

1: Hospitals and Treatment Facilities in the Ancient World | www.enganchecubano.com

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Education during the Empire[edit] Relief found in Neumagen near Trier, a teacher with three discipuli AD At the height of the Roman Republic and later the Roman Empire , the Roman system of education gradually found its final form. Formal schools were established, which served paying students; very little that could be described as free public education existed. The educator Quintilian recognized the importance of starting education as early as possible, noting that "memory They were generally exempted from studies during the market days which formed a kind of weekend on every eighth day of the year. In the 3rd century B. As Rome grew in size and in power, following the Punic Wars , the importance of the family as the central unit within Roman society began to deteriorate, [8] and with this decline, the old Roman system of education carried out by the paterfamilias deteriorated as well. The new educational system began to center more on the one encountered by the Romans with the prominent Greek and Hellenistic centers of learning such as Alexandria later on. It was becoming a literary educational system. The situation of the Greeks was ideal for the foundation of literary education as they were the possessors of the great works of Homer , Hesiod and the Lyric poets of Archaic Greece. The absence of a literary method of education from Roman life was due to the fact that Rome was bereft of any national literature. The military arts were all that Rome could afford to spend time studying. When not waging war, the Romans devoted what time remained to agriculture. The concern of Rome was that of survival, whether through defense or dominion. It was not until the appearance of Ennius " BC , the father of Roman poetry, that any sort of national literature surfaced. While the Romans adopted many aspects of Greek education, two areas in particular were viewed as trifle: Music to the Greeks was fundamental to their educational system and tied directly to the Greek paideia. The area that many Romans considered unimportant equates to our modern definition of music. To the Greeks, the ability to play an instrument was the mark of a civilized, educated man, and through an education in all areas of mousike it was thought that the soul could become more moderate and cultivated. The Romans did not share this view and considered the study of music as a path to moral corruption. Athletics, to the Greeks, was the means to obtaining a healthy and beautiful body, which was an end in and of itself and further promoted their love of competition. The Romans, though, did not share this stance either, believing that athletics was only the means to maintaining good soldiers. This illustrates one of the central differences between the two cultures and their view on education: The Romans, on the other hand, tended to be more practically minded when it came to what they taught their children. To them, it would appear, an area of study was good only as far as it served a better purpose or end determined outside of itself. Also, prior to the war, they had focused more on government and politics rather than army and military. Parents taught their children the skills necessary for living in the early republic, which included agricultural, domestic and military skills as well as the moral and civil responsibilities that would be expected from them as citizens. Roman education was carried on almost exclusively in the household under the direction of the paterfamilias. He taught his son not only to hurl a javelin, to fight in armor, and to ride a horse, but also to box, to endure both heat and cold, and to swim well". Mothers, though, cannot be overlooked for their roles as moral educators and character builders of their children. For a boy, this meant devotion to the state, and for a girl, devotion to her husband and family. However, it was common for children of more humble means to be instructed in a primary school, traditionally known as a ludus litterarius. They could be found in a variety of places, anywhere from a private residence to a gymnasium, or even in the street. The students would progress up from reading and writing letters, to syllables, to word lists, eventually memorizing and dictating texts. There was little sense of a class as a cohesive unit, exemplified by students coming and going at different times throughout the day. Their performance was measured through exercises that were either corrected or applauded based on performance. This created an unavoidable sense of competition amongst students. Children continued their studies with the

grammaticus until the age of fourteen or fifteen, at which point only the wealthiest and most promising students matriculated with a rhetor. Aulus Metellus, an Etruscan man wearing a Roman toga while engaged in rhetoric; the statue features an inscription in the Etruscan alphabet. The rhetor was the final stage in Roman education. Very few boys went on to study rhetoric. Early on in Roman history, it may have been the only way to train as a lawyer or politician. These students also learned other subjects such as geography, music, philosophy, literature, mythology and geometry. Unlike other forms of Roman education, there is not much evidence to show that the rhetor level was available to be pursued in organized school. Because of this lack of evidence, it is assumed that the education was done through the previously mentioned private tutors. In fact, their influence was so great that the Roman government expelled many rhetoricians and philosophers in BC. There were two fields of oratory study that were available for young men. The first of these fields was the deliberative branch of study. This field was for the training of young men who would later need to urge the "advisability or inadvisability" of measures affecting the Roman Senate. These orators would later enter into fields such as criminal law, which was important in gaining a public following. The support of the public was necessary for a successful political career in Rome. Tacitus pointed out that during his day the second half of the 1st century AD, students had begun to lose sight of legal disputes and had started to focus more of their training on the art of storytelling. The study of philosophy is distinctly Greek, but was undertaken by many Roman students. To study philosophy, a student would have to go to a center of philosophy where philosophers taught, usually abroad in Greece. Romans regarded philosophical education as distinctly Greek, and instead focused their efforts on building schools of law and rhetoric. Teachers College Press, *Education in Ancient Rome*: Lee Too, Y; Faroqhi, S. *Education in Greek and Roman Antiquity*. Smith, *Ancient Education* New York: Philosophical Library, , p. Oxford University Press, Pacal, *The Classical Journal*, Vol. Kaster, *Guardians of language: University of California Press*, *As the Romans Did: A Sourcebook in Roman Social History*. Oxford University Press, , p.

2: Health Care Around the World – Global Issues

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The Cuban health system is recognized worldwide for its excellence and its efficiency. Despite extremely limited resources and the dramatic impact caused by the economic sanctions imposed by the United States for more than half a century, Cuba has managed to guarantee access to care for all segments of the population and obtain results similar to those of the most developed nations. According to Margaret Chan, the world should follow the example of the island in this arena and replace the curative model, inefficient and more expensive, with a prevention-based system. It reflects, instead, a lack of political will on the part of leaders to protect their most vulnerable populations. The organization cites the case of the Caribbean island as the perfect counter-example [3]. Moreover, in May , in recognition of the excellence of its health care system, Cuba chaired the 67th World Health Assembly [4]. With an infant mortality rate of 4. This is also demonstrated by the quality of its health care system and the impact it has on the well-being of children and pregnant women. The infant mortality rate in Cuba is lower than it is in the United States and is among the lowest in the world. On the average, Cubans live 30 years longer than their Haitian neighbors. In , Cuba will have the highest proportion of its population over the age of 60 in all of Latin America. Indeed, since , Cuba has sent doctors and other health workers throughout the Third World to treat the poor. Currently, nearly 30, Cuban medical staff are working in over 60 countries around the world. This humanitarian campaign, implemented at the continental level under the aegis of the Bolivarian Alliance for the Peoples of Our America ALBA , operates without charge on the Latin American poor who suffer from cataracts and other eye diseases [8]. In a decade, nearly 3. Initially created for Venezuela, this social program was extended to the entire continent with the objective of operating on a total of six million people. Since its inception in , ELAM has graduated more than 20, doctors from over countries. Currently, 11, young people from over nations follow a career in medicine at the Cuban institution. They remain in place after the crises. Cuba can be proud of its health care system, a model for many countries [13]. This is possible if the political will exists to put human beings at the center of the project. Smith, foreword by Paul Estrade; translated by Larry R. Do you have information you want to share with HuffPost?

3: Evolution Of The Ancient Roman Soldier Over A Millennium

The Romans evolve a system of numerals which, until the end of the Middle Ages, is a handicap to western arithmetic Go to Roman numeral in World Encyclopedia (1 ed.) See this event in other timelines.

