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Opinion Article

Advancements of Clinical Technology in Healthcare Systems

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DESCRIPTION

The clinical definition of death and the procedures for establishing when clinical death has occurred have come under scrutiny because of developments in chemical and mechanical life-sustaining techniques. Medical technology has put the standards for judging death on a moral and medical level to the test. Some now emphasize "brain death" rather than the stoppage of the heart and breathing as the criteria for diagnosing clinical death due to technological advancements in healthcare [1]. The difficulty of transitioning from brain death to cardiac and respiratory cessation highlights the limitations of current ethical and medical standards in the face of technological advancement. Before a wise decision is reached, the circumstances of each situation must be properly "limned." Several moralists hold that an artificial measure is considered unusual even if it is not of a Jeri mental nature if it offers no chance of meaningful fit in a specific therapeutic circumstance.

We could apply the moral distinction between extraordinary and ordinary methods to the general treatment of the sick as well as the rights of the individual to choose whether or not extraordinary measures are ethically necessary. There are typically few to no questions after this diagnosis. There are currently significant differences in the diagnosis criteria used in each country, and thus in their legal regulations, despite the fact that science has advanced over the past few decades, including advancements in life-support technology. This can lead to misunderstandings among the general public and even among healthcare professionals. To prevent performing pointless medical procedures on patients who have already passed away, it is crucial to determine the moment of death [2].

Additionally, it's critical to do this to guarantee the transparency and clarity of the organ donation process. Most people experience death after their cardiorespiratory system has completely stopped working. Scientific evidence now shows that death was caused by the irreversible loss of brain functions, whether from an intracranial source or an extracranial origin. In order to tolerate differences, the minimal criteria for determining death should be strict, universal, and accepted in all fields of medicine. To preserve public trust, advance moral behavior that upholds people's fundamental rights, and advance high-quality healthcare, it is crucial to reach universal agreement on the clinical criteria for determining death [3].

However, there are some situations where using instrumental tests ought to be required. First, instrumental tests are required to confirm a lack of function in the hemisphere areas in situations containing a primary infratentorial lesion. Second, in cases without basic infratentorial injuries, instrumental tests might even be required. For instance, it might be hard to do the required clinical evaluations on a patient whose eyes have been damaged in specific circumstances [4].

Therefore, instrumental testing should be carried out under these circumstances. There is no one instrumental test that is suitable for all circumstances; the test to use should be determined by the situation, the pathology, and the available resources. Since test reliability might vary depending on the test administrator, it's crucial to make sure the test is given by someone who has the right qualifications to produce accurate findings. The determination of death should be delayed until the patient experiences cardio circulatory arrest, at which point the cardio circulatory arrest algorithm should be used to make the decision [5].

REFERENCES

1. Baird M, Daugherty L, Kumar KB, Arifkhanova A. Regional and gender differences and trends in the anaesthesiologist workforce. Anaesthesiology. 2015, 123(5):997-1012.
2. Bissing MA, Lange EM, Davila WF, Wong CA, McCarthy RJ, Stock MC et,. al. Status of women in academic anaesthesiology: a 10-year update. Anesth Analg. 2019;128(1):137-143.
3. Hamel MB, Ingelfinger JR, Phimister E, Solomon CG. Women in academic medicine—progress and challenges. N Engl J Med. 2006;355(3):310-312.
4. Jena AB, Olenski AR, Blumenthal DM. Sex differences in physician salary in US public medical schools. JAMA Intern Med. 2016;176(9): 1294-1304.
5. Maxwell JH, Randall JA, Dermody SM, Hussaini AS, Rao H, Nathan AS et,. al. Gender and compensation among surgical specialties in the Veterans Health Administration. Am J Surg. 2020;220(2):256-261.

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