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EDITORIAL

Hospital-based pediatric dentistry specialties

Las especialidades odontopediátricas hospitalarias

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Within the range of dental specialties offered in different institutions, there is a group of specialists that can be trained in hospitals or conventional schools of dentistry. Pediatric dentistry can be included within this group of specialties, this training has the same duration of two years, but clearly is not the same.

RESIDENT VERSUS GRADUATE STUDENT

In recent times, students of different dental specialties have been called residents, irrespectively of whether they reside in hospital or not. A residency encompasses approximately 7,200 hours of stay in hospital per year, compared to the 1,200 hours per year dedicated to study by a conventional dentistry graduate student. Another factor worth mentioning is the enormous change experienced by the dental specialty resident when he ventures into the medical environment, where is immediately forced to use the same language and terms with physicians con over 20,000 hours of training; this renders it one of the specialties with greater risk of professional wear syndrome (Burnout).[1]

In order to present a clinical case, graduate students possess the knowledge that cases must be comprehensively delivered, that is to say, clinical photographs, X-ray series and follow up for conventional cases.; nevertheless, for hospital residents, these challenges become major due to the complexity of clinical cases, where, simple activities such as **absolute isolation** (hemophilia, bulbous epidermolysis, Freeman Sheldon syndrome), **behavior handling** (global neurodevelopment retardation, autism, deafness), **radiographic series** (epilepsy, ataxia teleangectasia, genetic syndromes), **minimum intervention** (cardiac patients decompensated with risk of infectious endocarditis, cancer patients with risk of sepsis, immune-compromised and immune-competent patients), or the **simple follow-up** (out-of-town patient, disabled patients or those who unfortunately have suffered a fatal outcome) becomes practically unthinkable, in addition to the true heroic treatments that are undertaken in numberless patients, which could not in any way be called conventional. Nevertheless, clinical judgment of the stomatologist trained in hospitals under the dogma of **Evaluation-Risk-Benefit**, lead him to make the best decision for a quality treatment without risking patient integrity.

A student with hospital training, in addition to possessing knowledge in operative dentistry and orthopedics, is trained in the medical-stomatological handling of systemically compromised patients under four basic rules dictated by the ADA:[2] immunological risk, hemorrhagic risk, drug interaction and tolerance to dental care.

A different educational training is required in order to face complex problems such as natural exfoliation in severe hemophilic patients, odontogenic infections in cancer or decompensated diabetic patients, stratified dental restoration after dentoalveolar trauma caused by convulsion crises, dental extraction in dystrophic bullous epidermolysis, maxillary orthopedics in newborn with trisomy 21, minimum intervention dentistry in patients under transplant protocol; this required training isn't better or worse, its simply different.

Finally, it is worth mentioning that exams to acquire the degree of pediatric dentistry are applied by dentists, mainly specialists of out- of-hospital training, and are conducted with the methodological rigor applied to any student, regardless of whether he comes from a conventional school or a hospital. From my standpoint, students should be evaluated according to the training they received, even by

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teachers of the medical areas, in order to rescue that situation which should never have happened: the separation of medicine from dentistry.

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