orthodontic treatment

- Understanding Common Fee Structures in Orthodontics
  Understanding Common Fee Structures in Orthodontics Insurance Coverage That Reduces Out of Pocket Costs Exploring Payment Plans and Financing Arrangements Differences Between Flexible Spending and Health Savings Factors Influencing Variations in Treatment Pricing Asking the Right Questions During Cost Consultations Allocation of Funds for Long Term Orthodontic Care Prioritizing Necessary Treatments Within a Budget Navigating Claims and Reimbursements Step by Step How Location Affects Orthodontic Expenses Educating Patients on Financial Planning for Treatment Strategies to Keep Future Costs Predictable
- Role of Licensing and Certification in Orthodontics
  Role of Licensing and Certification in Orthodontics Safeguards That Protect Patient Wellbeing Responsibilities of Healthcare Providers in Treatment Importance of Proper Clinical Supervision Informed Consent and Patient Decision Making Identifying Red Flags in Unsupervised Orthodontic Options Maintaining Ethical Standards in Modern Practices The Impact of Research on Evidence Based Treatments Open Communication as a Pillar of Ethical Care Regulations Governing Teledentistry Platforms Balancing Innovation With Patient Protection How Professional Guidelines Shape Clinical Judgments
- About Us

Here's the article outline for 'Understanding Common Fee Structures in Orthodontics' focusing on orthodontic treatment for kids:

Navigating Orthodontic Treatments on a Budget: Smart Choices for Your Child's Smile

As a parent, managing your child's orthodontic care can feel like walking a financial tightrope. You want the best for your child's dental health, but the costs can quickly become overwhelming. The key is to prioritize treatments strategically without compromising your child's long-term oral well-being.

Regular brushing and flossing are essential with braces **Pediatric orthodontic care** American Association of Orthodontists.

First, understand that not all orthodontic issues are created equal. Some treatments are purely cosmetic, while others address critical functional problems that could impact your child's health and development. Consultation with a trusted orthodontist is crucial in distinguishing between necessary and optional treatments.

Start by focusing on interventions that prevent more serious complications. For instance, addressing severe bite misalignments or overcrowding early can prevent more expensive and invasive treatments later. Think of it like preventative maintenance for your child's dental health - a small investment now could save thousands down the road.

Consider flexible payment options and insurance coverage. Many orthodontic practices offer payment plans that can break down the total cost into manageable monthly installments. Some dental insurance plans also provide partial coverage for pediatric orthodontic work, so explore these avenues thoroughly.

Don't be afraid to have an open, honest conversation with your orthodontist about your budget constraints. Most professionals understand financial challenges and can help you develop a phased treatment approach that addresses the most critical issues first.

Ultimately, prioritizing orthodontic treatments is about balancing immediate needs with long-term oral health goals. By being strategic, informed, and proactive, you can provide your child with essential dental care without breaking the bank.

Traditional Fee Structures: Per-Treatment Pricing Models

Navigating the world of pediatric orthodontic care can be a complex and financially challenging journey for many families. As parents, we want the best for our children's dental health, but the costs associated with orthodontic treatments can often feel overwhelming.

The reality is that orthodontic care isn't just about creating a beautiful smile; it's about addressing critical dental and oral health issues that can impact a child's overall well-being. However, the financial burden can make parents feel caught between their child's health needs and their budget constraints.

Strategic treatment planning becomes crucial in these situations. It's not about avoiding necessary care, but rather about prioritizing treatments that are most critical to a child's dental development. Sometimes, this means breaking down complex treatments into more manageable stages or exploring alternative options that can provide essential care without breaking the bank.

Insurance coverage can be limited, and out-of-pocket expenses can quickly add up. Many orthodontists now offer flexible payment plans or financing options that can help families

manage these costs more effectively. The key is open communication with dental professionals who understand the financial challenges families face.

Parents should also consider preventative approaches that might reduce the extent of future treatments. Early intervention can sometimes minimize the complexity and cost of later orthodontic work. This might involve regular check-ups, addressing minor alignment issues before they become more significant problems, and maintaining good oral hygiene.

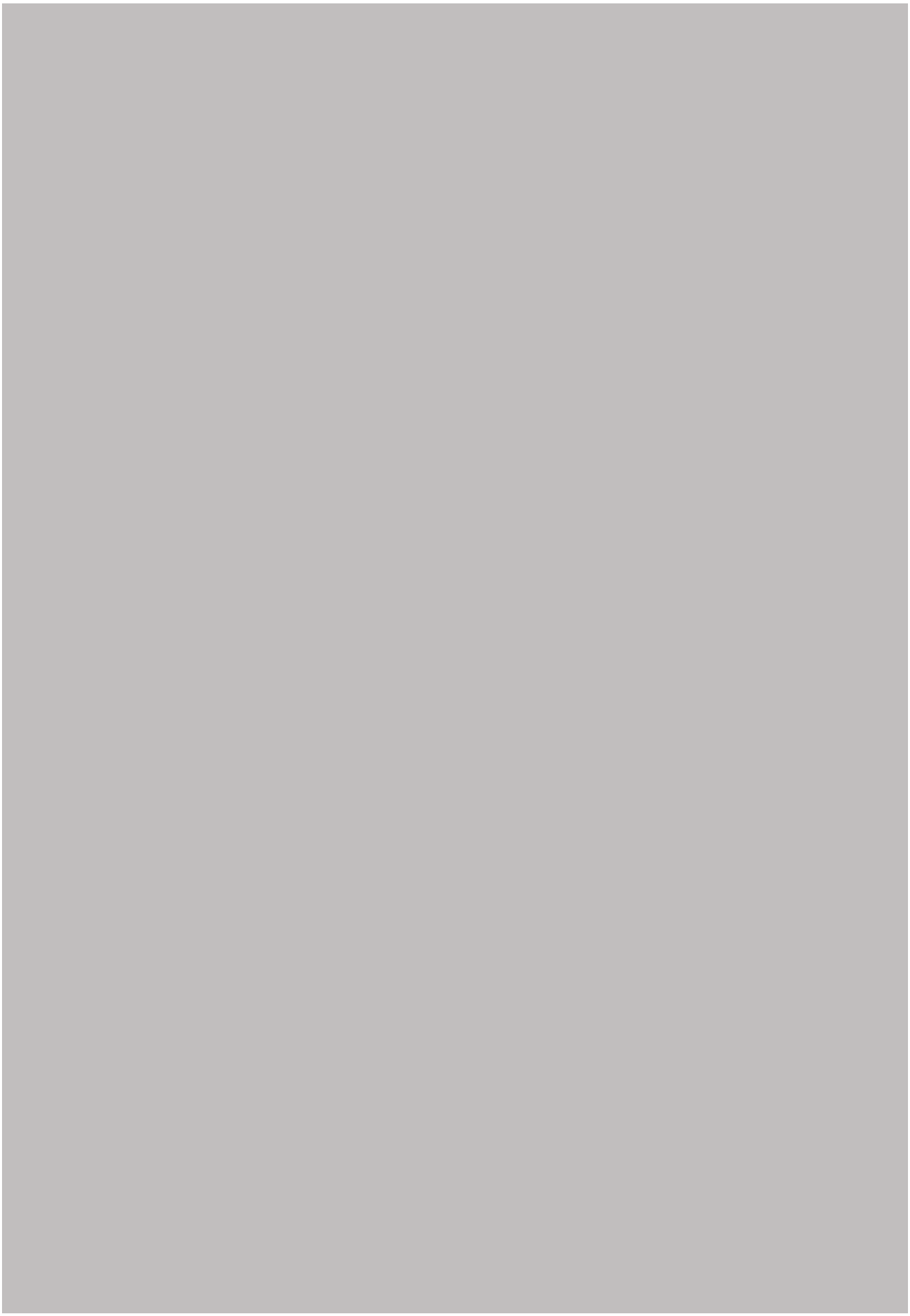
Ultimately, understanding and planning for pediatric orthodontic care is about finding a balance between necessary medical treatments and financial feasibility. It requires patience, research, and a proactive approach to managing your child's dental health.

The most important thing is to not let financial concerns prevent essential care. Many orthodontists are willing to work with families to find solutions that ensure children receive the treatment they need while respecting the family's financial limitations.

