# DOWNLOAD PDF MEDICINE IN SEARCH OF MEANING

## Chapter 1 : Medicine - Wikipedia

*practice of medicine, medicine - the learned profession that is mastered by graduate training in a medical school and that is devoted to preventing or alleviating or curing diseases and injuries; "he studied medicine at Harvard".*

In contrast, physicians in previous generations, such as the 17th-century physician Thomas Sydenham , who is known as the father of English medicine or "the English Hippocrates", had developed nosology the study of diseases via the clinical approach to diagnosis and management, by careful bedside study of the natural history of diseases and their treatment. Thus, the name "internal medicine" was adopted in imitation of the existing German term. The American College of Physicians defines internists as "physicians who specialize in the prevention, detection and treatment of illnesses in adults". Pressures on time have led to many internal medicine physicians to choose one practice setting, who may choose to practice only in the hospital, as a " hospitalist ", or only in an outpatient clinic, as a primary care physician. Medical education The training and career pathways for internists vary considerably across the world. Many programs require previous undergraduate education prior to medical school admission. This "pre-medical" education is typically four or five years in length. Graduate medical education programs vary in length by country. Medical education programs are tertiary -level courses , undertaken at a medical school attached to a university. In the United States, medical school consists of four years. Hence, gaining a basic medical education may typically take eight years, depending on jurisdiction and university. Following completion of entry-level training, newly graduated medical practitioners are often required to undertake a period of supervised practice before the licensure , or registration, is granted, typically one or two years. This period may be referred to as " internship ", "conditional registration", or " foundation programme ". Then, doctors may finally follow specialty training in internal medicine if they wish, typically being selected to training programs through competition. In North America, this period of postgraduate training is referred to as residency training , followed by an optional fellowship if the internist decides to train in a subspecialty. In Commonwealth countries, during that training period in internal medicine, trainees are often called senior house officers, and advance to registrar grade when they undergo a compulsory subspecialty training whilst commonly continuing service provision in the main speciality. In the United States, residency training for internal medicine lasts three years. Subspecialties[ edit ] The examples and perspective in this section may not represent a worldwide view of the subject. You may improve this article , discuss the issue on the talk page , or create a new article , as appropriate. December United States[ edit ] In the United States, two organizations are responsible for certification of subspecialists within the field: Physicians not only internists who successfully pass board exams get "board certified" status. American Board of Internal Medicine[ edit ].

## Chapter 2 : ASAM Definition of Addiction

*medical record administrator one responsible for the indexing, recording, and storage of medical records and reports of patients admitted to hospitals and other health care agencies, and who also prepares reports of births, deaths, transfers, and discharges of patients, and of treatments received.*

Aerospace medicine deals with medical problems related to flying and space travel. Addiction medicine deals with the treatment of addiction. Medical ethics deals with ethical and moral principles that apply values and judgments to the practice of medicine. Biomedical Engineering is a field dealing with the application of engineering principles to medical practice. Clinical pharmacology is concerned with how systems of therapeutics interact with patients. Conservation medicine studies the relationship between human and animal health, and environmental conditions. Also known as ecological medicine, environmental medicine , or medical geology. Disaster medicine deals with medical aspects of emergency preparedness, disaster mitigation and management. Diving medicine or hyperbaric medicine is the prevention and treatment of diving-related problems. Evolutionary medicine is a perspective on medicine derived through applying evolutionary theory. Forensic medicine deals with medical questions in legal context, such as determination of the time and cause of death, type of weapon used to inflict trauma, reconstruction of the facial features using remains of deceased skull thus aiding identification. Gender-based medicine studies the biological and physiological differences between the human sexes and how that affects differences in disease. Hospice and Palliative Medicine is a relatively modern branch of clinical medicine that deals with pain and symptom relief and emotional support in patients with terminal illnesses including cancer and heart failure. Hospital medicine is the general medical care of hospitalized patients. Physicians whose primary professional focus is hospital medicine are called hospitalists in the United States and Canada. Laser medicine involves the use of lasers in the diagnostics or treatment of various conditions. Medical humanities includes the humanities literature , philosophy , ethics , history and religion , social science anthropology , cultural studies , psychology , sociology , and the arts literature , theater, film, and visual arts and their application to medical education and practice. Health informatics is a relatively recent field that deal with the application of computers and information technology to medicine. Nosology is the classification of diseases for various purposes. Occupational medicine is the provision of health advice to organizations and individuals to ensure that the highest standards of health and safety at work can be achieved and maintained. Pain management also called pain medicine , or algiatry is the medical discipline concerned with the relief of pain. Pharmacogenomics is a form of individualized medicine. Podiatric medicine is the study of, diagnosis, and medical treatment of disorders of the foot, ankle, lower limb, hip and lower back. Sexual medicine is concerned with diagnosing, assessing and treating all disorders related to sexuality. Therapeutics is the field, more commonly referenced in earlier periods of history, of the various remedies that can be used to treat disease and promote health. Tropical medicine deals with the prevention and treatment of tropical diseases. It is studied separately in temperate climates where those diseases are quite unfamiliar to medical practitioners and their local clinical needs. Urgent care focuses on delivery of unscheduled, walk-in care outside of the hospital emergency department for injuries and illnesses that are not severe enough to require care in an emergency department. In some jurisdictions this function is combined with the emergency department. Veterinary medicine ; veterinarians apply similar techniques as physicians to the care of animals. Wilderness medicine entails the practice of medicine in the wild, where conventional medical facilities may not be available. Many other health science fields, e. Medical education and Medical license Medical students learning about stitches Medical education and training varies around the world. It typically involves entry level education at a university medical school , followed by a period of supervised practice or internship , or residency. This can be followed by postgraduate vocational training. A variety of teaching methods have been employed in medical education, still itself a focus of active research. Since knowledge, techniques, and medical technology continue to evolve at a rapid rate, many regulatory authorities require continuing medical education. Medical practitioners upgrade their knowledge in various ways, including medical journals , seminars, conferences, and online programs. A database of objectives covering

