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Knowledge Qualities of Medical Practitioners and Gynecology

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Abstract

The paper addresses a fundamental question about medical practitioners including Gynecologists. In other words, it is aimed to be answered, what constitutes the knowledge adequacy of a medical practitioner? In the attempt to answer it, the thesis draws from Derrida and uses well developed theories of management. It is proved that any answer is complicated and derives from how a medical practitioner considers the limits of a disease, the woman's health nature and the kind of language that he or she develops around a specific health illness. Moreover, the current theoretical research addresses the importance of realizing a specific woman's nature on extreme or lethal health issues, the restrictions that are imposed by the relevant medical community and the need for a personalized health service adjusted to a specific patient's demands of a medical case.

Introduction

The today's world constantly re-orientates the existence and meaning of human life. A medical practitioner is encouraged to work under contradictive circumstances achieving maximum results. That often translates to be innovative, highly skillful, flexible and intelligent. In other words, the medical practitioner works under heavy duty conditions facing manifold dilemmas, internal and external conflicts. For instance, she or he has to be communicative and, at the same time, decisive when it comes down to significant life-threatening situations. Medical Practitioners have to share with colleagues and retain pieces of knowledge for themselves. They have to follow specific operational rules of practice and, at the same time, direct the course of their actions in a highly idiosyncratic way of behavior under one particular cultural and working environment. All those issues, which have been well described by Foucault [1,2], preserve the power (ability to enforce an expert's view over others) of knowledge as an expert. That means that a working medical environment imposes its own limitations on the medical practice. This can be a certain way of perceiving and interpreting information of a medical case to the manners that a clinician follows on communicating with colleagues, caregivers and the administrative staff of a medical center. Every act and decision by medical staff has an impact and plays a significant role in the final quality of knowledge that is applied to a patient's indisposition. Thus, the gynecological and medical staff that facilitate women's baby delivery and health issues. They are encouraged/enforced to a certain mannerism and a cognitive perception which are related to a woman's nature, her role as mother, her place in a specific community or even society and the localized cultural norms that dominate a medical center. Based on that kind of understanding, this article seeks to explore and articulate what are the primary qualities of knowledge that should be considered adequate by medical specialists' to the cure of a nonroutine and a life-threatening sickness of patience?

Research in management had attempted to answer the question described above from different perspectives. For instance, studies in Knowledge innovative firms show that high skillful practitioners are considered to achieve adequacy of their knowledge when they obtain great income and great recognition by the community of their practice [3,4]. These two factors often determine a series of choices that researchers undertake about the lives and objectives of highly educated and innovative staff. Thus, the research provides a certain manufactured view of a "successful" typo that is based on assumptions that have proved often to be of great distance by the reality itself. The main reason is identified, that the assumptions constructed upon certain predispositions which change and are challenged accordingly, each time, by the pragmatic conditions which are scientifically examined [5]. Furthermore, Deleuze and Guattari [6] have concluded that ethical and cultural norms differ considerably between individuals of a similar medical practice since, each individual constantly re-positions and manifests a reality that

suits to unique and idiosyncratic aspects of his/her personality and development.

In other words, the qualities of medical knowledge that are developed and applied by doctors and trained caregivers to (life-threatening) patients preserve great diversification among individuals. Despite the above conclusions, the dominant example of medical practice and research remains stubbornly a "logocentric" [7]. That means that medical research counts on a repeated analytical methodology-the close observation of a patient's state, the recognition of its local causes and the effects of an illness. This subsequently reaches a (cognitive, methodological, ideological) pattern and plan as a prescription of treatment even to the rarest kind of diseases. In other words, surprisingly enough, all diseases and all natures of the human body, for examlpe an adult's woman in contrast to a man's or a child's. They are dealt with medical practice under the same glasses of perception, analysis, and rehabilitation. This dominantly logical paradigm, in medicine, is accompanied by subsequent research which repeatedly counts on the mentioned pattern of thought.

Moreover, medical research finds out the self-verification of their initial hypothesis [8,9]. Thus, it is often marginalized some incidents which often play a pivotal role in shaping, consciously/unconsciously/unexpectedly, the experiences and skills of doctors and nurses within their medical professions. They are cases which have to do with unexpected complications of bodies and the human organism. Also, they are required to be transcended following a non-"legalized" prescription of treatments according to international or national medical protocol. The catalog of such cases varies greatly and includes medical accidents, body malfunctions, wrong diagnoses, new kind of bug infections, gene's problems and unforeseen psychological factors which lead routine clinical cases to inconceivably medical complications. Also, yet, under those critical and extreme conditions of medical attentiveness. The appropriate therapy is faced by the dominant paradigm of research and medicine as a standard process of healing. Thus, it is suppressed the fact that cure is a highly individualized process that depends on the specialists' unique perceptions, their abilities to unlearn and relearn-fastly-new routes of medical practices. Hence, it is required their ability to try out and test a novel hypothesis so as their skills to conceptualize constantly new methods and different medical praxises.