More about us:

Social Media:

Facebook About Us:



Insurance Coverage and Impact on Orthodontic Expenses

Dental Misalignment in Children: A Comprehensive Evaluation

When it comes to children's dental health, assessing the severity of misalignment is more than just a cosmetic concern-it's about preventing potential long-term health complications. As parents and healthcare providers, we must carefully evaluate the impact of dental irregularities on a child's overall well-being.

Misaligned teeth can create a cascade of challenges that extend far beyond simple aesthetic considerations. Bite issues can lead to difficulties in proper chewing, speech development, and even psychological impacts related to self-esteem. Some children may experience jaw pain, increased risk of tooth decay, and challenges with oral hygiene due to hard-to-clean irregular tooth positioning.

The key is to prioritize treatments that offer the most significant long-term benefits while being mindful of budget constraints. Not every misalignment requires immediate intervention, but some cases demand prompt attention. Factors like the potential for future dental complications, impact on facial development, and the child's overall oral health must be carefully weighed.

Orthodontic assessments typically begin around age 7, allowing early detection of potential issues. This proactive approach can often prevent more extensive and expensive treatments later. We're looking at a delicate balance between necessary medical intervention and financial practicality.

Professional evaluations should consider multiple factors: the severity of misalignment, potential functional problems, risk of future dental complications, and the child's individual growth patterns. Some treatments can be delayed or staged to manage costs effectively, while others might require more immediate action.

Parents should work closely with dental professionals to develop a comprehensive treatment plan that addresses the most critical concerns first. This might mean prioritizing treatments that prevent more serious long-term issues while potentially deferring purely cosmetic corrections.

Ultimately, the goal is to ensure the child's dental health, functional ability, and confidence. Each case is unique, requiring a personalized approach that balances medical necessity with financial considerations.

Payment Plan Options for Pediatric Orthodontic Care

When it comes to orthodontic treatments, navigating the various options while staying mindful of your budget can feel like solving a complex puzzle. As someone who's been through the process of exploring dental corrections, I understand how overwhelming it can be to choose the right approach.

Traditional metal braces have long been the standard go-to treatment. They're typically the most affordable option, with costs ranging from $3,000 to $7,000. While they're highly effective, they're also the most noticeable, which can be a concern for adults and self-conscious teenagers. The metal brackets and wires are robust and can handle more complex dental alignments, making them a reliable choice for significant corrections.

Clear aligners like Invisalign have gained massive popularity in recent years. They're nearly invisible, removable, and often more comfortable than traditional braces. However, this convenience comes at a price - usually between $4,000 and $8,000. They work best for mild

to moderate alignment issues and require significant patient discipline in wearing them consistently.

Early intervention techniques are particularly interesting for parents considering orthodontic care for younger children. By addressing potential alignment issues before they become more complex, families can potentially save money in the long run. These techniques might involve space maintainers, partial braces, or strategic monitoring of dental development.

When prioritizing treatments, I recommend considering three key factors: the severity of dental misalignment, personal comfort preferences, and long-term financial planning. Sometimes, a staged approach can help spread out costs while still achieving optimal results.

Consulting with an orthodontist who offers flexible payment plans or financing options can also make these treatments more accessible. Many practices understand the financial strain and are willing to work with patients to find manageable solutions.

Ultimately, investing in your dental health is about balancing immediate costs with long-term benefits. A well-aligned smile isn't just about aesthetics - it impacts oral health, confidence, and overall well-being.

Factors Influencing Orthodontic Treatment Costs

Navigating Orthodontic Expenses: Smart Financial Planning

Managing orthodontic treatment costs can feel overwhelming, but with the right approach, you can make your dental care more affordable and accessible. Understanding your financial options is crucial to ensuring you can prioritize necessary treatments without breaking the

bank.

First, let's talk insurance. Many dental insurance plans offer partial coverage for orthodontic work, especially for children and teenagers. Before scheduling any procedures, carefully review your current insurance policy. Some plans cover a percentage of orthodontic expenses, which can significantly reduce your out-of-pocket costs. Don't hesitate to call your insurance provider and ask specific questions about orthodontic coverage.

Flexible spending accounts (FSAs) are another excellent resource. These tax-advantaged accounts allow you to set aside pre-tax dollars for medical expenses, including orthodontic treatments. By using FSA funds, you're essentially getting a discount on your treatment by reducing your taxable income. Just remember that FSA funds typically expire at the end of the year, so plan accordingly.

For those without comprehensive insurance or who need additional financial support, many orthodontic offices offer payment plans. These arrangements can break down the total cost into manageable monthly installments, making expensive treatments more accessible. Some practices even provide interest-free options for patients who demonstrate financial need.

Consider exploring alternative financing options like healthcare credit cards or personal medical loans. These can provide flexible payment terms and potentially lower interest rates compared to traditional credit cards. However, always read the fine print and understand the full terms before committing.

When budgeting for orthodontic care, prioritize treatments based on medical necessity and potential long-term benefits. Discuss with your orthodontist which procedures are most critical and which might be delayed without compromising your dental health.

Remember, investing in your oral health now can prevent more expensive treatments down the line. By being proactive, researching your options, and creating a strategic financial plan, you can manage orthodontic expenses effectively and confidently.

Comparing Different Orthodontic Practices and Their Pricing Strategies

Navigating Dental Care: Balancing Necessity and Aesthetics

When it comes to dental health, many people find themselves wrestling with a challenging financial decision: how to prioritize treatments when budget constraints come into play. The reality is that not all dental needs are created equal, and some issues demand immediate attention while others can wait.

Immediate dental health concerns should always take precedence over cosmetic treatments. If you're experiencing pain, infection, or structural damage that could lead to more serious complications, these are the treatments you simply can't afford to postpone. A severe cavity, an abscess, or a broken tooth that threatens your overall oral health needs to be addressed quickly, regardless of how it might look.

That said, it doesn't mean you have to completely abandon all cosmetic considerations. Sometimes, addressing a structural issue can also improve the aesthetic appearance of your teeth. For instance, a necessary crown might not only prevent further tooth decay but also enhance your smile's appearance.

The smart approach is to create a tiered treatment plan with your dentist. Prioritize treatments that prevent further damage or address existing health risks. This might mean dealing with cavities, gum disease, or structural problems first. Once those critical issues are resolved, you can start thinking about cosmetic enhancements like whitening or minor alignment corrections.

Financial planning is key. Many dental offices offer payment plans or work with insurance providers to make necessary treatments more affordable. Don't be afraid to have an open conversation about your budget and explore all available options.

Ultimately, investing in your dental health now can save you significant money and discomfort in the long run. Preventative care and addressing issues early are always more cost-effective than waiting until a minor problem becomes a major, expensive procedure.

Additional Fees and Potential Hidden Expenses in Orthodontic Treatment

When it comes to managing orthodontic care on a budget, finding smart and strategic approaches can make a significant difference in both your oral health and financial well-being. Most people don't realize that preventive measures can actually save them substantial money in the long run.

One key strategy is early intervention. By addressing potential alignment issues during childhood or early adolescence, you can often prevent more complex and expensive treatments later. Regular dental check-ups and consultations with orthodontic specialists can help identify potential problems before they become more serious and costly.

Another cost-effective approach involves exploring alternative treatment options. Traditional metal braces aren't the only solution anymore. Clear aligners, for instance, can sometimes be more affordable and offer greater flexibility. Additionally, some dental schools and community

health centers provide orthodontic services at reduced rates, which can significantly lower overall treatment expenses.

Maintaining excellent oral hygiene is also crucial. Consistent brushing, flossing, and professional cleanings can prevent complications that might require more extensive and expensive interventions. Simple habits like using fluoride toothpaste, avoiding sugary foods, and wearing protective mouthguards during sports can minimize potential dental issues.

Insurance and flexible payment plans are worth investigating too. Many dental insurance plans now offer partial coverage for orthodontic treatments, and many orthodontists provide installment plans that can spread costs over time, making treatment more manageable.

Ultimately, being proactive, informed, and strategic about your dental care can help you prioritize necessary treatments while keeping your budget intact. It's about finding the right balance between immediate needs and long-term oral health goals.

Navigating Orthodontic Care: Balancing Health and Financial Realities

When it comes to orthodontic treatment, patients often find themselves at a crossroads between medical needs and financial limitations. Consulting with orthodontic professionals becomes crucial in developing a strategic approach that addresses both health requirements and budgetary constraints.

