Accelerated Orthodontics

- **Innovative Approaches to Shorten Treatment Time**
  Innovative Approaches to Shorten Treatment Time The Role of Vibration Devices in Faster Tooth Movement Micro Osteoperforation and Its Effects on Treatment 3D Printing Techniques for Customized Appliances Benefits of Digital Impressions in Modern Orthodontics AI Assisted Treatment Planning for Precise Outcomes Remote Monitoring and Virtual Consultations Incorporating New Tools for Patient Compliance Practical Considerations of Accelerated Techniques Research Trends Shaping Future Orthodontic Practices Combining Traditional Methods With Cutting Edge Solutions Adapting to Technological Shifts in Orthodontic Care
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The American Association of Orthodontists (AAO) has long recognized the importance of early orthodontic intervention, with a clear and specific age in which children should receive their first evaluation. By age seven, children should have their first orthodontic check-up to identify potential issues early on, such as overcrowding or jaw growth problems. This early detection is crucial as it allows orthodontists to address these issues before they become more severe and complicated to correct.

Early intervention in orthodontics is not just about correcting existing problems but also about preventing future complications. By assessing a child's dental development at a young age, orthodontists can guide the growth of facial and jaw bones, ensuring that permanent teeth come in properly and that the jaw grows in alignment. Orthodontic expanders can create more space in the mouth for teeth **Braces for kids and teens** thumb sucking. This early treatment can prevent more severe orthodontic problems later in life, such as misaligned bites and jaw growth discrepancies.

The AAO's recommendations are based on the potential for early intervention to make orthodontic treatment more successful and less invasive. For instance, early detection of overcrowding can help avoid the need for more extensive treatments later, such as the removal of permanent teeth. Early orthodontic care also plays a significant role in a child's overall oral health and self-esteem, as a well-aligned smile can have a long-term impact on their well-being and self-esteem.

The future of orthodontic care is clearly heading in the same preventive and interceptive treatment models. By identifying and addressing issues early, orthodontists can provide more tailored and less invasive treatments, which are both cost and time more favorable for both children and their parents. This early intervention not only helps in preventing severe complications but also in setting the foundation for a lifetime of healthy, beautiful smiles.

The integration of advanced imaging and AI in orthodontic treatment planning is revolutionizing the field by enhancing precision, efficiency, and patient satisfaction. At the cornerstone of this transformation is the use of 3D scanning technologies, such as intraoral scanners and cone-beam computed tomography (CBCT), which provide detailed digital impressions of patients' dental structures. These high-fidelity images allow orthodontists to assess tooth position, occlusion, and facial proportions with greater accuracy, facilitating more effective treatment planning.

AI-powered software plays a crucial role in this process by analyzing the vast amounts of data collected from 3D scans. These systems can identify irregularities, such as malocclusions or

crowding, and assist in creating personalized treatment plans tailored to each patient's unique needs. AI algorithms can simulate tooth movements and predict treatment outcomes, enabling orthodontists to make informed decisions and adjust treatment plans as needed. This predictive capability not only streamlines the treatment process but also enhances patient communication by providing visual simulations of expected results.

Furthermore, AI-driven systems can automate administrative tasks, such as scheduling and record-keeping, allowing orthodontists to focus more on patient care. The integration of AI in orthodontics also facilitates remote monitoring and real-time feedback, ensuring that treatments stay on track and adjustments can be quickly and accurately administered.

The future of orthodontic care, particularly for children, is significantly impacted by these advancements. With precise digital impressions and personalized treatment plans, children can experience more comfortable and effective orthodontic treatments. The use of AI-powered aligners, for example, minimises the need for frequent manual adjustments, providing a more consistent and controlled tooth movement process. As technology continues to evolve, orthodontic practices are becoming more efficient, personalized, and patient-centric, ushering in a new era of orthodontic excellence.

The HealthyStart System

The future of orthodontic practices is undergoing a significant transformation, driven by a focus on patient comfort and sustainable practices. Innovations such as heat-activated wires and eco-friendly materials are at the forefront of this shift, making orthodontic treatments more comfortable and environmentally conscious. This trend is particularly appealing to modern patients who increasingly prioritize both their personal well-being and the environmental impact of their healthcare choices.

