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LETTER TO THE EDITOR

ISSUES REGARDING THE IMPACT OF TECHNOLOGY ON MEDICAL DECISION MAKING

Elena Gologan[1,*], Andrei Nicolae Gologan[1], Oana Timofte[1]
[1] "Grigore T Popa" University of Medicine and Pharmacy, Iasi, Romania
[*] corresponding author, E-mail: elenagologan2007@yahoo.com

Nowadays, medicine can no longer be practiced only as a vocation, the only tool used being the stethoscope, but tends towards systematization, being increasingly subject to the rigors imposed by the need for evidence as diagnostic and therapeutic work tools. The technological explosion (currently invading the medical space) imposes a rapid and continuous revision of the medical practice and changes the relationship between the medical staff and the patient.

But medical technology used for diagnostic and therapeutic purposes today tends to replace logical case judgment and it opens ways for exploratory excesses (some of questionable utility in the absence of a precise expectation). Moreover, technological development is often one step ahead of the development of human skills to use it and it often leads to risky investigations without practical benefit for the patient. Time, however, puts all these technologies in their place. Thus, some remain and develop, some transform and others disappear, remaining only in the history of medicine as a subject of study for history enthusiasts.

Learning curves of using new technologies must include the critical element from the beginning. Theoretical information on the technology and new devices is mandatory and becomes extremely time-consuming, requiring permanent courses to obtain both theoretical and practical skills, as well as the updating of previously acquired ones. The applicability of technology to humans requires precise knowledge of the following elements: indications, contraindications, risks, accidents, incidents, expectations, performances. There must always be an expectation of unforeseen elements that require the recalibration of the medical act. The acquisition of such practical skills is currently done on simulators to begin with and *in vivo* in the final stage.

As an expression of the crowning of a full medical activity, based on the fine knowledge of the human structure, clinical and investigative diagnostic methods as well as current therapies from all perspectives, the indication *not to do an investigation or not to administer a treatment* will have to be redefined, which is extremely difficult as long as the risk assessment criteria in the two variants (to do and not to do) are different, therefore inapplicable.

The need for protocols to guide medical activity arising in order to standardize medical activity in different medical centers, otherwise useful up to a point is sometimes generating "rest" in the logical judgment of the diagnostic and therapeutic medical approach.

These guidelines/protocols should only be used as indicative elements in the diagnostic approach, the rest being desirable to remain at the discretion of the attending physician, the only one in a position to appreciate their adaptability to the case.

In the didactic activity, the study of these guidelines/protocols must remain subordinate to the study of the diseases themselves (they have a volatile, transitory or even temporary antagonist character) while the diseases remain largely unchanged. Medical students should NOT learn protocols, they should learn diseases.

The optimal use of recent diagnostic and therapeutic technological conquests, which bring an indisputable benefit to patients, therefore requires a safe mastery of them without leaving out of the equation the fundamental element of the medical approach - the patient, who must remain an active participant in making decisions regarding his condition of health.