The process begins with a comprehensive evaluation that goes beyond simply identifying dental issues. Skilled orthodontists understand that treatment isn't one-size-fits-all. They take the time to listen to patients' concerns, assess the severity of dental misalignments, and consider long-term health implications.

A phased treatment approach emerges as the most practical solution for many patients. This might mean prioritizing the most critical interventions first - those that could prevent future complications or address immediate functional problems. For instance, a severe bite misalignment that could cause jaw pain or difficulty eating would typically take precedence over purely cosmetic concerns.

Financial planning becomes an integral part of the conversation. Experienced orthodontists often work with patients to create flexible payment plans, explore insurance options, and break down treatment into manageable stages. This might involve addressing the most pressing issues first and deferring less critical treatments until financial resources allow.

Communication is key throughout this process. Patients should feel empowered to discuss their budgetary limitations openly, and orthodontists should provide transparent, realistic options. Sometimes, this means finding creative solutions - perhaps a less expensive initial treatment that can be supplemented later or alternative approaches that meet both medical and financial needs.

Ultimately, the goal is to develop a treatment plan that protects the patient's oral health without causing undue financial stress. It's a delicate balance of medical expertise, financial planning, and patient-centered care that requires empathy, creativity, and a collaborative approach.

By working closely with orthodontic professionals and being proactive about treatment planning, patients can achieve optimal dental health while maintaining financial stability.

Navigating the world of pediatric orthodontic care can feel like walking a financial tightrope for many parents. It's not just about straightening teeth; it's about making smart financial decisions that don't break the bank while ensuring your child's dental health.

The first step in developing a comprehensive financial strategy is understanding the full scope of treatment. Not all orthodontic needs are created equal. Some issues require immediate attention, while others can be monitored or addressed later. This means prioritizing treatments that are critical for your child's oral health and potential long-term medical concerns.

Savings is your first line of defense. Many parents start setting aside money specifically for dental care early on. Consider opening a dedicated savings account or exploring flexible spending accounts (FSAs) that can help offset orthodontic expenses. Some families even start saving when their children are still very young, anticipating potential future dental work.

Payment plans are a lifesaver for many. Most orthodontic practices offer flexible monthly payment options that can spread the cost over several months or even years. Don't be afraid to have an open conversation with your orthodontist about financial constraints. Many are willing to work out arrangements that make treatment more accessible.

Supplemental funding sources can be a game-changer. Dental insurance, health savings accounts, and even some community health programs might provide additional financial support. Some families explore options like dental schools that offer discounted treatments or local health clinics with sliding scale fees.

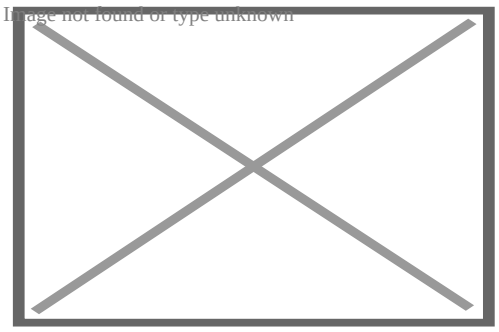
The key is to be proactive and strategic. Research thoroughly, ask questions, and don't be afraid to shop around. Remember, the cheapest option isn't always the best, but neither is the most expensive. It's about finding the right balance between quality care and financial feasibility.

Ultimately, investing in your child's dental health is an investment in their overall well-being. A thoughtful, comprehensive approach to financing orthodontic care can make a world of difference in both your child's smile and your financial peace of mind.

About pediatrics

This article is about the branch of medicine. For the journal, see Pediatrics (journal). For the branch of dentistry, see Pedodontics.

Pediatrics



A pediatrician examines a neonate.

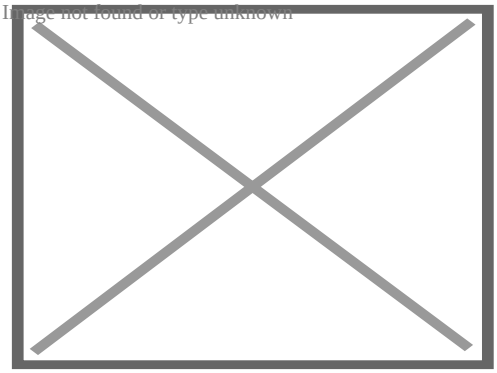
Focus	**Infants, Children, Adolescents, and Young Adults**
Subdivisions	*Paediatric cardiology, neonatology, critical care, pediatric oncology, hospital medicine, primary care, others (see below)*
Significant diseases	Congenital diseases, Infectious diseases, Childhood cancer, Mental disorders
Significant tests	World Health Organization Child Growth Standards
Specialist	**Pediatrician**

Glossary Glossary of medicine

Pediatrics (American English) also spelled **paediatrics** (British English), is the branch of medicine that involves the medical care of infants, children, adolescents, and young adults. In the United Kingdom, pediatrics covers many of their youth until the age of 18.[1] The American Academy of Pediatrics recommends people seek pediatric care through the age of 21, but some pediatric subspecialists continue to care for adults up to 25.[2][3] Worldwide age limits of pediatrics have been trending upward year after year.[4] A medical doctor who specializes in this area is known as a **pediatrician**, or **paediatrician**. The word *pediatrics* and its cognates mean "healer of children", derived from the two Greek words: ??Ã¡Â¿â€“? (*pais* "child") and Ã¡Â¼Â°???Ã•Å’?(*iatros* "doctor, healer"). Pediatricians work in clinics, research centers, universities, general hospitals and children's hospitals, including those who practice pediatric subspecialties (e.g. neonatology requires resources available in a NICU).

History

[edit]



Part of Great Ormond Street Hospital in London, United Kingdom, which was the first pediatric hospital in the English-speaking world.

The earliest mentions of child-specific medical problems appear in the *Hippocratic Corpus*, published in the fifth century B.C., and the famous *Sacred Disease*. These publications discussed topics such as childhood epilepsy and premature births. From the first to fourth centuries A.D., Greek philosophers and physicians Celsus, Soranus of Ephesus, Aretaeus, Galen, and Oribasius, also discussed specific illnesses affecting children in their works, such as rashes, epilepsy, and meningitis.[5] Already Hippocrates, Aristotle, Celsus, Soranus, and Galen[6] understood the differences in growing and maturing organisms that necessitated different treatment: *Ex toto non sic pueri ut viri curari debent* ("In general, boys should not be treated in the same way as men").[7] Some of the oldest traces of pediatrics can be discovered in Ancient India where children's doctors were called *kumara bhrtya*.[6]

Even though some pediatric works existed during this time, they were scarce and rarely published due to a lack of knowledge in pediatric medicine. *Sushruta Samhita*, an ayurvedic text composed during the sixth century BCE, contains the text about pediatrics.[8] Another ayurvedic text from this period is *Kashyapa Samhita*.[9][10] A second century AD manuscript by the Greek physician and gynecologist Soranus of Ephesus dealt with neonatal pediatrics.[11] Byzantine physicians Oribasius, Aëtius of Amida, Alexander Trallianus, and Paulus Aegineta contributed to the field.[6] The Byzantines also built *brephotrophia* (crêches).[6] Islamic Golden Age writers served as a bridge for Greco-Roman and Byzantine medicine and added ideas of their own, especially Haly Abbas, Yahya Serapion, Abulcasis, Avicenna, and Averroes. The Persian philosopher and physician al-Razi (865–925), sometimes called the father of pediatrics, published a monograph on pediatrics titled *Diseases in Children*.[12][13] Also among the first books about pediatrics was *Libellus [Opusculum] de aegritudinibus et remediis infantium* 1472 ("Little Book on Children Diseases and Treatment"), by the Italian pediatrician Paolo Bagellardo.[14][5] In sequence came Bartholomäus Metlinger's *Ein Regiment der Jungerkinder* 1473, Cornelius Roelans (1450–1525) no title Buchlein, or Latin compendium, 1483, and Heinrich von Louffenburg (1391–1460) *Versehung des Leibs* written in 1429 (published 1491), together form the *Pediatric Incunabula*, four great medical treatises on children's physiology and pathology.[6]