One of the key advancements in patient comfort is the development of heat-activated wires. These wires use body heat to gently move teeth, reducing discomfort and making braces more pleasant to wear. This technology aligns with the broader emphasis on patient-centered care, where orthodontists use visual tools like 3D models to ensure patients are well-informed about their treatment process. Clear communication and transparency are crucial in fostering trust and satisfaction among patients.

Sustainability is also becoming a crucial consideration in orthodontic care. Practices are adopting eco-friendly packaging for aligners and using recyclable materials for dental tools to minimize waste. The integration of digital workflows has further enhanced sustainability by reducing the use of paper and other disposable items. This shift towards environmentally conscious practices not only reduces the carbon footprint of dental clinics but also aligns with the growing demand from patients who seek providers that prioritize sustainability.

Innovations in materials science are also driving the adoption of sustainable practices. The use of biodegradable materials, such as polylactic acid (PLA), is becoming more common in orthodontics. These materials are designed to degrade over time, minimizing long-term waste. The incorporation of 3D printing technology is also contributing to sustainability by reducing waste associated with mass production and allowing for the creation of custom, biodegradable brackets tailored to individual patients.

Overall, the future of orthodontic practices is characterized by a blend of technological advancements, patient comfort, and sustainable practices. As these trends continue to evolve, orthodontists will be better positioned to meet the evolving needs of their patients while contributing to a more environmentally conscious healthcare landscape.

This non-invasive approach targets the natural development of children's teeth and jaw, using soft

dental appliances to align teeth and address breathing issues, reducing the need for more invasive treatments.

The field of orthodontics is rapidly evolving, with significant advancements in tools and methods that are revolutionizing the way treatments are approached. One of the most exciting developments is the use of self-ligating braces, which have transformed traditional metal braces by reducing friction and discomfort. These braces employ specialized clips instead of elastic bands to hold the archwire in place, allowing teeth to move more freely and quickly. This results in shorter treatment times and fewer visits to the orthodontist, making the process more comfortable and efficient for patients, especially children.

Another innovation that is making orthodontic treatments less invasive is the temporary anchorage devices (TADs), which are small titanium screws placed in the jawbone. These devices provide additional stability during treatment, enabling precise tooth movement without the need for bulky appliances like headgear. This not only reduces discomfort but also shorters the treatment duration, making orthodontic care more accessible and appealing to a diverse patient base.

The use of digital technology is also a significant force in modern orthodontics. Digital impressions and intraoral scanning have replaced traditional molds, providing precise 3D images of a patient's teeth and jaw. This allows for more accurate diagnoses and personalized treatment plans. Additionally, advancements in clear aligners, such as Invisalign, offer patients a discreet and comfortable alternative to traditional braces. These aligners are custom-made using advanced 3D technology and are becoming increasingly popular among adults and teens.

Furthermore, the introduction of AI in orthodontic treatment planning is a game-changer. AI algorithms can analyze vast amounts of data to predict the most effective treatment paths, leading to more personalized and efficient treatment plans. This not only reduces overall

treatment time but also leads to better outcomes, as AI can help orthodontists make more informed and precise treatment adjustments.

Innovations in orthodontic tools and methods are not only improving patient outcomes but are also making treatments more appealing and accessible. As technology and materials continue to advance, we can expect even more efficient, comfortable, and effective orthodontic treatments in the future. This will continue to shape the future of orthodontic practices, offering patients a variety of options that are more personalized and less invasive than ever before.

Myobrace: A No-Braces Approach

The landscape of orthodontic treatment for children is evolving, offering a diverse range of options tailored to their unique needs and age. Traditional braces, clear aligners, and lingual braces are among the most popular treatments, each providing effective and discreet solutions for children. This shift in treatment options is part of a wider trend in orthodontics, driven by advancements in technology and a growing focus on personalized care.