Health care in wealthy countries All industrialized nations, with the exception of the United States, implement some form of universal health care. Universal health care in all wealthy countries except US The main ways universal health care is achieved in wealthy nations include: Government run tax funded systems, e. With the worsening global financial crisis hitting America hard, more are likely to lose medical insurance which is often associated with a job. The US does, however, through Federal law provide public access to emergency services, regardless of ability to pay. However, the emergency services system has sometimes felt strain due to patients being unable to pay for emergency services and many who cannot afford regular health care either use emergency services for treatment, or let otherwise preventable conditions get worse, requiring emergency treatment. The New York Times reports that life expectancy disparities are mirroring the widening income inequality in recent decades. Other health issues that are pronounced in the US, such as obesity, high cost of medical drugs, lack of access for large numbers of people, have been concerns for many years. The US has not seen health as a human right, but as a privilege. However, President Barack Obama has tried to challenge this view, with proposed reforms to provide universal health care through health insurance for all. This has been met with wrath from the right wing, even though—as the charts above show—the US spends the most per person in the world on health care, yet does not get the best for all that money; most other industrialized nations get better, faster and cheaper health care. In the previous link, author and former Washington Post reporter, T. Reid, looks at 5 myths that many Americans have about health care around the world and concludes: In many ways, foreign health-care models are not really foreign to America, because our crazy-quilt health-care system uses elements of all of them. The government provides health care, funding it through general taxes, and patients get no bills. Premiums are split between workers and employers, and private insurance plans pay private doctors and hospitals. Everyone pays premiums for an insurance plan run by the government, and the public plan pays private doctors and hospitals according to a set fee schedule. This fragmentation is another reason that we spend more than anybody else and still leave millions without coverage. Which, in turn, punctures the most persistent myth of all: In terms of results, almost all advanced countries have better national health statistics than the United States does. In terms of finance, we force , Americans into bankruptcy each year because of medical bills. In France, the number of medical bankruptcies is zero. Large pharmaceutical companies are known to have enormous influence in the US. They have also had a lot of influence on various international trade policies such as those on intellectual property, sometimes to the detriment of poorer countries facing health crises as described in the global health overview page on this web site. In the US, high drug prices have been an issue for many years, with some people even going across the border to Canada to get more affordable medicines. While that sounds like a large amount, according to investigative reporter Greg Palast, it is actually an agreement that drug companies will reduce the amount by which they increase their drug costs over the next 10 years, locking in a doubling of costs. Inter Press Service , who adds that the media has given little or no information about the demographics of the polls being conducted, and whether respondents include the estimated one in three citizens who lacked health insurance at some point in While tax-funded and government run, it provides access to all citizens and is mostly free at point of use. The British system includes free primary care paying doctors and running hospitals through decentralized trusts. Almost all treatment is free. For working age citizens, prescriptions are obtained with a flat fee with pharmacists often telling patients if the same drug is cheaper over the counter than through prescription. Dentist and optician visits typically have some fee associated with them, with dentistry having been increasingly privatized for many, many years. There is a parallel private health option but is used by a small percentage of the population usually the wealthy, by definition. Over the years, the NHS has changed in various ways, but even the parties traditionally hostile to big government the Conservative party typically state at least publicly support for the institution. There have been a number of problems within the NHS, which the

right wing in the US are keen to expose even if it includes exaggerating or bending the truth about NHS problems. There are also concerns that under the guise of necessary reforms due to the effects of the global financial crisis , a privatization agenda is being pushed onto the NHS. SpinWatch, for example, claims that private healthcare companies have built a dense and largely opaque network of political contacts in the UK with one aim " to influence policy in their interests and get the reforms they want: Web of private healthcare influence Private Healthcare Network Map , March Click for larger version Using favorable terms such as freedom and choice , some of the reform plans have been intensely criticized, such as giving GPs General Practitioners " also known as Family Doctors more control over their budgets. At first glance this sounds ideal: However, GPs themselves are worried about this because they have not been consulted on this plan as it would not just meant they have to also become accountants " without extra budgets to do this " but that they would end up having to ration limited resources and some people may not be able to get treatment as needed, while diluting the power of the NHS as a universal system throughout the country. For an overview of health systems in various other countries, try the following:

4: History of medicine - Wikipedia

Herophilus, a contemporary of Euclid, practiced medicine in Alexandria in the third century B.C., and seems to have been the first Western scientist to dissect the human body. He made especially impressive contributions to many branches of anatomy and also developed influential views on many other aspects of medicine.

This article has been cited by other articles in PMC. Abstract The purpose of this research paper is to compare health care systems in three highly advanced industrialized countries: The first part of the research paper will focus on the description of health care systems in the above-mentioned countries while the second part will analyze, evaluate and compare the three systems regarding equity and efficiency. Finally, an overview of recent changes and proposed future reforms in these countries will be provided as well. We start by providing a general description and comparison of the structure of health care systems in Canada, Germany and the United States. Health insurance coverage is universal. General taxes finance NHI through a single payer system only one third-party payer is responsible for paying health care providers for medical services. Consumer co-payments are negligible and physician choice is unlimited. Production of health care services is private; physicians receive payments on a negotiated fee for service and hospitals receive global budget payments Method used by third party payers to control medical care costs by establishing total expenditure limits for medical services over a specified period of time. Most of the population lives within miles of the United States border. From the American point of view, Canada provides a good comparison and contrast in terms of the structure of its health care systems. The Canadian health care system began to take on its current form when the province of Saskatchewan set up a hospitalization plan immediately after WWII. The rural, low-income province was plagued by shortages of both hospital beds and medical practitioners. The main feature of this plan was the creation of the regional system of hospitals: In , the federal parliament enacted the Hospital and Diagnostic Services Act laying the groundwork for a nationwide system of hospital insurance. By all ten provinces and the two territories had hospital insurance plans of their own with the federal government paying one half of the costs. Since the health care system has moved in different directions. While Canada has had publicly funded national health insurance, the United States has relied largely on private financing and delivery. During this period, spending in the United States has grown much more rapidly despite large groups that either uninsured or minimally insured. The provisions of the Canada Health Act define the health care delivery system as it currently operates. Under the Act, each provincial health plan is administered at the provincial level and provides comprehensive first dollar coverage of all medically necessary services. With minor exceptions, health coverage is available to all residents with no out of pocket charges. Most physicians are paid on a fee for service basis and enjoy a great deal of practice autonomy. Private health insurance for covered services is illegal. Most Canadians have supplemental private insurance for uncovered services, such as prescription drugs and dental services. As a result, virtually all physicians are forced to participate and each health plan effectively serves all residents in the province Henderson Patients do not participate in the reimbursement process, and reimbursement exclusively takes place between the public insurer the government and the health care provider. The monetary exchange is practically non-existent between patient and health care provider. The ministry of health in each province is responsible for controlling medical costs. Cost control is attempted primarily through fixed global budgets and predetermined fees for physicians. Specifically, the operating budgets of hospitals are approved and funded entirely by the ministry in each province and an annual global budget is negotiated between the ministry and each individual hospital. Capital expenditures must also be approved by the ministry, which funds the bulk of the spending. Physician fees are determined by periodic negotiations between the ministry and provincial medical associations the Canadian version of the American Medical Association. With the passage of the Canada Health Act of , the right to extra billing was removed in all provinces. Extra billing or balance billing refers to a situation in which the physician bills the patient some dollar amount above the predominated fee set by third party payer. For the profession as a whole, negotiated fee increases are implemented in steps, conditional on the rate of increase in the volume of services. If volume per physician arises faster than a predetermined percentage,