While more information about childhood diseases became available, there was little evidence that children received the same kind of medical care that adults did.[15] It was during the seventeenth and eighteenth centuries that medical experts started offering specialized care for children.[5] The Swedish physician Nils Rosén von Rosenstein (1706–1773) is considered to be the founder of modern pediatrics as a medical specialty,[16][17] while his work *The diseases of children, and their remedies* (1764) is considered to be "the first modern textbook on the subject".[18] However, it was not until the nineteenth century that medical professionals acknowledged pediatrics as a separate field of medicine. The first pediatric-specific publications appeared between the 1790s and the 1920s.[19]

Etymology

[edit]

The term pediatrics was first introduced in English in 1859 by Abraham Jacobi. In 1860, he became "the first dedicated professor of pediatrics in the world."[20] Jacobi is known as the *father of American pediatrics* because of his many contributions to the field.[21][22] He received his medical training in Germany and later practiced in New York City.[23]

The first generally accepted pediatric hospital is the *Hôpital des Enfants Malades* (French: *Hospital for Sick Children*), which opened in Paris in June 1802 on the site of a previous

orphanage.[24] From its beginning, this famous hospital accepted patients up to the age of fifteen years,[25] and it continues to this day as the pediatric division of the Necker-Enfants Malades Hospital, created in 1920 by merging with the nearby *Necker Hospital*, founded in 1778.[26]

In other European countries, the Charité (a hospital founded in 1710) in Berlin established a separate Pediatric Pavilion in 1830, followed by similar institutions at Saint Petersburg in 1834, and at Vienna and Breslau (now WrocÃ…â€šaw), both in 1837. In 1852 Britain's first pediatric hospital, the Hospital for Sick Children, Great Ormond Street was founded by Charles West.[24] The first Children's hospital in Scotland opened in 1860 in Edinburgh.[27] In the US, the first similar institutions were the Children's Hospital of Philadelphia, which opened in 1855, and then Boston Children's Hospital (1869).[28] Subspecialties in pediatrics were created at the Harriet Lane Home at Johns Hopkins by Edwards A. Park.[29]

Differences between adult and pediatric medicine

[edit]

The body size differences are paralleled by maturation changes. The smaller body of an infant or neonate is substantially different physiologically from that of an adult. Congenital defects, genetic variance, and developmental issues are of greater concern to pediatricians than they often are to adult physicians. A common adage is that children are not simply "little adults". The clinician must take into account the immature physiology of the infant or child when considering symptoms, prescribing medications, and diagnosing illnesses.[30]

Pediatric physiology directly impacts the pharmacokinetic properties of drugs that enter the body. The absorption, distribution, metabolism, and elimination of medications differ between developing children and grown adults.[30][31][32] Despite completed studies and reviews, continual research is needed to better understand how these factors should affect the decisions of healthcare providers when prescribing and administering medications to the pediatric population.[30]

Absorption

[edit]

Many drug absorption differences between pediatric and adult populations revolve around the stomach. Neonates and young infants have increased stomach pH due to decreased acid secretion, thereby creating a more basic environment for drugs that are taken by mouth.[31][30][32] Acid is essential to degrading certain oral drugs before systemic

absorption. Therefore, the absorption of these drugs in children is greater than in adults due to decreased breakdown and increased preservation in a less acidic gastric space.[31]

Children also have an extended rate of gastric emptying, which slows the rate of drug absorption.[31][32]

Drug absorption also depends on specific enzymes that come in contact with the oral drug as it travels through the body. Supply of these enzymes increase as children continue to develop their gastrointestinal tract.[31][32] Pediatric patients have underdeveloped proteins, which leads to decreased metabolism and increased serum concentrations of specific drugs. However, prodrugs experience the opposite effect because enzymes are necessary for allowing their active form to enter systemic circulation.[31]

Distribution

[edit]

Percentage of total body water and extracellular fluid volume both decrease as children grow and develop with time. Pediatric patients thus have a larger volume of distribution than adults, which directly affects the dosing of hydrophilic drugs such as beta-lactam antibiotics like ampicillin.[31] Thus, these drugs are administered at greater weight-based doses or with adjusted dosing intervals in children to account for this key difference in body composition.[31][30]

Infants and neonates also have fewer plasma proteins. Thus, highly protein-bound drugs have fewer opportunities for protein binding, leading to increased distribution.[30]

Metabolism

[edit]

Drug metabolism primarily occurs via enzymes in the liver and can vary according to which specific enzymes are affected in a specific stage of development.[31] Phase I and Phase II enzymes have different rates of maturation and development, depending on their specific mechanism of action (i.e. oxidation, hydrolysis, acetylation, methylation, etc.). Enzyme capacity, clearance, and half-life are all factors that contribute to metabolism differences between children and adults.[31][32] Drug metabolism can even differ within the pediatric population, separating neonates and infants from young children.[30]

Elimination

[edit]

Drug elimination is primarily facilitated via the liver and kidneys.[31] In infants and young children, the larger relative size of their kidneys leads to increased renal clearance of medications that are eliminated through urine.[32] In preterm neonates and infants, their kidneys are slower to mature and thus are unable to clear as much drug as fully developed kidneys. This can cause unwanted drug build-up, which is why it is important to consider lower doses and greater dosing intervals for this population.[30][31] Diseases that negatively affect kidney function can also have the same effect and thus warrant similar considerations.[31]

Pediatric autonomy in healthcare

[edit]

A major difference between the practice of pediatric and adult medicine is that children, in most jurisdictions and with certain exceptions, cannot make decisions for themselves. The issues of guardianship, privacy, legal responsibility, and informed consent must always be considered in every pediatric procedure. Pediatricians often have to treat the parents and sometimes, the family, rather than just the child. Adolescents are in their own legal class, having rights to their own health care decisions in certain circumstances. The concept of legal consent combined with the non-legal consent (assent) of the child when considering treatment options, especially in the face of conditions with poor prognosis or complicated and painful procedures/surgeries, means the pediatrician must take into account the desires of many people, in addition to those of the patient.[*citation needed*]

History of pediatric autonomy

[edit]

The term autonomy is traceable to ethical theory and law, where it states that autonomous individuals can make decisions based on their own logic.[33] Hippocrates was the first to use the term in a medical setting. He created a code of ethics for doctors called the *Hippocratic Oath* that highlighted the importance of putting patients' interests first, making autonomy for patients a top priority in health care.[34]

In ancient times, society did not view pediatric medicine as essential or scientific.[35] Experts considered professional medicine unsuitable for treating children. Children also had no rights. Fathers regarded their children as property, so their children's health decisions were entrusted to them.[5] As a result, mothers, midwives, "wise women", and general practitioners treated the children instead of doctors.[35] Since mothers could not rely on professional medicine to take care of their children, they developed their own methods, such as using alkaline soda ash to remove the vernix at birth and treating teething pain with opium or wine. The absence of proper pediatric care, rights, and laws in health care to prioritize children's health led to many of their deaths. Ancient Greeks and Romans sometimes even killed healthy female babies and infants with deformities since they had no adequate medical treatment and no laws prohibiting infanticide.[5]

In the twentieth century, medical experts began to put more emphasis on children's rights. In 1989, in the United Nations Rights of the Child Convention, medical experts developed the Best Interest Standard of Child to prioritize children's rights and best interests. This event marked the onset of pediatric autonomy. In 1995, the American Academy of Pediatrics (AAP) finally acknowledged the Best Interest Standard of a Child as an ethical principle for pediatric decision-making, and it is still being used today.[34]

Parental authority and current medical issues

[edit]

The majority of the time, parents have the authority to decide what happens to their child. Philosopher John Locke argued that it is the responsibility of parents to raise their children and that God gave them this authority. In modern society, Jeffrey Blustein, modern philosopher and author of the book *Parents and Children: The Ethics of Family*, argues that parental authority is granted because the child requires parents to satisfy their needs. He believes that parental autonomy is more about parents providing good care for their children and treating them with respect than parents having rights.[36] The researcher Kyriakos Martakis, MD, MSc, explains that research shows parental influence negatively affects children's ability to form autonomy. However, involving children in the decision-making process allows children to develop their cognitive skills and create their own opinions and, thus, decisions about their health. Parental authority affects the degree of autonomy the child patient has. As a result, in Argentina, the new National Civil and Commercial Code has enacted various changes to the healthcare system to encourage children and adolescents to develop autonomy. It has become more crucial to let children take accountability for their own health decisions.[37]

In most cases, the pediatrician, parent, and child work as a team to make the best possible medical decision. The pediatrician has the right to intervene for the child's welfare and seek advice from an ethics committee. However, in recent studies, authors have

denied that complete autonomy is present in pediatric healthcare. The same moral standards should apply to children as they do to adults. In support of this idea is the concept of paternalism, which negates autonomy when it is in the patient's interests. This concept aims to keep the child's best interests in mind regarding autonomy. Pediatricians can interact with patients and help them make decisions that will benefit them, thus enhancing their autonomy. However, radical theories that question a child's moral worth continue to be debated today.[37] Authors often question whether the treatment and equality of a child and an adult should be the same. Author Tamar Schapiro notes that children need nurturing and cannot exercise the same level of authority as adults.[38] Hence, continuing the discussion on whether children are capable of making important health decisions until this day.