Traditional braces, while effective, are often seen as less discreet. However, they are a well-known and time-t
ed method for correcting dental issues such as overcrowding, overbites, and underbites. In recent years, there has been a significant move to more discreet options. Clear aligners, for example, have become increasingly popular among children and teenagers due to their comfort and aesthetic benefits. These aligners are made from clear, custom-fited materials that are less visually appealing than traditional braces, making them ideal for older children and teenagers who are conscious about their appearance during treatment.

Lingual braces offer an even more discreet option, as they are placed on the back of the teeth, making them less detect
e. This type of braces is particularly suitable for children who are seeking a more aesthetic treatment option without the need for aligners. The choice between these treatments often

comes
s to the specific needs of the child, including the complexity of their dental issues and their age.

The future of orthodontic treatment for children is also being influenced by emerging trends in digital orthodontics. Technologies such as intraoral scanning and 3D printing are transforming the way orthodontists diagnose and plan treatment. These advancements allow for more precise and efficient fabrication of dental appliances, including custom aligners and orthodontic models. Additionally, the incorporation of artificial intelligence in treatment planning is expected to enhance the accuracy and effectiveness of orthodontic care by analyzing vast amounts of data to predict the most effective treatment outcomes.

Another significant trend shaping the future of orthodontics is the growth of interdisciplinary collaboration. Orthodontists are increasingly working with other dental specialists to develop comprehensive treatment plans that address the full spectrum of a child's dental needs. This approach not only leads to better outcomes but also offers a more holistic approach to dental care.

Innovations in remote monitoring and teleorthodontics are also making orthodontic care more accessible and convenient. Virtual consultations and remote tracking technologies enable children to receive expert advice without the need for in-person visits, making it easier for them to stay on track with their treatment plans.

In the coming years, the field of orthodontics will continue to evolve with a focus on personalized care, advanced technologies, and increased accessibility. As these trends continue to shape the landscape of orthodontic practices, children will have access to a wider range of effective and discreet treatment options, ensuring that their dental health and aesthetic needs are better than
er supported.

Myobrace offers a brace-free solution that corrects poor oral habits, guiding jaw and teeth

alignment development in children, promoting natural growth and oral health.

In the rapidly moving world of orthodontics, innovative technologies are revolutionizing the way treatments are delivered and monitored. One of the most significant research areas is the use of artificial intelligence (AIDr) in remote patient monitoring, a development that Dr. Wright and Dr. Feusier highlight as particularly beneficial for orthodontic care. This technology allows patients to track their progress without the need for frequent office visits, making it especially appealing for children with busy schedules or those living in remote areas.

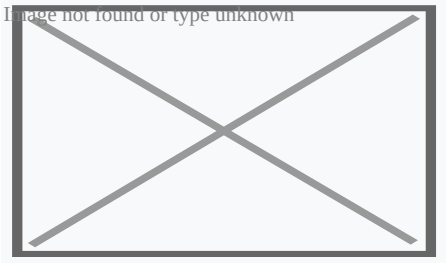
Remote monitoring tools, often in the form of smartphone-based platforms like Dental Monitoring, utilize AI to track a patient's orthodontic progress. These platforms allow patients to send images of their teeth to their orthodontists, who can then review and provide feedback remotely. This not only reduces the time spent commuting and waiting in waiting room but also enables orthodontists to manage more patients effectively. By using AI-driven remote monitoring, clinicians can identify potential issues early, potentially shorting treatment times and improving outcomes.

The benefits of remote monitoring are numerous. It increases access to care for those in underserved areas and offers convenience for those with busy schedules. Additionally, AI can detect even the most slight changes in tooth movement, ensuring that treatment plans are optimized and any complications are identified and treated early. This approach also helps in improving patient adherence to treatment plans by including reminders and guidance through the app, which can lead to better overall oral hygiene.

In conclusion, the use of AI in remote patient monitoring is a game-changer for the orthodontic practice of the 2020s. By enhancing efficiency, improving outcomes, and making care more convenient, this technology is set to revolutionize how orthodontic treatments are delivered in the modern world. Dr. Wright and Dr. Feusier's work in highlighting AI's potential in this space is a significant step in the ongoing transformation of orthodontic care.

