen more to patients. Patients spend more time in healthcare services than regulators or quality controllers, and can recognize problems such as service delays, poor hygiene, and poor conduct.^[12] Patients are particularly good at identifying soft problems, such as attitudes, communication, and 'caring neglect',^[9] that are difficult to capture with institutional monitoring.^[13]

One important way in which patients can be placed at the centre of healthcare is for health services to be more open about patient complaints.^[14] Each year many hundreds of thousands of patients complain about the care they have received, and these complaints contain valuable information for any health services which want to learn about and improve patient experience.^[15]

See also

[edit]

- Casualty
- e-Patient
- Mature minor doctrine
- Nurse-client relationship
- Patient abuse
- Patient advocacy
- Patient empowerment
- Patients' Bill of Rights
- Radiological protection of patients
- Therapeutic inertia
- Virtual patient
- Patient UK

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External links

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 "Time Magazine's Dr. Scott Haig Proves that Patients Need to Be Googlers!" – Mary Shomons response to the Time Magazine article "When the Patient is a Googler"

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Articles about hospitals

History of hospitals, Hospital network, Category:Hospitals

- Accreditation
- Bed
- Coronary care unit
- Emergency department
- Emergency codes
- Hospital administrators
- Hospital information system
- Hospital medicine
- Hospital museum
- Hospitalist
- Intensive care unit
- Nocturnist
- On-call room
- Operating theater
- Orderly
- Patients
- Pharmacy
- \circ Wards
- Almshouse
- Asclepeion (Greece)
- Bimaristan (Islamic)
- Cottage hospital (England)
- Hôtel-Dieu (France)
- Valetudinaria (Roman)
- Vaishya lying in houses (India)
- Xenodochium (Middle Ages)

Common hospital

components

Archaic forms

Geographic service area	 Base hospital (Australia) Community hospital General hospital Regional hospital or District hospital Municipal hospital
Complexity of services	 Day hospital Secondary hospital Tertiary referral hospital Teaching hospital Specialty hospital
Unique physical traits	 Hospital ship Hospital train Mobile hospital Underground hospital Virtual Hospital
Limited class of patients	 Military hospital Combat support hospital Field hospital Prison hospital Veterans medical facilities Women's hospital

- Charitable hospital
- For-profit hospital
- Non-profit hospital
- State hospital
- Private hospital
- Public hospital
- Voluntary hospital
- Defunct
- Cancer
- Children's hospital
- Eye hospital
- Fever hospital
- Leper colony
- Lock hospital
- Maternity hospital
- Psychiatric hospital
- Rehabilitation hospital
- Trauma center
- Verterinary hospital

Funding

Condition treated

	∘ 5th
	• 6th
	• 7th
	• 8th
	• 9th
	• 10th
	• 11th
	• 12th
Century established	• 13th
	• 14th
	• 15th
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	• 18th
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	• 20th
	• 21st

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