Modern advancements

[edit]

According to the Subcommittee of Clinical Ethics of the Argentinean Pediatric Society (SAP), children can understand moral feelings at all ages and can make reasonable decisions based on those feelings. Therefore, children and teens are deemed capable of making their own health decisions when they reach the age of 13. Recently, studies made on the decision-making of children have challenged that age to be 12.[37]

Technology has made several modern advancements that contribute to the future development of child autonomy, for example, unsolicited findings (U.F.s) of pediatric exome sequencing. They are findings based on pediatric exome sequencing that explain in greater detail the intellectual disability of a child and predict to what extent it will affect the child in the future. Genetic and intellectual disorders in children make them incapable of making moral decisions, so people look down upon this kind of testing because the child's future autonomy is at risk. It is still in question whether parents should request these types of testing for their children. Medical experts argue that it could endanger the autonomous rights the child will possess in the future. However, the parents contend that genetic testing would benefit the welfare of their children since it would allow them to make better health care decisions.[39] Exome sequencing for children and the decision to grant parents the right to request them is a medically ethical issue that many still debate today.

Education requirements

[edit]

Globe icon
Image not found or type unknown

The examples and perspective in this section **deal primarily with United States and do not represent a worldwide view of the subject**. You may improve this section, discuss the issue on the talk page, or create a new section, as appropriate. *(September 2019) (Learn how and when to remove this message)*

Aspiring medical students will need 4 years of undergraduate courses at a college or university, which will get them a BS, BA or other bachelor's degree. After completing college, future pediatricians will need to attend 4 years of medical school (MD/DO/MBBS) and later do 3 more years of residency training, the first year of which is called "internship." After completing the 3 years of residency, physicians are eligible to become certified in pediatrics by passing a rigorous test that deals with medical conditions related to young children.[*citation needed*]

In high school, future pediatricians are required to take basic science classes such as biology, chemistry, physics, algebra, geometry, and calculus. It is also advisable to learn a foreign language (preferably Spanish in the United States) and be involved in high school organizations and extracurricular activities. After high school, college students simply need to fulfill the basic science course requirements that most medical schools recommend and will need to prepare to take the MCAT (Medical College Admission Test) in their junior or early senior year in college. Once attending medical school, student courses will focus on basic medical sciences like human anatomy, physiology, chemistry, etc., for the first three years, the second year of which is when medical students start to get hands-on experience with actual patients.[40]

Training of pediatricians

[edit]

Pediatrics

Image not found or type unknown

Occupation	
Names	○ Pediatrician ○ Paediatrician
Occupation type	Specialty
Activity sectors	Medicine

	Description
Education required	○ Doctor of Medicine ○ Doctor of Osteopathic Medicine ○ Bachelor of Medicine, Bachelor of Surgery (MBBS/MBChB)
Fields of employment	Hospitals, Clinics

The training of pediatricians varies considerably across the world. Depending on jurisdiction and university, a medical degree course may be either undergraduate-entry or graduate-entry. The former commonly takes five or six years and has been usual in the Commonwealth. Entrants to graduate-entry courses (as in the US), usually lasting four or five years, have previously completed a three- or four-year university degree, commonly but by no means always in sciences. Medical graduates hold a degree specific to the country and university in and from which they graduated. This degree qualifies that medical practitioner to become licensed or registered under the laws of that particular country, and sometimes of several countries, subject to requirements for "internship" or "conditional registration".

Pediatricians must undertake further training in their chosen field. This may take from four to eleven or more years depending on jurisdiction and the degree of specialization.

In the United States, a medical school graduate wishing to specialize in pediatrics must undergo a three-year residency composed of outpatient, inpatient, and critical care rotations. Subspecialties within pediatrics require further training in the form of 3-year fellowships. Subspecialties include critical care, gastroenterology, neurology, infectious disease, hematology/oncology, rheumatology, pulmonology, child abuse, emergency medicine, endocrinology, neonatology, and others.[41]

In most jurisdictions, entry-level degrees are common to all branches of the medical profession, but in some jurisdictions, specialization in pediatrics may begin before completion of this degree. In some jurisdictions, pediatric training is begun immediately following the completion of entry-level training. In other jurisdictions, junior medical doctors must undertake generalist (unstreamed) training for a number of years before commencing pediatric (or any other) specialization. Specialist training is often largely under the control of '*pediatric organizations* (see below) rather than universities and depends on the jurisdiction.

Subspecialties

[edit]

Subspecialties of pediatrics include:

(*not an exhaustive list*)

- Addiction medicine (multidisciplinary)
- Adolescent medicine
- Child abuse pediatrics
- Clinical genetics
- Clinical informatics
- Developmental-behavioral pediatrics
- Headache medicine
- Hospital medicine
- Medical toxicology
- Metabolic medicine
- Neonatology/Perinatology
- Pain medicine (multidisciplinary)
- Palliative care (multidisciplinary)
- Pediatric allergy and immunology
- Pediatric cardiology
    - Pediatric cardiac critical care
- Pediatric critical care
    - Neurocritical care
    - Pediatric cardiac critical care
- Pediatric emergency medicine
- Pediatric endocrinology
- Pediatric gastroenterology
    - Transplant hepatology
- Pediatric hematology
- Pediatric infectious disease
- Pediatric nephrology
- Pediatric oncology
    - Pediatric neuro-oncology
- Pediatric pulmonology
- Primary care
- Pediatric rheumatology
- Sleep medicine (multidisciplinary)
- Social pediatrics
- Sports medicine

Other specialties that care for children

[edit]

(*not an exhaustive list*)

- Child neurology
    - Addiction medicine (multidisciplinary)
    - Brain injury medicine
    - Clinical neurophysiology
    - Epilepsy

    - Headache medicine
    - Neurocritical care
    - Neuroimmunology
    - Neuromuscular medicine
    - Pain medicine (multidisciplinary)
    - Palliative care (multidisciplinary)
    - Pediatric neuro-oncology
    - Sleep medicine (multidisciplinary)
  - Child and adolescent psychiatry, subspecialty of psychiatry
  - Neurodevelopmental disabilities
  - Pediatric anesthesiology, subspecialty of anesthesiology
  - Pediatric dentistry, subspecialty of dentistry
  - Pediatric dermatology, subspecialty of dermatology
  - Pediatric gynecology
  - Pediatric neurosurgery, subspecialty of neurosurgery
  - Pediatric ophthalmology, subspecialty of ophthalmology
  - Pediatric orthopedic surgery, subspecialty of orthopedic surgery
  - Pediatric otolaryngology, subspecialty of otolaryngology
  - Pediatric plastic surgery, subspecialty of plastic surgery
  - Pediatric radiology, subspecialty of radiology
  - Pediatric rehabilitation medicine, subspecialty of physical medicine and rehabilitation
  - Pediatric surgery, subspecialty of general surgery
  - Pediatric urology, subspecialty of urology

See also

[edit]

- American Academy of Pediatrics
- American Osteopathic Board of Pediatrics
- Center on Media and Child Health (CMCH)
- Children's hospital
- List of pediatric organizations
- List of pediatrics journals
- Medical specialty
- Pediatric Oncall
- Pain in babies
- Royal College of Paediatrics and Child Health
- Pediatric environmental health

References

[edit]