In other words, it is under the above mentioned excessive-untypical and unforeseen-conditions, that doctors and nursing staff surpass themselves, their previously applied standard medical knowledge, and transform it into novel, unpredictable and tacit formulations. In that way, medical adequacy of knowledge is synthesized based on a personified space of knowledge which depends on the minds and hearts of medical practitioners. Hence, this type of new formulated knowledge is founded on a constantly evoking, evolving and manifested medical practice within difficult or irremediable medical conditions of a patient. It resolves itself around a new type of medically constructed language which includes fake/true incidents and manifold medical theories, practicalities and generic vs. idiosyncratic rules of actions. This kind of language has a strong printing effect within any knowledgeable practitioner of healing. Since, it perpetually re-organizes, differs and adds new conceptualizations to past categories of knowledge.

Therefore, it is a visible and a tacit kind of languages' styles, rules and categories that run parallel, underneath, and cut through a dominant adopted model of medical language that it presented by doctor's and practitioners within a localized medical domain. Hence, such as in gynecology, the adequacy of medical knowledge is tested and recreated by facing extreme, emergent and incurable illnesses. It relies and depends on a pluralistic system of languages that act as interim and provisional forms of categories between what is dreamed off and what be finally achieved to the case of a (woman) patience [10]. Thus, undeniably, in the end, it is the excessive efforts and abilities of doctors, nursery staff and patients that allow specific medical unique solutions to evoke offering sufficient care and support.

In correlation to the above said, it is vital that extreme health problems do not follow regulatory patterns of medical responses [8,11]. As a result, patients that suffer from irreversible consequences of a disease, they are marginalized and are viewed by the medical community as subjects of an isolated and a future study. Despite that, doctors and nurses are nudged by their personal and professional interest. In that process, they understand better and correlate themselves with the idiosyncratic nature of a unique health issue. They achieve to intervene, mix and transform past common medical knowledge to new sustainable ideas. In other words, the adequacy of a medical practitioner's experience relies on his or her desire and ability to re-construct constantly new viable prescriptions of a language that offers a higher than before soothing to significant health problems. Thus, it can be claimed that Knowledge adequacy of medical staff relies on their tacit and idiosyncratic capacity to foresee a medical condition and to respond quickly and efficiently before it unfolds. Hence, to provide, quite often, a differed course of treatment-without violating widely acceptable medical protocols.

In fact, it is most true than not, that a vast majority of medically prescribed treatments do not follow a regulatory pattern of anticipated therapeutic responses. Because each medical case is composed uniquely by both chaotic and pragmatic circumstances. Thus, adequacy of medical knowledge is achieved when staff are able to perpetually re-shape themselves, their skills, their attitudes and their knowledge to innovative courses of actions and conceptualizations. These are manifestations which did not occupy medical staff' recollection previously and their existent medicated body of knowledge. These medical kinds of risks might lead to permanent health damages to patients as it occurs

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to extreme or incurable diseases. However, they propel health staff to advance and to reposition themselves towards their own limits and general medical rules of the medical community.

Consequently, with time, always new narratives are prescribed becoming acceptable between members of a medical branch- such as gynecologists-and medical staff which is imposed by externalized medical necessities. These, so often, refer to new kinds of technology that promise better than the past therapies - for instance, the rediscovery of woman's nature and its orientation. However, at the same time, those new medical inventions and theories undergo a renewed cycle of demolition and re-constitution within the individual mental space of a medical practitioner [12]. In other words, any acclaimed adequacy of therapeutic medical knowledge lacks stable and vital meanings and rules of actions which would allow them to retain permanency through the future's long term medicine practice and substantial consideration of a patient's therapy. As a result, the most convincing medical arguments suffer from misapprehension, and inadequacies, especially, when they come down to extreme or incurable medical diseases. In other words, they become subjects that doctors, uninterruptedly, aim to transcend to find out the next new or more advanced than previously believed medical solution. This is reflected on the study of Anderson and Goolishian [13] who address the agony of medical practitioners as they continually revisit their unassailable body of medical knowledge and manifest, each time, a slightly different, from a previously known, prescription of health care.

Furthermore, this written work proposes that the adequacy of the medical staff's knowledge depends considerably on his or her imagination and ability to see beyond the idol of a sickness-upon the glass [14]. It is always the incredible desire of doctors, care attendants, and administrative staff to make the impossible a reality. Thus, to perform a "miracle" by turning their dream into a viable truth. This act of daring and violation. It aims to obey the medical rules of scientifically acceptable knowledge.