About crossbite

Crossbite



Unilateral posterior crossbite

Specialty Orthodontics

In dentistry, **crossbite** is a form of malocclusion where a tooth (or teeth) has a more buccal or lingual position (that is, the tooth is either closer to the cheek or to the tongue) than its corresponding antagonist tooth in the upper or lower dental arch. In other words, crossbite is a lateral misalignment of the dental arches.[1][2]

Anterior crossbite

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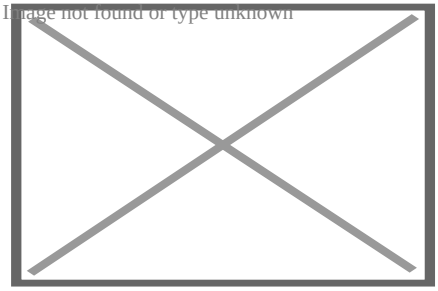

Class 1 with anterior crossbite

An anterior crossbite can be referred as negative overjet, and is typical of class III skeletal relations (prognathism).

Primary/mixed dentitions

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An anterior crossbite in a child with baby teeth or mixed dentition may happen due to either dental misalignment or skeletal misalignment. Dental causes may be due to

displacement of one or two teeth, where skeletal causes involve either mandibular hyperplasia, maxillary hypoplasia or combination of both.

Dental crossbite

[edit]

An anterior crossbite due to dental component involves displacement of either maxillary central or lateral incisors lingual to their original erupting positions. This may happen due to delayed eruption of the primary teeth leading to permanent teeth moving lingual to their primary predecessors. This will lead to anterior crossbite where upon biting, upper teeth are behind the lower front teeth and may involve few or all frontal incisors. In this type of crossbite, the maxillary and mandibular proportions are normal to each other and to the cranial base. Another reason that may lead to a dental crossbite is crowding in the maxillary arch. Permanent teeth will tend to erupt lingual to the primary teeth in presence of crowding. Side-effects caused by dental crossbite can be increased recession on the buccal of lower incisors and higher chance of inflammation in the same area. Another term for an anterior crossbite due to dental interferences is *Pseudo Class III Crossbite or Malocclusion*.

Single tooth crossbite

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Single tooth crossbites can occur due to uneruption of a primary teeth in a timely manner which causes permanent tooth to erupt in a different eruption pattern which is lingual to the primary tooth.[3] Single tooth crossbites are often fixed by using a finger-spring based appliances.[4][5] This type of spring can be attached to a removable appliance which is used by patient every day to correct the tooth position.

Skeletal crossbite

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An anterior crossbite due to skeletal reasons will involve a deficient maxilla and a more hyperplastic or overgrown mandible. People with this type of crossbite will have dental compensation which involves proclined maxillary incisors and retroclined mandibular incisors. A proper diagnosis can be made by having a person bite into their centric relation will show mandibular incisors ahead of the maxillary incisors, which will show the skeletal discrepancy between the two jaws.[6]

Posterior crossbite

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Bjork defined posterior crossbite as a malocclusion where the buccal cusps of canine, premolar and molar of upper teeth occlude lingually to the buccal cusps of canine, premolar and molar of lower teeth.[7] Posterior crossbite is often correlated to a narrow maxilla and upper dental arch. A posterior crossbite can be unilateral, bilateral, single-tooth or entire segment crossbite. Posterior crossbite has been reported to occur between 7–23% of the population.[8][9] The most common type of posterior crossbite to occur is the unilateral crossbite which occurs in 80% to 97% of the posterior crossbite cases.[10][3] Posterior crossbites also occur most commonly in primary and mixed dentition. This type of crossbite usually presents with a *functional shift of the mandible towards the side of the crossbite*. Posterior crossbite can occur due to either skeletal, dental or functional abnormalities. One of the common reasons for development of posterior crossbite is the size difference between maxilla and mandible, where maxilla is smaller than mandible.[11] Posterior crossbite can result due to