subsequent fee increases are scaled down or eliminated to cap gross billings – the product of the fee and the volume of each service – at some predetermined target. The possible scaling down of fee increases is supposed to create an incentive for a more judicious use of resources. Physicians enjoy nearly complete autonomy in treating patients. In spite of the differences it is fair to say that each provincial plan is a public sector monopsony, serving as a single buyer of medical services within the province and holding down medical care prices below market rates. The key element in the Canadian strategy to control overall spending is the regionalization of high tech services. Government regulators make resource allocation decisions. This control extends to capital investment in hospitals, specialty mix of medical practitioners, location of recent medical graduates, and the diffusion of high tech diagnostic and surgical equipment. Access to open heart surgery and organ transplantation is also restricted. That same year the CT scanners in Canada meant one for every 100,000 citizens. Recent studies found Canadian deficits in several areas including angioplasty, cardiac catheterization and intensive care. Waiting lists for certain surgical and diagnostic procedures are common in Canada. Nationwide, the average wait for treatment is 18 weeks. If care required diagnostic imaging, waiting times are even longer. Canadians are sacrificing access to modern medical technology for first dollar coverage for primary care. Treatment delays are causing problems for certain vulnerable segments of the Canadian population, particularly the elderly who cannot get reasonable access to the medical care they demand, including hip replacement, cataract surgery and cardiovascular surgery. Several lessons can be learned from the Canadian experience. Products provided at zero price are treated as if they have zero resource cost. Resource allocation decisions become more inefficient over time and government is forced either to raise more revenue or curb services. A second lesson from the Canadian experience is that everything has a cost. The Canadian system delegates this authority to the government. Resource allocation is practiced, not through the price mechanism, but by setting limits on the investment in medical technology. Proponents will argue that using waiting lists as a rationing measure is reasonable and fair. Opponents find the lists unacceptable and an unwelcome encroachment on individual decision-making in the medical sector. Proponents of the single payer alternative must deal with the fact that Canadians face waiting lists for some medical services especially for high tech specialty care. To avoid delays in treatment, many Canadians travel south to the United States for more advanced treatment. Critics of the Canadian system must deal with the fact that most Canadians support their version of Medicare. The single most important defense of medical care delivery in Canada is that it works relatively well. The German system of social benefits is based on the concept of social insurance as embodied in the principle of social solidarity. This principle is a firmly held belief that government is obliged to provide a wide range of social benefits to all citizens, including medical care, old age pensions, unemployment insurance, disability payments, maternity benefits and other forms of social welfare. Bismarck saw the working class movement of that time as a threat. This concern led him to advocate the expansion of the existing sickness benefit societies to cover workers in all low wage occupations. In 1883, the Sickness Insurance Act was passed, representing the first social insurance program organized on a national level. The German Democratic Republic East Germany was under the influence of the former Soviet Union and adapted the socialist form of government. The Federal Republic of Germany West Germany maintained its connections with the West and continued to utilize the pre-war economic system including the health care delivery system. East and West Germany were reunited in 1990 and since that time the former East Germany has been subjected to most West German laws including legislation relating to the medical insurance system. With the combined population of 82 million people, Germany is divided into 16 provinces Laender, each with a great deal of independence in determining matters related to health care. Over the past years the system has grown to the point where virtually all of the population is provided access to medical care. All individuals are required by law to have health insurance. Sickness funds are private, not for profit insurance companies that collect premiums from employees and employers. Those earning more than this limit may choose private health insurance instead. One of every 10 Germans covered by sickness fund insurance also purchases private supplementary insurance to cover co-payments and other amenities. Individual health insurance premiums for workers are calculated on the basis of income and not age or the number of dependents. Premiums are collected through a payroll tax deduction; the average contribution was 10.5% of gross wages. The social

insurance component is organized around some localized sickness funds. The sickness funds are independent and self-regulating. They pay providers directly for services provided to their members at rates that they negotiate with individual hospitals. The sickness funds are required by law to provide a comprehensive set of benefits. These include physician ambulatory care provided by physicians in private practice, hospital care, home nursing care, a wide range of preventive services and even visits to health spas. Patient cost sharing is minimal. The funds, like disability insurance also provide additional cash payments to those who are unemployed as a result of illness. The system is weak in several areas. In particular, public health services and psychiatric services are minimal. As for reimbursement, ambulatory providers are paid on a fee for service basis, hospitals on a prospective basis. Both public and private including for profit hospitals exist, though the public hospitals account for about half the beds. Hospitals tend to use salaried physicians, and unlike the United States physicians in private practice generally do not have admitting privileges. Thus, many doctors have invested in elaborately equipped clinics to compete with hospitals by being able to perform a wide range of procedures. The German experience is especially relevant to the United States. Coverage is provided through a large number of relatively small and independent plans. In this sense, the delivery of health care is similar to that found in the United States where, for the most part, large numbers of employee groups, independent insurers, and providers reach agreements without direct government intervention. Many Americans propose mandated coverage for the working uninsured. Germany relies on a mandated approach where coverage for certain conditions is required by law. Germany also introduced cost controls similar in principle to prospective payment under the U. Government Role and Involvement In the German health care system, each level of government has specific responsibilities.

5: Cuba's Health Care System: a Model for the World | HuffPost

An automated clinical medical record and audit system was developed to evaluate the effect of modifying physician behavior at the control points in the ambulatory care process and to determine if this change was reflected in patient care cost outcomes. This study compared clinical and cost results.

Project Background Chronic diseases are the single most rapidly growing health care challenge in both the developing and developed world. The number of individuals with chronic diseases such as diabetes, kidney disease, pulmonary disease, heart disease and glaucoma, are increasing world wide – often at unprecedented rates. Monitoring chronic diseases is critical for optimizing individual treatment and sustaining long-term outcomes. In many areas, both within the U. Travel costs for physicians and patients, together with limited time per patient for each interaction, reduce the ability of physicians to accurately modify treatment for each individual. Chronic disease in the elderly presents the greatest technical and deployment challenge for deep monitoring. Chronic elderly conditions show extensive inter-individual and time-dependent variations. Disease conditions can persist for decades with periods of crisis and recovery. Chronic disease in the elderly is also pervasive. Although the most likely to be chronically ill, the elderly are the least likely to accept advanced technologies. Consequently, developing inexpensive and robust deep-monitoring strategies and technologies – that are accepted and used by the elderly population – will be essential for providing personalized disease monitoring and management where it is most needed. In contrast, the population demographics that need to be monitored the most are the elderly and economically disadvantaged. The four technologies consisted of: The device has moved from concept to patient testing at the U-M Diabetes Clinic. A low cost, wireless temperature sensor being used at the U-M Diabetes Clinic to measure diabetic foot inflammation temperatures. The device is currently being tested in an approved clinical laboratory setting at the U-M Health System. Based on these results, a novel machine-vision system for high-resolution 3D eye imaging and measurement has been designed. During Phase 2 of this project, these four novel technologies will be developed, tested and deployed to local U-M clinical sites, the clinical results will be analyzed and the technologies will be refined for robustness and reduction in manufacturing cost. The final technologies will then be deployed in low-resource locations in Michigan, rural Jamaica and Ghana Potential Transformative Impact The Deep Monitoring Project intends to build a foundation in Phase 2 that will engage and motivate students, staff, and faculty – and strengthen the University of Michigan – beyond its proposed 4-year timeframe. It includes a balance of academic research novelty and real-world implementation into the U-M Health System and the developing world. The Deep Monitoring Project was designed to quickly and effectively establish new health assessment technologies for elderly chronic disease patients. The use of a consistent implementation and testing strategy, a defined target population and existing University of Michigan expertise in clinical research, basic science and engineering allows each of the four technologies to benefit from prior experiences. This project recognizes the wider domains of healthcare that can impact any technology, including cultural contexts, healthcare costs, business demands, patient perceptions and legal issues. We understand and value the power of the University of Michigan to bring together faculty, health care workers and students knowledgeable in these areas from across the campus. The investigators envision that inexpensive monitoring will fundamentally change the effectiveness of chronic disease medical care globally and locally. Its most significant impact will be on remote and underserved populations with limited financial resources. However, as these technologies progress, individualized health monitoring of all patients will be based on quantitative knowledge of changes in individual physiology, tracked densely over time at a low cost.