1. **^** *"Paediatrics" (PDF). nhs.uk. Archived (PDF) from the original on 13 July 2020. Retrieved 2 July 2020.*
2. **^** *"Choosing a Pediatrician for Your New Baby (for Parents) - Nemours KidsHealth". kidshealth.org. Archived from the original on 14 July 2020. Retrieved 13 July 2020.*

3. **^** *"Age limits of pediatrics". Pediatrics.* ***81*** *(5): 736. May 1988. doi:10.1542/peds.81.5.736. PMID 3357740. S2CID 245164191. Archived from the original on 19 April 2017. Retrieved 18 April 2017.*
4. **^** *Sawyer, Susan M.; McNeil, Robyn; Francis, Kate L.; Matskarofski, Juliet Z.; Patton, George C.; Bhutta, Zulfiqar A.; Esangbedo, Dorothy O.; Klein, Jonathan D. (1 November 2019). "The age of paediatrics". The Lancet Child & Adolescent Health.* ***3*** *(11): 822–830. doi:10.1016/S2352-4642(19)30266-4. ISSN 2352-4642. PMID 31542355. S2CID 202732818.*
5. ^ ***a b c d e*** *Duffin, Jacalyn (2010). History of Medicine, Second Edition: A Scandalously Short Introduction. University of Toronto Press.*
6. ^ ***a b c d e*** *Colón, A. R.; Colón, P. A. (January 1999). Nurturing children: a history of pediatrics. Greenwood Press. ISBN 978-0-313-31080-5. Retrieved 20 October 2012.*
7. **^** Celsus, *De Medicina*, Book 3, Chapter 7, § 1.
8. **^** *John G. Raffensperger. Children's Surgery: A Worldwide History. McFarland. p. 21.*
9. **^** *David Levinson; Karen Christensen. Encyclopedia of modern Asia. Vol. 4. Charles Scribner's Sons. p. 116.*
10. **^** *Desai, A.B. Textbook Of Paediatrics. Orient blackswan. p. 1.*
11. **^** *Dunn, P. M. (1995). "Soranus of Ephesus (Circa AD 98-138) and perinatal care in Roman times". Archives of Disease in Childhood. Fetal and Neonatal Edition.* ***73*** *(1): F51 – F52. doi:10.1136/fn.73.1.f51. PMC 2528358. PMID 7552600.*
12. **^** *Elgood, Cyril (2010). A Medical History of Persia and The Eastern Caliphate (1st ed.). London: Cambridge. pp. 202–203. ISBN 978-1-108-01588-2. "By writing a monograph on 'Diseases in Children' he may also be looked upon as the father of paediatrics."*
13. **^** U.S. National Library of Medicine, "Islamic Culture and the Medical Arts, Al-Razi, the Clinician" [1] Archived 5 January 2018 at the Wayback Machine
14. **^** "*Achar S Textbook Of Pediatrics (Third Edition)*". A. B. Desai (ed.) (1989). p.1. ISBN 81-250-0440-8
15. **^** *Stern, Alexandra Minna; Markel, Howard (2002). Formative Years: Children's Health in the United States, 1880-2000. University of Michigan Press. pp. 23–24. doi:10.3998/mpub.17065. ISBN 978-0-472-02503-9. Archived from the original on 30 November 2021. Retrieved 30 November 2021.*
16. **^** *Lock, Stephen; John M. Last; George Dunea (2001). The Oxford illustrated companion to medicine. Oxford University Press US. p. 173. ISBN 978-0-19-262950-0. Retrieved 9 July 2010. "Rosen von Rosenstein."*
17. **^** *Roberts, Michael (2003). The Age of Liberty: Sweden 1719–1772. Cambridge University Press. p. 216. ISBN 978-0-521-52707-1. Retrieved 9 July 2010.*
18. **^** *Dallas, John. "Classics of Child Care". Royal College of Physicians of Edinburgh. Archived from the original on 27 July 2011. Retrieved 9 July 2010.*
19. **^** *Duffin, Jacalyn (29 May 2010). History of Medicine, Second Edition: A Scandalously Short Introduction. University of Toronto Press.*
20. **^** *Stern, Alexandra Minna; Markel, Howard (2002). Formative Years: Children's Health in the United States, 1880-2000. University of Michigan Press. pp. 23–24. doi:10.3998/mpub.17065. ISBN 978-0-472-02503-9. Archived from the original on 30 November 2021. Retrieved 30 November 2021.*

21. **^** "*Broadribb's Introductory Pediatric Nursing*". Nancy T. Hatfield (2007). p.4. ISBN 0-7817-7706-2
22. **^** *"Jacobi Medical Center - General Information". Archived from the original on 18 April 2006. Retrieved 6 April 2006.*
23. **^** *Kutzsche, Stefan (8 April 2021). "Abraham Jacobi (1830–1919) and his transition from political to medical activist". Acta Paediatrica.* ***110*** *(8): 2303–2305. doi:10.1111/apa.15887. ISSN 0803-5253. PMID 33963612. S2CID 233998658. Archived from the original on 7 May 2023. Retrieved 7 May 2023.*
24. ^ ***a b*** *Ballbriga, Angel (1991). "One century of pediatrics in Europe (section: development of pediatric hospitals in Europe)". In Nichols, Burford L.; et al. (eds.). History of Paediatrics 1850–1950. Nestlé Nutrition Workshop Series. Vol. 22. New York: Raven Press. pp. 6–8. ISBN 0-88167-695-0.*
25. **^** official history site (in French) of nineteenth century paediatric hospitals in Paris
26. **^** *"Introducing the Necker-Enfants Malades Hospital". Hôpital des Necker-Enfants Malades.*
27. **^** *Young, D.G. (August 1999). "The Mason Brown Lecture: Scots and paediatric surgery". Journal of the Royal College of Surgeons Edinburgh.* ***44*** *(4): 211–5. PMID 10453141. Archived from the original on 14 July 2014.*
28. **^** *Pearson, Howard A. (1991). "Pediatrics in the United States". In Nichols, Burford L.; et al. (eds.). History of Paediatrics 1850–1950. Nestlé Nutrition Workshop Series. Vol. 22. New York: Raven Press. pp. 55–63. ISBN 0-88167-695-0.*
29. **^** *"Commentaries: Edwards A Park". Pediatrics.* ***44*** *(6). American Academy of Pediatrics: 897–901. 1969. doi:10.1542/peds.44.6.897. PMID 4903838. S2CID 43298798.*
30. ^ ***a b c d e f g h*** *O'Hara, Kate (2016). "Paediatric pharmacokinetics and drug doses". Australian Prescriber.* ***39*** *(6): 208–210. doi:10.18773/austprescr.2016.071. ISSN 0312-8008. PMC 5155058. PMID 27990048.*
31. ^ ***a b c d e f g h i j k l m*** *Wagner, Jonathan; Abdel-Rahman, Susan M. (2013). "Pediatric pharmacokinetics". Pediatrics in Review.* ***34*** *(6): 258–269. doi:10.1542/pir.34-6-258. ISSN 1526-3347. PMID 23729775.*
32. ^ ***a b c d e f*** *Batchelor, Hannah Katharine; Marriott, John Francis (2015). "Paediatric pharmacokinetics: key considerations". British Journal of Clinical Pharmacology.* ***79*** *(3): 395–404. doi:10.1111/bcp.12267. ISSN 1365-2125. PMC 4345950. PMID 25855821.*
33. **^** *Katz, Aviva L.; Webb, Sally A.; COMMITTEE ON BIOETHICS; Macauley, Robert C.; Mercurio, Mark R.; Moon, Margaret R.; Okun, Alexander L.; Opel, Douglas J.; Statter, Mindy B. (1 August 2016). "Informed Consent in Decision-Making in Pediatric Practice". Pediatrics.* ***138*** *(2): e20161485. doi:10.1542/peds.2016-1485. ISSN 0031-4005. PMID 27456510. S2CID 7951515.*
34. ^ ***a b*** *Mazur, Kate A.; Berg, Stacey L., eds. (2020). Ethical Issues in Pediatric Hematology/Oncology. pp. 13–21. doi:10.1007/978-3-030-22684-8. ISBN 978-3-030-22683-1. S2CID 208302429.*
35. ^ ***a b*** *Stern, Alexandra Minna; Markel, Howard (2002). Formative Years: Children's Health in the United States, 1880-2000. University of Michigan Press. pp. 23–24. doi:10.3998/mpub.17065. ISBN 978-0-472-02503-9. Archived from the original on 30*