- Upper Airway Obstruction where people with "adenoid faces" who have trouble breathing through their nose. They have an open bite malocclusion and present with development of posterior crossbite.[12]
- Prolong digit or suckling habits which can lead to constriction of maxilla posteriorly[13]
- Prolong pacifier use (beyond age 4)[13]

Connections with TMD

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Unilateral posterior crossbite

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Unilateral crossbite involves one side of the arch. The most common cause of unilateral crossbite is a narrow maxillary dental arch. This can happen due to habits such as digit sucking, prolonged use of pacifier or upper airway obstruction. Due to the discrepancy between the maxillary and mandibular arch, neuromuscular guidance of the mandible causes mandible to shift towards the side of the crossbite.[14] This is also known as Functional mandibular shift. This shift can become structural if left untreated for a long time during growth, leading to skeletal asymmetries. Unilateral crossbites can present with following features in a child

- Lower midline deviation[15] to the crossbite side
- Class 2 Subdivision relationships
- Temporomandibular disorders [16]

Treatment

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A child with posterior crossbite should be treated immediately if the child shifts their mandible on closing, which is often seen in a unilateral crossbite as mentioned above. The best age to treat a child with crossbite is in their mixed dentition when their palatal sutures have not fused to each other. Palatal expansion allows more space in an arch to relieve crowding and correct posterior crossbite. The correction can include any type of palatal expanders that will expand the palate which resolves the narrow constriction of the maxilla.[9] There are several therapies that can be used to correct a posterior crossbite: braces, 'Z' spring or cantilever spring, quad helix, removable plates, clear aligner therapy, or a Delaire mask. The correct therapy should be decided by the orthodontist depending on the type and severity of the crossbite.

One of the keys in diagnosing the anterior crossbite due to skeletal vs dental causes is diagnosing a CR-CO shift in a patient. An adolescent presenting with anterior crossbite may be positioning their mandible forward into centric occlusion (CO) due to the dental interferences. Thus finding their occlusion in centric relation (CR) is key in diagnosis. For anterior crossbite, if their CO matches their CR then the patient truly has a skeletal component to their crossbite. If the CR shows a less severe class 3 malocclusion or teeth not in anterior crossbite, this may mean that their anterior crossbite results due to dental interferences.[17]

Goal to treat unilateral crossbites should definitely include removal of occlusal interferences and elimination of the functional shift. Treating posterior crossbites early may help prevent the occurrence of Temporomandibular joint pathology.[18]

Unilateral crossbites can also be diagnosed and treated properly by using a Deprogramming splint. This splint has flat occlusal surface which causes the muscles to deprogram themselves and establish new sensory engrams. When the splint is removed, a proper centric relation bite can be diagnosed from the bite.[19]

Self-correction

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Literature states that very few crossbites tend to self-correct which often justify the treatment approach of correcting these bites as early as possible.[9] Only 0–9% of crossbites self-correct. Lindner et al. reported that 50% of crossbites were corrected in 76 four-year-old children.[20]

See also

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- List of palatal expanders
- Palatal expansion
- Malocclusion

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External links

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Classification	○ **ICD-10**: K07.2 D ○ **ICD-9-CM**: 524.27

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Orthodontics

Diagnosis	○ Bolton analysis ○ Cephalometric analysis ○ Cephalometry ○ Dentition analysis ○ Failure of eruption of teeth ○ Little's Irregularity Index ○ Malocclusion ○ Scissor bite ○ Standard anatomical position ○ Tooth ankylosis ○ Tongue thrust
Conditions	○ Overbite ○ Overjet ○ Open bite ○ Crossbite ○ Dental crowding ○ Dental spacing ○ Bimaxillary Protrusion ○ Prognathism ○ Retrognathism ○ Maxillary hypoplasia ○ Condylar hyperplasia ○ Overeruption ○ Mouth breathing ○ Temperomandibular dysfunction