6: Education in ancient Rome - Wikipedia

Planners and architects designing the Building for the Third Century of MGH Medicine were guided by the principles of green construction – the practice of creating environmentally-friendly, resource-efficient structures in order to protect the health of occupants while reducing waste and pollution.

He contributed to a significant body of medical writings, but it is difficult to determine precisely which works of the corpus are actually his. Even these few data are not indisputable. If, for example, you had thought of going to Hippocrates of Cos, the Asclepiad, and were about to give him your money, and someone had said to you: Moreover the shortness of the passage cited in Protagoras places the names of Hippocrates and the artists close together, while no such close juxtaposition exists in the passage from Phaedrus. Even were it possible to deny the extraordinary fame of Hippocrates during his own lifetime, it would still be necessary to explain why he, rather than anyone else, early became legendary. It is reasonable to assume that the tenacious and varied legend, analyzed skillfully by Edelstein, became attached to a person of some prominence, rather than to a mere physician. The legendary Hippocrates appears variously as a heroic sage; as a Greek patriot who spurns the offers of Artaxerxes I ; and as a friend of Democritus of Abdera, who, being thought mad by his fellow townsmen, convinces Hippocrates of his sanity. An apocryphal decree further credits him with having saved Athens from the plague. None of these stories has any basis in historical fact; indeed, it is not known whether Hippocrates ever met Democritus, for example. Not only must it be concluded that the legend is based on a real person, and a famous one, but it must also be accepted that that person was the author of a number of famous books. It was certainly not true for his contemporaries that Hippocrates was a name with no writings attached to it, and it is true for us to only a limited degree, since we possess many medical works from the time and from the school of Cos. It is very probable that some of the most outstanding of these are by Hippocrates. Plato suggests that he wrote and circulated medical books Phaedrus, b-c , while Diocles of Carystus end of the fourth and beginning of the third century b. It is now necessary to examine the Hippocratic corpus to determine which works might actually be attributed to Hippocrates himself. The corpus, or Collection, consists of about sixty medical works, the great majority of which date from the last decades of the fifth century b. The problem of dating the treatises is aided by internal evidence, as well as by the testimony of Diocles of Carystus and Ctesias of Cnidus. For example, the Collection contains a great many echoes of pre-Socratic philosophy and explicit citations of Empedocles Ancient Medicine 20 and Melissus of Samos Nature of Man 1 , but almost nothing that shows post-Socratic thought, except in a few of the later works. The people and places mentioned in Epidemics are also helpful. Moreover, one of the most important of the treatises, Nature of Man, which is very closely connected to other works of the corpus, can confidently be attributed to Polybius, the disciple and son-in-law of Hippocrates, through the testimony of Aristotle History of Animals III, 3, ba. Although the date of the majority of the works in the Collection may thus readily be established, not all of the treatises fall within this period; some are known to be of certain later date, while a few of the texts, such as the Oath and Nature of Man, may be slightly earlier, although this is more difficult to determine. In sum, however, it is certain that most of the Collection should be placed between and b. A number of the treatises certainly belong to the school of Cnidus, and not to that of Cos. All the gynecological treatises, too, as well as the single work Generation-Nature of the Child-Diseases IV, must be supposed to be at least para-Cnidian, while the philosophical presuppositions of Regimen, Breaths, and On Flesh, are incompatible with the school of Cos. Another group of treatises may with equal confidence be considered to be Coan, however. It would indeed be surprising if one or another of these works were not written by him, but because of the lack of adequate documentation this final attribution is the most difficult to make. In light of these considerations, vocabulary can undoubtedly vary. There is almost unchallengeable evidence to show that of these Hippocrates wrote at least Prognostic and Joints. If we accept this evidence to show that the two works in question are by Hippocrates, it is implicit that several others must also be by him. It is further possible that he may have written other treatises that are now lost, since the Collection frequently mentions works that are no longer extant and the beginning of the Regimen, in particular, tells us that there existed a

vast medical literature, of which the Collection is only a fraction. A further complication in assigning specific works to Hippocrates lies in that the problem of individual authorship was undoubtedly not as acute for the Asclepiads as it is now. One may assume that literary ownership was a hazier and generally less important concept than it is today; it should be noted that chapter 1 of Regimen in Acute Diseases attributes the two editions of the Cnidian Maxims to a group of authors, which is not merely a figure of speech. There can be no doubt that the Coans adhered to the same practice. It is certain, however, that the great Coan works that Hippocrates did not write himself nevertheless reflect his thought and his teaching. And do you think you can know the nature of the soul intelligently without knowing the nature of the whole? Hippocrates the Asclepiad says that the nature of the body can not be understood without it. Yes, friend, and he was right. Still, we ought not to be content with Hippocrates, but we should examine by reason and see whether its answer agrees with his conception of nature. Then consider what reason as well as Hippocrates says about nature. The first interpretation is unacceptable; it is then therefore necessary to determine if the doctrine implicit in the platonic interpretation is easily deductible from Coan writings, or whether it contradicts the doctrine of Cos. What one finds in the Coan writings is an emphasis on the importance to the body of such ambient effects as heat, winds, and rain, a doctrine radically different from the micro-macrocosmic philosophical system similar to that found in the para-Cnidian Regimen that Plato attributes to Hippocrates. Indeed, several passages in the extant writings could appear ambiguous in this way to a philosopher, and such distortions in no way invalidate the writings as being genuinely Hippocratic. The second major document is a papyrus in the British Museum, which was described by Sir Frederic Kenyon in and published by H. It contains approximately 1, lines and dates from the second century of the Christian era. Lacunae, oversights, and errors in the text suggest that it represents a collection of notes made by a medical student for his personal use; it is certain, however, that the second section of the papyrus, which is devoted to the etiology of disease, reproduces the work of Meno, the disciple of Aristotle whose existence and writings were known to Galen. Meno gives us the doctrines of twenty physicians, seven of whom are not known to us from any other source. Meno allots more space to Hippocrates V, VII, 40 than to anyone save Plato, who receives the greatest share because of the important of the Timaeus for even the school of Aristotle. Moreover, like Aristotle in the Politics, Meno designates Hippocrates by name alone, as he does Polybius, thus confirming the eminent position that Hippocrates held in the medicine of the time. According to Meno, Hippocrates explained diseases as the result of bad air or bad diet. Air is essential for health and must circulate freely in the body; its impairment results in epidemics. Defective nourishment produces a variety of diseases; an excessive quantity or a poor quality of food leads to a tumult in the stomach and the generation of waste products from which winds arise and spread into the body to cause illness. Resemblances between this text and Breaths are strong, but for our purposes they must be considered coincidental, since there is no way in which that work may be attributed to Hippocrates. It thus becomes necessary to assume that Meno is drawing upon one or more works by Hippocrates that have since been lost as suggested by, among other things, his allusion to the plant stratiotes, which is not mentioned in the Collection. The doctrine of ambient factors is pronounced in the works that survive, and it is likewise possible to speculate that Breaths, too, draws upon lost treatises. We must conclude, therefore, that we do possess a number of great medical works from the school of Hippocrates, and that Hippocrates himself was almost certainly the author of at least several of them. The essential step, therefore, is to define the contribution of the school of Cos, which is difficult in itself given the symbiosis that may be assumed to have existed among the members of a medical school and among the schools themselves. A review of those themes which seem to be fundamental to the school of Cos should begin with its essential concept of disease processes. In an internal disease, such as is often caused by fluxes of indigestible humors, coctionâ€” a kind of slow cooking that restores equilibrium and normal properties to the disturbed humorsâ€”may occur. The crisis is marked by critical signs and symptoms and occurs on certain critical days in the course of the disease, although Coan speculations on these matters are more or less hazy and vary from treatise to treatise. A less frequently found notion is that of the deposit, a localized complaint that may be the forerunner of or sequel to a disease. The deposit can metastasizeâ€” travel from one part of the body to anotherâ€” which may mark the transformation of one disease into another. The Coans also recognized the phenomenon of recurrence or relapse. These basic