November 2021. Retrieved 30 November 2021.
36. **^** *Friedman, Lainie Ross (2004). Children, families, and health care decision making. Clarendon Press. ISBN 0-19-925154-1. OCLC 756393117.*
37. ^ ***a b c*** *Martakis, K.; Schröder-Bäck, P.; Brand, H. (1 June 2018). "Developing child autonomy in pediatric healthcare: towards an ethical model". Archivos Argentinos de Pediatria.* ***116*** *(3): e401 – e408. doi:10.5546/aap.2018.eng.e401. ISSN 0325-0075. PMID 29756714. S2CID 46889502.*
38. **^** *Schapiro, Tamar (1 July 1999). "What Is a Child?". Ethics.* ***109*** *(4): 715–738. doi:10.1086/233943. ISSN 0014-1704. S2CID 170129444. Archived from the original on 30 November 2021. Retrieved 30 November 2021.*
39. **^** *Dondorp, W.; Bolt, I.; Tibben, A.; De Wert, G.; Van Summeren, M. (1 September 2021). "'We Should View Him as an Individual': The Role of the Child's Future Autonomy in Shared Decision-Making About Unsolicited Findings in Pediatric Exome Sequencing". Health Care Analysis.* ***29*** *(3): 249–261. doi:10.1007/s10728-020-00425-7. ISSN 1573-3394. PMID 33389383. S2CID 230112761.*
40. **^** *"What Education Is Required to Be a Pediatrician?". Archived from the original on 7 June 2017. Retrieved 14 June 2017.*
41. **^** *"CoPS". www.pedsubs.org. Archived from the original on 18 September 2013. Retrieved 14 August 2015.*

Further reading

[edit]

- *BMC Pediatrics* - open access
- *Clinical Pediatrics*
- *Developmental Review* - partial open access
- *JAMA Pediatrics*
- *The Journal of Pediatrics* - partial open access

External links

[edit]

Image not found or type unknown

Wikimedia Commons has media related to ***Pediatrics***.

Image not found or type unknown

Wikibooks has a book on the topic of: ***Pediatrics***

Image not found or type unknown

Look up ***paediatrics*** or ***pediatrics*** in Wiktionary, the free dictionary.

- Pediatrics Directory at Curlie
- Pediatric Health Directory at OpenMD
- v

- t
- e

Medicine

Specialties and subspecialties	**Surgery**	○ Cardiac surgery ○ Cardiothoracic surgery ○ Endocrine surgery ○ Eye surgery ○ General surgery ○ ○ Colorectal surgery ○ ○ Digestive system surgery ○ Neurosurgery ○ Oral and maxillofacial surgery ○ Orthopedic surgery ○ Hand surgery ○ Otolaryngology ○ ○ ENT ○ Pediatric surgery ○ Plastic surgery ○ Reproductive surgery ○ Surgical oncology ○ Transplant surgery ○ Trauma surgery ○ Urology ○ ○ Andrology ○ Vascular surgery
	Internal medicine	○ Allergy / Immunology ○ Angiology ○ Cardiology ○ Endocrinology ○ Gastroenterology ○ ○ Hepatology ○ Geriatrics ○ Hematology ○ Hospital medicine ○ Infectious diseases ○ Nephrology ○ Oncology ○ Pulmonology ○ Rheumatology
	Obstetrics and gynaecology	○ Gynaecology ○ Gynecologic oncology ○ Maternal–fetal medicine ○ Obstetrics ○ Reproductive endocrinology and infertility ○ Urogynecology
	Diagnostic	○ Radiology ○ ○ Interventional radiology ○ ○ Neuroradiology ○ ○ Nuclear medicine ○ Pathology ○ ○ Anatomical ○ ○ Clinical pathology

Medical education

- Medical school
- Bachelor of Medicine, Bachelor of Surgery
- Bachelor of Medical Sciences
- Master of Medicine
- Master of Surgery
- Doctor of Medicine
- Doctor of Osteopathic Medicine
- MD–PhD
  - Medical Scientist Training Program

Related topics

- Alternative medicine
- Allied health
- Molecular oncology
- Nanomedicine
- Personalized medicine
- Public health
- Rural health
- Therapy
- Traditional medicine
- Veterinary medicine
- Physician
  - Chief physician
- History of medicine

- Image not found or type unknown Category
- Image not found or type unknown Commons
- Image not found or type unknown Wikiproject
- Image not found or type unknown Portal
- Image not found or type unknown Outline

- v
- t
- e

Infants and their care

Health (Pediatrics)	○ Baby food ○ Birth weight ○ Breast pump ○ Breastfeeding ○ Breastfeeding and medications ○ Breastfeeding and mental health ○ Bottle feeding ○ Colic ○ Cradle cap ○ Esotropia ○ Failure to thrive ○ Immunization ○ Infant and toddler safety ○ Infant bathing ○ Infant feeding ○ Infant food safety ○ Infant formula ○ Infant massage ○ Infant respiratory distress syndrome ○ Infant sleep training ○ Neonatal intensive care unit ○ Newborn care and safety ○ Oral rehydration therapy ○ Pedialyte ○ Preterm birth ○ Shaken baby syndrome ○ Soy formula ○ SIDS

Development

- Attachment parenting
- Baby-led weaning
- Baby talk
- Babbling
- Birth defect
- Childbirth
- Crawling
- Gestational age
- Infant visual development
- Irritant diaper dermatitis
- Infant cognitive development
- Infant crying
- Kangaroo care
- Mother
- Nursery rhyme
- Object permanence
- Parent
- Parenting
- Peekaboo
- Play
- Prenatal development
- Prenatal development table
- Teething
- Walking
- Weaning

Socialization and Culture

- Attachment
- Babysitting
- Child abuse
- Child care
- Child custody
- Children's rights
  - UN Child rights
- Circumcision
- Foster care
- Grandparent visitation
- Infant swimming
- Milk bank
- Nanny
- Wet nurse

Infant care and equipment

- Baby bouncer
- Baby gate
- Baby monitor/Hidden camera
- Baby powder
- Baby shampoo
- Baby toy
- Baby walker
- Bib
- Baby swing
- Baby transport
- Bassinet
- Car seat safety
- Cloth diaper
- Cradle board
- Diaper
- Diaper bag
- Baby wipes
- Haberman Feeder
- High chair
- Infant bed *(American 'crib' and 'cradle', British 'cot')*
- Infant carrier
- Infant clothing
- Pacifier
- Playpen
- Stroller
- Supplemental nursing system
- Swaddling
- Swim diaper
- Teether
- Travel cot

Other topics

- Baby shower
- Babywearing
- Child neglect
- Closed adoption
- Cry room
- Infant ear piercing
- Open adoption
- Prenatal cocaine exposure
- Neonatal withdrawal syndrome
- Parental child abduction
- Parental responsibility
- Parenting plan
- Paternity
    - Paternity fraud

Authority control databases Image not found or type unknown **Edit this at Wikidata**	
National	○ Germany ○ Japan ○ Czech Republic ○ Latvia ○ Israel
Other	○ NARA

About patient

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

- v
- t
- e

Part of a series on Patients

Patients

Concepts

- Doctor-patient relationship
- Medical ethics
- Patient participation
- Patient-reported outcome
- 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

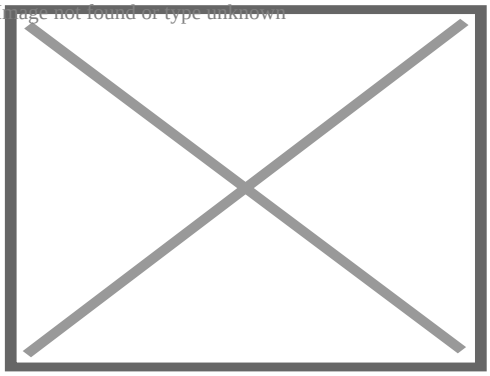
[edit]

The word patient originally meant 'one who suffers'. This English noun comes from the Latin word *patiens*, the present participle of the deponent verb, *patior*, meaning 'I am suffering', and akin to the Greek verb ?ÃŽÂ¬????? (*paskhein* 'to suffer') and its cognate noun ?ÃŽÂ¬??? (*pathos*).