Appliances	○ ACCO appliance ○ Archwire ○ Activator appliance ○ Braces ○ Damon system ○ Elastics ○ Frankel appliance ○ Invisalign ○ Lingual arch ○ Lip bumper ○ Herbst Appliance ○ List of orthodontic functional appliances ○ List of palatal expanders ○ Lingual braces ○ Headgear ○ Orthodontic technology ○ Orthodontic spacer ○ Palatal lift prosthesis ○ Palatal expander ○ Quad helix ○ Retainer ○ SureSmile ○ Self-ligating braces ○ Splint activator ○ Twin Block Appliance
Procedures	○ Anchorage (orthodontics) ○ Cantilever mechanics ○ Fiberotomy ○ Interproximal reduction ○ Intrusion (orthodontics) ○ Molar distalization ○ SARPE ○ Serial extraction
Materials	○ Beta-titanium ○ Nickel titanium ○ Stainless steel ○ TiMolium ○ Elgiloy ○ Ceramic ○ Composite ○ Dental elastics

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Organizations	○ American Association of Orthodontists ○ American Board of Orthodontics ○ British Orthodontic Society ○ Canadian Association of Orthodontists ○ Indian Orthodontic Society ○ Italian Academy of Orthodontic Technology ○ Society for Orthodontic Dental Technology (Germany)
Journals	○ American Journal of Orthodontics and Dentofacial Orthopedics ○ The Angle Orthodontist ○ Journal of Orthodontics
Institution	○ Angle School of Orthodontia

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Dental disease involving the jaw

General	○ Jaw abnormality ○ malocclusion ○ Orthodontics ○ Gnathitis
Size	○ Micrognathism ○ Maxillary hypoplasia
Maxilla and Mandible	○ Cherubism ○ Congenital epulis ○ Torus mandibularis ○ Torus palatinus
Other	○ Jaw and base of cranium ○ Prognathism ○ Retrognathism ○ Dental arch ○ Crossbite ○ Overbite ○ Temporomandibular joint disorder

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About patient

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

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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

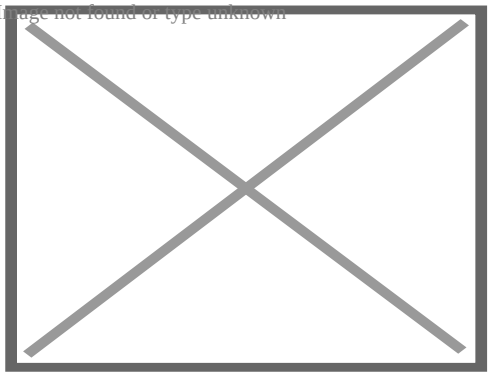
[edit]

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*).

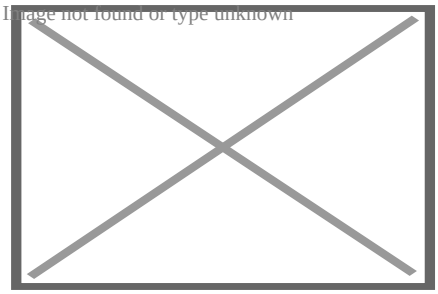
This language has been construed as meaning that the role of patients is to passively accept and tolerate the suffering and treatments prescribed by the healthcare providers, without engaging in shared decision-making about their care.[1]

Outpatients and inpatients

[edit]



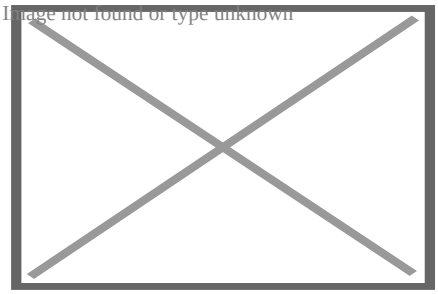
Patients at the Red Cross Hospital in Tampere, Finland during the 1918 Finnish Civil War



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

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[edit]

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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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Century established	○ 5th ○ 6th ○ 7th ○ 8th ○ 9th ○ 10th ○ 11th ○ 12th ○ 13th ○ 14th ○ 15th ○ 16th ○ 17th ○ 18th ○ 19th ○ 20th ○ 21st

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