concepts are not, however, peculiar to the school of Cos. Practically all of them may also be found in Cnidian writings, employed in a way that suggests established usage. The doctrine of humors is found in the teachings of both schools, as it is throughout medical teachings of the times; it undoubtedly antedates Hippocrates. The Coan writings would seem to imply the four humors specified in *Nature of Man*—phlegm, blood, yellow bile, and black bile. The Cnidian treatises also embrace a theory of four humors, being in this instance those set forth in *Diseases IV*, namely water, blood, phlegm, and bile, various forms of the latter two being dominant in matters of nosology. It is thus in detail that the two schools differed. As we have seen, ambient factors and diet are fundamental to the medical teachings of Cos; of the treatise *Airs, Waters, Places*, for example, being devoted to the role of such factors as air, location, climate, and season. Cnidian writings also allude to these factors in the description and treatment of certain diseases, although unlike the Coan corpus none of them is also mentioned in the non-Coan or para-Cnidian *Regimen*. The Cnidian treatises proper contain a discussion of diet as the greater part of the section devoted to therapy of each disease. The two schools are here so close in theory that despite the direct anti-Cnidian polemic of the *Regimen in Acute Diseases*, it can easily be shown that the essential elements of the dietary rules presented in this treatise are all advocated in the Cnidian writings. Coan prognosis consisted in stating the past and present state of the disease and predicting its course after making an examination of the current symptoms but before questioning the patient perhaps as a rationalization of shamanistic medicine. At any rate, the Cnidians described, often in rather different terms, a very similar procedure. The Coan writers polemicized against such tendencies in both *Nature of Man* and *Ancient Medicine*; while no such open polemic is extant among the Cnidian writings, Cnidus would seem to be as far from espousing a cosmological medicine as its rival. Both schools also rejected any sort of magico-religious medicine. This sort of medicine was vigorously attacked in Coan writings. Both are nevertheless influenced by pre-Socratic ideas in certain of their aspects. For example, the Coan *Nature of Man* displays a philosophical orientation in many of its arguments, while the Cnidian *Generation-Nature of the Child* presents embryological conceptions similar to those of several pre-Socratic thinkers. The influence of Democritus, in particular, is certain. A frequent generalization is that the medicine of Cos was more sensitive to the patient, while that of Cnidus was more greatly concerned with the disease. In light of this it is said that the notion of the individual and the complexity of individual cases were more respected at Cos, while Coan medicine placed less emphasis on therapy and Coan nosology was more apt to be general than that of Cnidus which is said to be more concerned with the localization of the disease. Once again, this contrast is more apparent than real. A further examination of the extant works from the two schools must, however, lead to a different conclusion. There remain to us from the school of Cos treatises devoted to one aspect or concept of medicine or to individual cases of disease; nothing comparable remains from Cnidus, which has left us only treatises on diseases. It is difficult to compare works so dissimilar in subject matter. If, for instance, there were a Coan treatise dealing explicitly with the same material as dealt with in *Disease II*, we might arrive at legitimate conclusions. The only Coan work dealing with a specific malady is *Fractures, Joints*, and it is immediately apparent that a luxation or fracture does not have an etiology comparable with a case of phthisis or gout, and that the symptoms and treatment must be just as different. It is thus difficult to generalize about the fundamental difference in medicine as practiced at Cos and Cnidus when only the subject matter of the extant works would seem to be at issue. Indeed, when the subject matter is similar, as in the Coan writings that present some data concerning etiology, dietetics, and therapy in specific diseases, one is struck by the resemblances between the two schools. For example, *Aphorisms and Epidemics* reveal the same rash positions as Cnidian gynecological writings see Joly, Niveau, pp. The point is often made that while fluxes of the humors were a frequent consideration in Cnidian etiology, the physicians of Cos made little use of them. Bourgey writes, It is very characteristic that while the most typical treatises, *Prognostic, Regimen in Acute Disease, Fractures, Joints and Aphorisms*, contain precise references to the existence of the humors, they do not speak of their circulation through the organism and do not attempt to construct on these foundations an arbitrary nosology [op. Yet there is no reason for the author of these tracts to take up the fluxes of the humors, since they are irrelevant to his subjects especially *Fractures, Joints*. It is, moreover, by the flux of a humor that the author of *The Sacred Disease* explains epilepsy, while that of *Airs, Waters, Places* mentions in chapter

VIIa flux that comes from the head and upsets the stomach, and the nosology stated in chapter IV of Nature of Man is predicted on the same idea. One ought not, however, to conclude that in these instances—and many others—the school of Cos was actually actually influenced by the school of Cnidus. Such influence would mean that a Coan physician would have had to consult a Cnidian whenever he considered the etiology of a disease; in therapy, too, each time a Coan describes a drug, the similarity to Cnidian texts is evident. The very number of the similarities between the schools makes such a thing unlikely. Despite these similarities, a qualitative difference between the medicine of Cos and Cnidus has been assumed by, among others, Bourgey, who elaborated the philosophical medicine of his opinion in great detail and with utmost conviction. It is my opinion that he thus overvalues Coan medicine and thereby exaggerates the differences that actually existed between it and other schools.

7: 3rd century BCE: c. BCE - c. BCE - Oxford Reference

Parkinson's disease: the beginning of the third century. For Parkinson's Awareness Week, we invited our Associate Editor of Journal of Clinical Movement Disorder, Dr. Pichet Termsarasab, to take a look back to the discovery of the disease and tell us about its clinical features and advances in the diagnosis and treatment.