Moreover, at the same time, it demands to reconstruct the existing rules and perceptions of healing time, space and substances. In this line of thought, the end of medicine lies on constructing that kind of technology and human knowledge which would be able to cure every type of disease. This proposition, therefore, manifests the orientation and the origins of the medical profession and practice. So it is toward that supreme-imaginary, fake, ineffective- condition that human health's knowledge performs as a medical profession. Therefore, it is argued that medical practice counts on some fake-oneiric-origins of knowledge to reveal the truth-as a true nature of human disease. In other words, the medical practice faces the ultimate threat of chasing ghosts, seeing the impossible and believing in a full scale and complete therapy of any human bodily and mental disposition. And this is because, like all sciences, medicine counts on linguistic constitutions which offer temporary, small-scaled reassurances without being able to unravel, once and forever, any definitive truth about health reality itself [15].

Consequently, it is proposed that medical practice should turn its attention contemplating and recognizing, on each case, its limitations. It needs to de-construct to re-compose new medical categories, theories, and methods of knowledge. Only, in that way, it would be possible medicine to raise advantages towards current miscomprehensions of medical cases and elliptic conceptualizations. Thus, through this article, it is suggested that medicine aims to become the primary vehicle, not only of studying a specific stage of a disease providing an adequate solution. However, medicine re-opens the consideration of human nature, its limits and its countless possibilities seeking to transgress human behavior into a self-responsive and ethically efficient community of medical practice. In that framework, it is proposed that gynecology should claim to pinpoint the unique bodily conditions a female's nature and its mentality. So to excel them by manifesting new conditions of therapy through personified models of medical treatment.

Therefore, the current thesis argues that medical practice (and gynecology) should seek and count on a knowledge that examines and frames the human nature. It should repeatedly determine medical processes, abilities, materials and staff' imagination. Therefore, it is claimed that doctors, nurses, medical staff and the medical, scientific community ought to scrutinize and elevate the conditions that turn a "healthy" situation into a human sick mindful body. Hence, medical attention, especially for women, needs to be many-vocal, multi-languaged and to incorporate the spirit, ethos, and mentality under which a body concludes unwell. In that way, it is preserved the right the medical practice of gynecology to enforce a new perspective of a woman's nature which aims to reflect and understand itself, its deferred conditions of health and its way of life.

Author's Short Biography

Dimitris Lamproulis has completed his PhD in the University of Aberdeen, UK. His thesis refers to in use values and the creation of knowledge that transforms into innovations. He has participated in numerous conferences and, he has published articles to DMI, EJBO, Journal of Organizational knowledge Management and Journal of knowledge Management. Also, he is a Lecturer to Technological Educational Institution in Larisa, Greece. His research focuses on the areas of knowledge creation, innovation, organizational culture.

References

1. Foucault M (1969) The Archaeology of Knowledge. Gallimard, France.
2. Foucault M (1973) The Birth of Clinic. Routledge, London.
3. Alvesson M (2000) Social identity and the problem of Loyalty in knowledge-intensive firms. Journal of management studies, 37(8): 1101-1123.
4. Brown AD, Kornberger M, Clegg SR, Carter C (2010) Invisible walls" and "silent hierarchies": A case study of power relations in an architecture firm. Human Relations 63(4): 525-549.
5. Heidegger M (1962) Being and time, trans. In: J Macquarrie, E Robinson (Eds.), Greece.

6. Deleuze G, Guattari F (1983) AntiOedipus: Schizophrenia and Capitalism, Minneapolis. University of Minnesota Press, Chicago.
7. Derrida J (1974) Of Grammatology. The Johns Hopkins University Press, USA, p. 560.
8. Funtowicz SO, Ravetz JR (1992) Science for the post-normal age. Futures 25(7): 739-755.
9. May C (2007) The Clinical Encounter and the Problem of Context. Sociology 41(1): 29-45.
10. Bakhtin MMs (1981) The Dialogic Imagination Summary. University Texas Press, USA.
11. Clegg SR, Kornberger M, Rhodes C (2005) Learning/Becoming/Organizing. Organization 12(2): 147-167.
12. Clegg SR, Rhodes C, Kornberger M (2007) Desperately Seeking Legitimacy: Organizational Identity and Emerging Industries. Organization Studies 28(4): 495- 513.
13. Anderson H, Goolishian H (1992) The client is the expert: A not-knowing approach to therapy. In: McNamee S, Gergen K (Eds.), Social construction and the therapeutic process, pp. 25-39.
14. Derrida J (1967) writing and Difference. The University of Chicago Press, Routledge, USA, p. 362.
15. Lamproulis D (2017) A Linguistic Perspective of Knowledge Creation, Sharing and Its Novel Implementation. Journal of Organizational Knowledge Management, pp. 1-23.

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