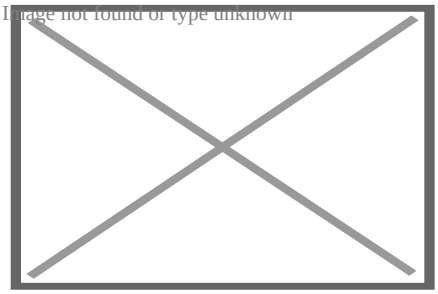
This language has been construed as meaning that the role of patients is to passively accept and tolerate the suffering and treatments prescribed by the healthcare providers, without engaging in shared decision-making about their care.[1]

Outpatients and inpatients

[edit]

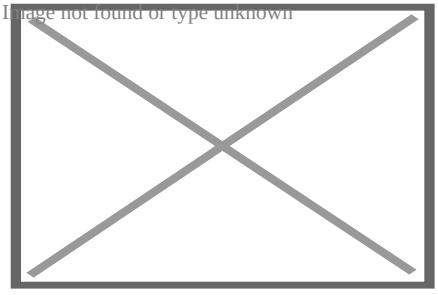


Patients at the Red Cross Hospital in Tampere, Finland during the 1918 Finnish Civil War



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 *office-based 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 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

References

[edit]

1. **^** *Neuberger, J. (1999-06-26). "Do we need a new word for patients?". BMJ: British Medical Journal. **318** (7200): 1756–1758. doi:10.1136/bmj.318.7200.1756. ISSN 0959-8138. PMC 1116090. PMID 10381717.*
2. **^** *"Unpaid carers' rights are overlooked in hospital discharge". Health Service Journal. 8 September 2021. Retrieved 16 October 2021.*

3. **^** *Institute of Medicine (US) Committee on Quality of Health Care in America; Kohn, L. T.; Corrigan, J. M.; Donaldson, M. S. (2000). Kohn, Linda T.; Corrigan, Janet M.; Donaldson, Molla S. (eds.). To Err Is Human: Building a Safer Health System. Washington D.C.: National Academy Press. doi:10.17226/9728. ISBN 0-309-06837-1 . PMID 25077248.*
4. **^** *Bates, David W.; Singh, Hardeep (November 2018). "Two Decades Since: An Assessment Of Progress And Emerging Priorities In Patient Safety". Health Affairs.* ***37*** *(11): 1736–1743. doi:10.1377/hlthaff.2018.0738. PMID 30395508.*
5. **^** *American Red Cross (1993). Foundations for Caregiving. St. Louis: Mosby Lifeline. ISBN 978-0801665158.*
6. **^** *Clark, Jack A.; Mishler, Elliot G. (September 1992). "Attending to patients' stories: reframing the clinical task". Sociology of Health and Illness.* ***14*** *(3): 344–372. doi: 10.1111/1467-9566.ep11357498.*
7. **^** *Stewart, M (24 February 2001). "Towards a Global Definition of Patient Centred Care". BMJ.* ***322*** *(7284): 444–5. doi:10.1136/bmj.322.7284.444. PMC 1119673. PMID 11222407.*
8. **^** *Frampton, Susan B.; Guastello, Sara; Hoy, Libby; Naylor, Mary; Sheridan, Sue; Johnston-Fleece, Michelle (31 January 2017). "Harnessing Evidence and Experience to Change Culture: A Guiding Framework for Patient and Family Engaged Care". NAM Perspectives.* ***7*** *(1). doi:10.31478/201701f.*
9. ^ ***a b*** *Reader, TW; Gillespie, A (30 April 2013). "Patient Neglect in Healthcare Institutions: A Systematic Review and Conceptual Model". BMC Health Serv Res.* ***13****: 156. doi:10.1186/1472-6963-13-156. PMC 3660245. PMID 23631468.*
10. **^** *Bloche, MG (17 March 2016). "Scandal as a Sentinel Event--Recognizing Hidden Cost-Quality Trade-offs". N Engl J Med.* ***374*** *(11): 1001–3. doi:10.1056/NEJMp1502629. PMID 26981930.*
11. **^** *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary. London: Stationery Office. 6 February 2013. ISBN 9780102981476. Retrieved 23 June 2020.*
12. **^** *Weingart, SN; Pagovich, O; Sands, DZ; Li, JM; Aronson, MD; Davis, RB; Phillips, RS; Bates, DW (April 2006). "Patient-reported Service Quality on a Medicine Unit". Int J Qual Health Care.* ***18*** *(2): 95–101. doi:10.1093/intqhc/mzi087. PMID 16282334.*
13. **^** *Levtzion-Korach, O; Frankel, A; Alcalai, H; Keohane, C; Orav, J; Graydon-Baker, E; Barnes, J; Gordon, K; Puopulo, AL; Tomov, EI; Sato, L; Bates, DW (September 2010). "Integrating Incident Data From Five Reporting Systems to Assess Patient Safety: Making Sense of the Elephant". Jt Comm J Qual Patient Saf.* ***36*** *(9): 402–10. doi:10.1016/s1553-7250(10)36059-4. PMID 20873673.*
14. **^** *Berwick, Donald M. (January 2009). "What 'Patient-Centered' Should Mean: Confessions Of An Extremist". Health Affairs.* ***28*** *(Supplement 1): w555 – w565. doi: 10.1377/hlthaff.28.4.w555. PMID 19454528.*
15. **^** *Reader, TW; Gillespie, A; Roberts, J (August 2014). "Patient Complaints in Healthcare Systems: A Systematic Review and Coding Taxonomy". BMJ Qual Saf.* ***23*** *(8): 678–89. doi:10.1136/bmjqs-2013-002437. PMC 4112446. PMID 24876289.*

External links

[edit]

Image not found or type unknown

Wikimedia Commons has media related to ***Patients***.

Image not found or type unknown

Look up ***patient*** in Wiktionary, the free dictionary.

- *Jadad AR, Rizo CA, Enkin MW (June 2003). "I am a good patient, believe it or not". BMJ. **326** (7402): 1293–5. doi:10.1136/bmj.326.7402.1293. PMC 1126181. PMID 12805157.*
  a peer-reviewed article published in the British Medical Journal's (BMJ) first issue dedicated to patients in its 160-year history
- *Sokol DK (21 February 2004). "How (not) to be a good patient". BMJ. **328** (7437): 471. doi:10.1136/bmj.328.7437.471. PMC 344286.*
  review article with views on the meaning of the words "good doctor" vs. "good patient"
- "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"

- v
- t
- e

Articles about hospitals

History of hospitals, Hospital network, Category:Hospitals

Common hospital components

- 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
- Wards

Archaic forms	○ Almshouse ○ Asclepeion (Greece) ○ Bimaristan (Islamic) ○ Cottage hospital (England) ○ Hôtel-Dieu (France) ○ Valetudinaria (Roman) ○ Vaishya lying in houses (India) ○ Xenodochium (Middle Ages)
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
Funding	○ Charitable hospital ○ For-profit hospital ○ Non-profit hospital ○ State hospital ○ Private hospital ○ Public hospital ○ Voluntary hospital ○ Defunct

Condition treated	○ Cancer ○ Children's hospital ○ Eye hospital ○ Fever hospital ○ Leper colony ○ Lock hospital ○ Maternity hospital ○ Psychiatric hospital ○ Rehabilitation hospital ○ Trauma center ○ Verterinary hospital
Century established	○ 5th ○ 6th ○ 7th ○ 8th ○ 9th ○ 10th ○ 11th ○ 12th ○ 13th ○ 14th ○ 15th ○ 16th ○ 17th ○ 18th ○ 19th ○ 20th ○ 21st

Lists of hospitals in: Africa, Asia, Europe, North America, Oceania, South America

Authority control databases: National Image not found or type unknown **Edit this at Wikidata**

- Germany
- United States
- Japan
- Czech Republic
  - 2
- Latvia
- Israel

City : Zagreb

State : Hrvatska

Zip : 10000

Address : IQDENT - Ortodontska Klinika

Company Website : **https://iqdent.hr/**

USEFUL LINKS

Orthodontic treatment can help improve your child's smile

Orthodontic treatment for children

Sitemap

Privacy Policy

About Us

Follow us