Roman soldier at the Battle of Dyrrhachium, circa 48 BC. Dattatreya Mandal July 13, Starting out as a backwater inhabited by cattle rustlers who made their camps and rudimentary dwellings among the hills and the swamp lands, Rome emerged as the eternal city that was the focal point of an ancient superpower marshaling its influence from the mines of Spain to the sands of Iraq. In all of these, the singular factor that played its crucial role was the Roman military, an institution driven by the exploits of the determined and trained ancient Roman soldier. Now our popular culture tends to identify the Roman soldier as the quintessential Roman legionary of the first centuries of the common era. And while part of this scope holds true, since the Roman Empire did reach its greatest extent in the early phases of 2nd century AD, the notion of a Roman soldier is obviously not a static entity that remained unchanged over the centuries – in terms of both his social status and the arms he bore. Keeping that in mind, let us take a gander at the evolving nature of the ancient Roman soldier over a period of almost a millennium, from circa 8th century BC to 3rd century AD. Early Roman soldiers, circa 7th century BC. Illustration by Richard Hook. Early Roman soldier and Italic allies, circa 8th -6th century BC. Pinterest In fact, the legions of early Rome were conscripted only as part-time soldiers, and had their main occupation as farmers and herders. This stringent economic system prevented them from taking part in extended campaigns that hardly went beyond a month, thus keeping military actions short and decisive. Moreover, these legions had to pay for their own arms and armaments – which at times was compensated only by a small pay from the state. Weapons and Warfare The popular notion of the Roman army fighting in maniples is a correct one if only perceived during the later years after 4th century BC. However, in the preceding centuries, the Roman military system was inspired by its more-advanced neighbor and enemy – the Etruscans. The Roman hoplites formed the first three classes under the Servian reforms of 6th century BC. As per historical tradition, the very adoption of the hoplite tactics was fueled by the sweeping military reforms undertaken by the penultimate Roman ruler Servius Tullius, who probably reigned in 6th century BC. In that regard, the Roman army and its mirroring peace-time society, was segregated into classes classis. Celts attacking the Roman hoplites, early 4th century BC. The first three classes fought as the traditional hoplites, armed with spears and shields – though the armaments decreased based on their economic statuses. The fourth class was only armed with spears and javelins, while the fifth class was scantily armed with slings. Finally, the sixth and poorest class was totally exempt from military service. This system once again alludes to how the early Roman army was formed on truly nationalistic values. The greatest strength of the Roman army had always been its adaptability and penchant for evolution. Like we mentioned before how the early Romans from their kingdom era adopted the hoplite tactics of their foes, and defeated them in turn. However, by the time of the first Samnite War in around 4th century BC, the Roman army seemed to have endorsed newer formations that were more flexible in nature. This change in battlefield stratagem was probably in response to the Samnite armies – and as a result, the maniple formations came into existence instead of the earlier rigid phalanx. The Samnite Warriors, circa 4th century. The Romans were probably equipped in a similar Italic fashion. Triarius and Hastatus, circa late 4th century-early 3rd century BC. The Ancient Roman Soldier, circa 3rd century BC – late 2nd century BC Roman hastati, circa 3rd century BC – Illustration by Johnny Shumate The military overhaul, indicating the transition from phalanx formations to manipular ones, is sometimes referred to as the Polybian reform especially in the post BC period. Starting from left – Hastati, Velites, Triarii and Principes. The soldiers represent the Polybian reforms, after BC. This symbolically bound them with the Roman state, their commander, and more importantly to their fellow comrade-in-arms. In terms of historical tradition, this oath was only formalized before the commencement of the Battle of Cannae, to uphold the faltering morale of the Hannibal-afflicted Roman army. Illustration by Angus McBride. Now, according to modern estimation, the

male population of Rome circa BC was around , So, considering the number of casualties at the Battle of Cannae, the baleful figures pertained to 5 to 10 percent of the total number of Roman males in the Republic considering there were also Italic allies present in the battle – with all the casualties occurring in a single day! Note the similarity of arms and armaments. Pinterest The last phase of the Roman Republic was marked by yet another military overhaul, better known as the Marian reforms circa BC. Alluding to a far more influential course of action than the previous centuries of military reorganizations, these reforms resulted in the military inclusion of the *capite censi*, the landless Romans who were now assessed in the census and counted as potential recruits that could bolster the army. Consequently, the state was responsible for providing the arms and equipment to these previously disfranchised masses, thus allowing many of the poorer men to be employed as professional soldiers of the burgeoning Roman realm. Pinterest The reforms also focused on the formation of a standing army, as opposed to conscripted militias who were available seasonally within the timeframe of a year. Furthermore, the reforms also touched upon the provision of retirement pensions and land grants to military men who had completed their terms of service. Suffice it to say, the series of reforms credibly improved the prowess of the Roman military machine, especially with the adoption of standardized equipment and training of most ranks of soldiers. Simply put, by the end of this epoch, the Roman legions were far more uniform in their appearance, while adopting systematic policies, orderly discipline and reliable battlefield tactics. On the flip side, the Marian reforms indirectly paved the way for the fall of the Roman Republic. The legions, by virtue of their intrinsic organization and habitual fraternity, were more loyal to their ambitious generals than the state and senate. And by the middle of 1st century AD, the service was further extended to 25 years. Now beyond official service lengths, the protocols were rarely followed in times marked by wars. This resulted in retaining of the legionaries well beyond their service periods, with some men fighting under their legions for over three to four decades. Suffice it to say, such chaotic measures frequently resulted in mutinies. According to Cicero, this might have been the prime factor that motivated the disparate troops under Marc Antony. Popular practice also alludes to the penchant for plundering – with the soldiers tending to strip the dead as the very first act after achieving victory over their foes. However, the life of a legionary was not all about triumphs, mutinies and plundering. There were definitely some progressive measures put forth by the Romans when it came to bravery. This in turn equated to a societal status that was higher than ordinary civilians, which made the discharged legionary exempt from taxes and other civic duties. Illustration by Nikolay Zubkov While Roman legions fighting with their full capacity was a regular occurrence during early 2nd century AD, by the middle of 3rd century the conflicts faced by the Roman Empire and the changing emperors were volatile from both the geographical and logistical scope. Phalangarii of emperor Caracalla. Roman officers, circa late 3rd century AD. Emperor Gallienus who ruled alone from 253 to 268 AD created his own mobile field army consisting of special detachments from the praetorians, legio II Parthica and other guard units.

8: Medical One – Twenty Third Century Systems Ghana

The Indians introduced the concepts of medical diagnosis, prognosis, and advanced medical ethics. The Hippocratic Oath was written in ancient Greece in the 5th century BCE, and is a direct inspiration for oaths of office that physicians swear upon entry into the profession today.

View, schedule and make appointments using web portals. View medical information from the Internet. Find healthcare providers, and Find pharmacies. However their use in healthcare has limitations due to: Interference with medical devices – smart phones receive and transmit information using radio frequency RF and can interfere with some critical medical devices transmitting wired or wireless electric signals such as cardiac monitors and pace makers. Cell phones, however, can be set to hospital modes like airplane mode that alleviates such problems. The use of slate-type tablets like iPad is now becoming very popular in all walks of life including the healthcare. Because of their larger size and wireless capabilities, the Tablets PCs are a balance between screen size and portability. Traditionally Electronic Medical Records EMR have been limited to office tables, but with Tablet PCs, users have the ability to access medical records from anywhere like the smart phones. The Tablet PCs can allow the healthcare users to: Explain clinical results to patients at the bedside or in the consultation room s to enhance discussion of the results and possible courses of treatment by showing these on the Tablet PC in terms of procedures and results. Look up resources from anywhere such as drug names, diagnoses and treatment options. Consult data just before or during the treatment like surgery or any other type of medical intervention. Several vendors have already started offering iPad version of EMRs. Despite the forgoing benefits of the Tablet PCs, few constraints still remain: Detraction of doctors from the traditional bedside care because the focus may become the Table PC for entering and viewing the information rather than the patient. Requires more resource management as the normal PCs are stationary and less like to be moved and misplaced. Risk of theft, especially when the Tablets PCs are used to store unencrypted patient sensitive information and they use no authentication as strong password or biometric technology. Most diagnostics are made with large screens and multiple monitors to uncover hidden details. A touch screen is more institutive to use than mouse. Enhanced usability in hospital settings where clinicians use gloves or other protective apparel ER, surgery or where small number of repetitive tasks need to be done quickly ER admittance. Innovative user interface provides rich user experience by touching the icon for the function. Easy navigation and 3D diagnostic models cardiac CT scan can be manipulated with multi-touch rotations. Microsoft Ink is one such technology. A charting system can accept stylus input and convert it into text. Its uses in healthcare arena encompass: Drawing images such as in surgery to communicate between the doctor and the patient. Annotating diagnostic images such as X-ray and MRI scans to indicate important features. Authenticating reports quickly and easily by placing signatures just like with wet ink. This can take days by the time it becomes a part of the medical record, and sometimes it never does if the Physician does not vet and authenticate the transcribed report. At times the Physician may not even read the report and signs it in hurry leading to incorporation of errors in the medical record. Voice recognition is one such technology that resolves this issue. The Physician can dictate directly into a computer using microphone that recognizes the spoken words and translates them into text. The Physician can then proofread on screen and digitally sign it. EHR has several inbuilt capabilities: It can help the physician to view medical record with the touch of button or click of a mouse including medical histories, lab reports, and diagnostic imaging reports. Data can be entered directly and becomes a part of the digital medical record. The inbuilt database of literature helps Physician make evidence-based rather than opinion-based decision, called Clinical Decision Support CDS system. Reportable medical conditions to the government and the accrediting agencies are transmitted automatically. Once completed, it will work as healthcare information highway just like the Internet accessible from anywhere, anytime, by any device and anyone authorized. PHR could be paper-based or electronic where the patients would enter data about their health status from different sources. The PHR can lend the following benefits: Improve patient tracking – clinicians can monitor disease management, oversee progress, and track medication dosages and compliance. Encourage patient participation – patients interested in their health take

better care of their health. Inputting data into PHR would encourage patients to stay on track with their health maintenance. Offer social networking integration – through PHR the patients can interact with other patients and share information with those with the same medical issues. Constraints to PHR include security and privacy of the health information and accuracy and worthiness of data as the Physician may not trust the data entered by the patients assuming that patients used incorrect technique or unstandardized equipment. Portal services are available on the Internet anytime and from anywhere. In either case, patients can access their medical information and interact with providers through the Internet. Medical applications of nanotechnologies include imaging the internal organs whereby a small capsule containing nanodevices, such as light source and a camera, is ingested. While passing through the digestive system it emits radio signals that are captured by a receiver worn by patient on a belt around the waste. Nanodevices can also be used in microsurgeries of eyes, blood vessels and in tissue regeneration where they release growth chemicals to catalyze tissue healing. They also have a great potential in controlled release of hormones, enzymes or therapeutic chemicals at the selected sites. They can be designed to be placed under the skin to monitor blood glucose and release insulin accordingly. Their other use could be placement in blood vessels to monitor blood pressure and release of medication to control blood pressure. Efforts are underway to help regenerate neurons nerves and brain cells using special nanodevices. Their other significant role would be to repair DNA or replace the defective part of DNA using nanodevices that can carry correct DNA chunk and place at the defective part. Traditionally viruses have been used for this purpose but they have resulted in tumor generation. Nanodevices, being inert, would have huge potential in this regard. Early trials with animals have shown some success. Human genome contains 46 chromosomes, 23 from each parent that house , genes. Each gene pair is responsible for determining one trait. Each male sperm and female ovum contains 23 chromosomes and at the time of fertilization both combine to form 46 chromosomes as zygote that develops first into embryo and then into fetus. From the pair of genes from both the parents responsible for the same trait e. The genome analysis of a person can identify the defective codes that can lead to development of a disease or disorder, called risk factors. If genome of a person is known, vulnerability of that person to diseases can be taken care of through prevention and control of the environmental factors that trigger that disease. DNA expression of traits is greatly affected by the environments. Epigenetics is the science that researches the effect of environments on the gene expression. The environments that affect gene expression include pollution, radiation, chemicals, and social habits like smoking, drinking, work and food habits. At present almost diseases and disorders have been traced back to abnormal genetics due to missing, incorrect, or modified DNA code s through mutations disorders of DNA that may be inherited or occur during the life time of a person abruptly or over a period. The most common genetic diseases are sickle cell anemia, cystic fibrosis, Duchenne Muscular Dystrophy DMD , Huntington Disease HD , breast cancer, prostate cancer, Down syndrome, and several others that owe their origin to error, substitution, addition, deletion, and modification of inherited DNA codes. An effort is in continuum to treat these diseases through stem cells and inserting correct DNA codes for the defective or missing codes. Some tests are now routinely performed during prenatal and on birth to detect any genetic abnormality and treat or manage it accordingly. Twenty-four GPS satellites currently orbit Earth and transmit signals to GPS receivers, which determine the location, direction, and speed of the receiver. GPS has multitude of applications in several disciplines. Its main function is to track the location of the signal transmitting unit and has been extensively used in navigation of ships, airplanes and now automobiles. Its use in healthcare is a recent event and is still on the rise. In the retail supply chain, RFID is already well established as a way to reduce theft and track objects from manufacture through shipment to delivery. For a variety of reasons, adoption of RFID by healthcare has been sluggish because the payback is less immediately visible than what most companies prefer. Basic RFID is already being used to track patients for anti-elopement and anti-abduction programs. RFID is also beginning to show use to provide more extensive patient identification than traditional bar coding can, and to track and locate capital equipment within the hospital. In years to come, RFID could be used for a variety of applications, including counterfeiting of medical products. Telemedicine includes a growing variety of applications and services using two-way video, email, smart phones, wireless tools and other forms of telecommunications

technology. Major benefits of Telemedicine include improved access to healthcare, cost effectiveness, improved quality and patient demand, especially in rural and remote areas while its constraints are lack of infrastructure and reimbursement from the third-party payers. This would shift the emphasis from opinion-based medical practice to evidence-based medical practice. Point a provider to the reference material and information. Identify possible risks for adverse events and errors. Raise alerts and provide reminders. Encourage adherence to standards. Constraints to CDS may include: Patient data accuracy – patient data must be entered consistently and accurately for a CDS to contain the latest information. CDS system accuracy – the CDS system needs to be intelligent enough to be able to identify similar cases and present to the user when requested. Alert fatigue – a CDS system must not produce too many alerts otherwise user suffers from alert fatigue and develops a tendency to ignore. Usability – CDS systems are often vendor-specific and do not integrate well with other systems and hence the user may choose not to use the CDS when it starts becoming nuisance instead of aid. Although still in infancy, its potential for managing chronic illnesses of the aging population is becoming evident. Its existing examples include linkages with blood pressure monitors, glucose monitors, weight scales, pulse oximeters, etc. The healthcare can benefit from cloud computing in terms of: Scalable hardware – hardware resources can be turned on based on need. Efficiency and performance – since servers are virtualized, different instances can reside on the same hardware and also moved around depending on the need to make the best use of hardware without compromising performance.

9: Comparisons of Health Care Systems in the United States, Germany and Canada

The prosperity of the 2nd century CE gave way in the 3rd century to a period of civil war, barbarian invasions and conflict with foreign armies. These disrupted agriculture, trade, and production and damaged the flow of taxes and troops.

Perhaps the most rudimentary form of the hospital prior to this were the healing temples of ancient Greece. Healing temples were sacred sites created for the sick to receive divine aid. They were often associated with public baths and spa-type facilities whose priest-physicians administered rituals of healing, massage, and herbal medicines. Overall, Greek medicine combined a philosophy of proper living, with regular exercise, proper diet, and massage, augmented by herbal drugs and regular visits to a healing temple for ritual devotions and tribute. Physicians, surgeons, and other specialists would typically provide specific treatments including surgeries and amputations at the home of the patient. Both Greek and Roman cultures were engaged in bloody wars and found it necessary to make advances in the medical treatment of wounds and illnesses. The Roman Empire was built by and dependent upon its powerful military, and although it was not a physician-friendly society, it did advance the concept of the military hospital, as well as the public water supply and sanitation systems. Later, as Christianity spread throughout the Roman world, charitable institutions for the poor and societal outcasts such as lepers and plague sufferers were established, and they gradually developed into charitable hospitals that offered various medical treatments for patients and medical training for physicians in several Roman cities. When Roman civilization declined and fell, education, medicine, and medical facilities also declined, and they did not recover to even the levels reached in late Rome until well after the Renaissance.

Background The historical time period from b. The earliest civilizations of Mesopotamia, Egypt, Greece, and Rome grew from their military successes, and they were plagued by periodic wars, dependent upon slavery, and dominated by ritual pagan religions. Texts from the earlier Sumerian and Egyptian civilizations contain instructions for the treatment of physical wounds, and include herbal-based medicines for various internal illnesses. Their medicine and religion were closely interrelated and virtually inseparable. They sought divine aid from their gods of war and healing, and their drugs were herbal-based concoctions and likely of a limited effectiveness. They practiced *haruspicy*—divination by examination of animal entrails—chanted incantations, and displayed amulets, often in temples or at ritual altars. More elaborate medical treatments were performed by priest-physicians at the estate of the affluent patient, or at a temple visited by the lower-class patients. These temples were the closest approximation to any known medical facility in the Mediterranean and Middle Eastern civilizations prior to the first century b. The Code of Hammurabi indicates that Sumerian medicine included prescribed medical treatments, use of medical instruments, and regulations such as the charging of fees and penalties for therapeutic failures. Egyptian medicine and religion were both state-controlled hierarchies, and their concept of health included the belief that diseases are caused by spirits, intestinal putrefaction, or worms. Medicine and religion were closely connected: Some of the Sumerian and Egyptian surgical instruments that have been found were used to lance abscesses, cauterize infections and wounds, and were combined with many drugs and antiseptics of vegetable and mineral origins. These civilizations did not establish any facilities for medical care or treatment. By the fifth century b. Greek medicine was practiced by a range of folk healers and priest-physicians who also used a combination of ritual divination procedures and applications of herbal-based drugs. While clearly influenced by Egyptian medicine initially, the Greeks began to develop a more open and secular approach to health and disease. Greek culture emphasized the benefits of rigorous exercise and proper diet to develop a healthy body and mind, and the sacredness of healing is evidenced by their reliance on their gods of healing and disease, such as Apollo, and his son Asclepius. The cult of Asclepius gradually gained widespread following throughout the Greek world, and hundreds of Asclepian healing temples were built and visited by the sick and injured. The temples were located in salubrious locations near springs, and their priests were trained in the use of mineral baths, massage, diet, and herbal drugs. The patient paid tribute and made a request of the god, then slept within the confines of the temple, probably aided by an opiate, and the god would visit in a dream. The patient would wake in the

morning and have his dreams interpreted by a priest-physician, who would then perform the proper animal sacrifice and administer an herbal medicine as a cure. The healing temples became associated with the bath or spa, where exercise, massage, mineral baths, and various herbal medicines were employed vigorously and combined with the Greek doctrine of proper diet and moral philosophy perhaps even psychotherapy. The preventive and therapeutic benefits of this approach to health were likely to do no harm at the least and probably offered substantial health improvements in many cases. While healers of various types had their shops and physicians and surgeons apparently associated with apothecaries on contract basis, there were no facilities that could be construed as public hospitals. The Hippocratic school of medicine, which advocated the careful study of the patient and the illness, can be considered the first major advance in medical care and treatment, and it began the separation of medicine from religion. Hippocratic medicine was based on the bedside visit and careful physical examination, with cautious drug therapies and strict dietary regulations. Heroic intervention and risky procedures were rejected, although specialists trained in wound treatments, fractures, and amputations were allowed to perform their necessary functions in extreme cases. Hippocrates advocated a proper moral philosophy, bathing, sex, and sleep. However, for all the intellectual interest they had in medicine, the ancient Greeks had little interest in hospitals. Roman cities and towns also constructed sanitary drainage systems and large aqueducts to provide clean water supplies. When Rome fell, it was plagued by a failure of its drainage systems and the subsequent increase in associated diseases, notably malaria. After Rome, it was not until the seventeenth century that Europe saw the existence of any public hospitals and medical facilities, and the standards of urban sanitation climbed back to the levels that Rome enjoyed at its pinnacle. Impact As the roots of Western medicine were being established in ancient Greece, a gradual demystification of illnesses and a separation of medicine and disease from religious doctrine and divine causes began. Greek culture was dominated by wars with its neighboring city-states, which necessitated improved medical treatment of arrow and sword wounds. Greek war heroes were also described as skilled healers, and a strong mythical and religious connection was attached to all healing and medical treatments. Medicine practiced in the third century b. Medical treatment at this time was as advanced as any in seventeenth-century Europe, but in both cases the societies lacked any type of hospital facilities. The medicine practiced in Rome was largely of Greek origin, with both male and female physicians. Initially, Roman leaders accused the newly arriving Greek physicians of being little more than paid killers. Romans believed disease, famine, and pestilence to be the wrath of vengeful and angry gods. As the need for improved health care continued to grow in Rome, Greek medicine became more prevalent as Greek medical sects and healing cults became more widespread. The Romans of course also valued the same preventive approaches endorsed by Greek culture and medicine: As towns enlarged into cities with large populations and trading centers, Roman public officials recognized the correlation between disease and hygiene. Public granaries were strictly regulated for cleanliness; public latrines and plumbed sanitation to control sewage were established in many Roman areas; and a good, clean, reliable water source was a prime directive of public works in Roman cities. Though none of these constructs were hospitals or medical treatment facilities, they are the precursors of institutions built for the health benefits of the general public. The Roman ethic of military organization and improvement extended from the battlefield to the development of the standard military hospital. The sick and wounded were treated in buildings set aside for this purpose, with large, well lit halls that had individual cells and larger rooms set off of the corridors, as well as baths, latrines, and food-preparation areas. Roman soldiers and officers were treated with respect and honor, and this was certainly extended to their proper medical treatment. Roman military hospitals have been found as far north as the Rhine river in Germany. Surgeries, splints, drainage tubes, and healing salves were applied to wounds. This was also true for Roman gladiators, who received care from the best Roman physicians, including Galen c. When Christianity began to replace the Roman pagan faith, one of its most powerful tools of persuasion was its appeal to the poor, sick, and lame, who were promised the miraculous healing powers of Christ. Though the Church doctrine subordinated medicine to theology and the physician to the priest, the obligation of charity became very strong. Alms for the needy led to houses for the poor and for lepers, such as the ones established by the Church of Rome in a. Christianity employed the use of holy relics, oils, and baptisms, as well as the retelling of the Bible stories of

healing miracles, but many Christian converts sought to do more. In Roman towns, churches and monasteries began to carry the burden of charity and medical care for the poor and needy. It is believed that at the Monastery of the Pantokrator in the Greek town of Caesarea a. In Rome, a student of Saint Jerome became well known for her incredible acts of charity. She is said to have bodily carried even the most filthy and wretched off the streets, washing and caring for them herself, and she is credited with having established a public clinic for the poor and sick in Rome a. Important hospitals were also founded by the churches and monasteries of Edessa , Monte Cassino , Iona , Ephesus , and St. These hospitals became large complexes that included a hierarchy of physicians and specialists, with hundreds of beds, as well as teaching facilities, and homes for the poor, elderly, and lepers. The hospital in Jerusalem had over beds by the mid-sixth century, and St. When the city of Rome was sacked by Alaric the Goth in a. As the populations of its towns and cities dwindled, education and medicine suffered similar fates, and Europe slipped into many centuries of decline. The empire of the East, centered in Byzantium, remained strong and continued the traditions of medicine, as did the growing Islamic and Jewish communities. Medicine in these areas was reinvigorated by the addition of new ideas to the Greek and Roman traditions. But without the wealth of the Roman Empire, the hospitals of the Mediterranean area declined and disappeared, and did not return until the twelfth through the fourteenth centuries, when urban hospitals were created as charitable establishments by the ruling princes and patricians of Europe. Source Book of Medical History. The Greatest Benefit to Mankind: A MedicalHistory of Humanity. Norton and Company, Cite this article Pick a style below, and copy the text for your bibliography. Understanding the Social Significance of Scientific Discovery. Retrieved November 15, from Encyclopedia. Then, copy and paste the text into your bibliography or works cited list. Because each style has its own formatting nuances that evolve over time and not all information is available for every reference entry or article, Encyclopedia.

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