medical knowledge, as suggested by national societies across the United States, can be searched at http: In general, this entails a medical degree from a university and accreditation by a medical board or an equivalent national organization, which may ask the applicant to pass exams. This restricts the considerable legal authority of the medical profession to physicians that are trained and qualified by national standards. It is also intended as an assurance to patients and as a safeguard against charlatans that practice inadequate medicine for personal gain. While the laws generally require medical doctors to be trained in "evidence based", Western, or Hippocratic Medicine, they are not intended to discourage different paradigms of health. In the European Union, the profession of doctor of medicine is regulated. A profession is said to be regulated when access and exercise is subject to the possession of a specific professional qualification. The regulated professions database contains a list of regulated professions for doctor of medicine in the EU member states, EEA countries and Switzerland. Doctors who are negligent or intentionally harmful in their care of patients can face charges of medical malpractice and be subject to civil, criminal, or professional sanctions.

## Chapter 3 : Search | Definition of Search by Merriam-Webster

*The online Medical Dictionary on blog.quintoapp.com allows alphabetical browsing in the combined electronic versions of more than one authoritative medical reference, insuring access to correct spellings, as well as immediate, direct access to a known search term typed into the search box on the site: A medical dictionary reveals that large numbers.*

The treatment of many human disease conditions requires surgical intervention in order to assist, augment, sustain, or replace a diseased organ, and such procedures involve the use of materials foreign to the body. These materials, known as biomaterials, include synthetic polymers and, to aâ€¦ Organization of health services It is generally the goal of most countries to have their health services organized in such a way to ensure that individuals, families, and communities obtain the maximum benefit from current knowledge and technology available for the promotion, maintenance, and restoration of health. In order to play their part in this process, governments and other agencies are faced with numerous tasks, including the following: Health services of any nature reflect a number of interrelated characteristics, among which the most obvious, but not necessarily the most important from a national point of view, is the curative function; that is to say, caring for those already ill. Others include special services that deal with particular groups such as children or pregnant women and with specific needs such as nutrition or immunization; preventive services, the protection of the health both of individuals and of communities; health education; and, as mentioned above, the collection and analysis of information. Levels of health care In the curative domain there are various forms of medical practice. They may be thought of generally as forming a pyramidal structure, with three tiers representing increasing degrees of specialization and technical sophistication but catering to diminishing numbers of patients as they are filtered out of the system at a lower level. Only those patients who require special attention either for diagnosis or treatment should reach the second advisory or third specialized treatment tiers where the cost per item of service becomes increasingly higher. The first level represents primary health care , or first contact care, at which patients have their initial contact with the health-care system. The vast majority of patients can be fully dealt with at the primary level. Those who cannot are referred to the second tier secondary health care , or the referral services for the opinion of a consultant with specialized knowledge or for X-ray examinations and special tests. Secondary health care often requires the technology offered by a local or regional hospital. Increasingly, however, the radiological and laboratory services provided by hospitals are available directly to the family doctor, thus improving his service to patients and increasing its range. The third tier of health care, employing specialist services, is offered by institutions such as teaching hospitals and units devoted to the care of particular groupsâ€”women, children, patients with mental disorders, and so on. The dramatic differences in the cost of treatment at the various levels is a matter of particular importance in developing countries, where the cost of treatment for patients at the primary health-care level is usually only a small fraction of that at the third level; medical costs at any level in such countries, however, are usually borne by the government. Ideally, provision of health care at all levels will be available to all patients; such health care may be said to be universal. The well-off, both in relatively wealthy industrialized countries and in the poorer developing world, may be able to get medical attention from sources they prefer and can pay for in the private sector. The vast majority of people in most countries, however, are dependent in various ways upon health services provided by the state, to which they may contribute comparatively little or, in the case of poor countries, nothing at all. Costs of health care The costs to national economics of providing health care are considerable and have been growing at a rapidly increasing rate, especially in countries such as the United States, Germany , and Sweden; the rise in Britain has been less rapid. This trend has been the cause of major concerns in both developed and developing countries. Some of this concern is based upon the lack of any consistent evidence to show that more spending on health care produces better health. There is a movement in developing countries to replace the type of organization of health-care services that evolved during European colonial times with some less expensive, and for them, more appropriate, health-care system. In the industrialized world the growing cost of health services has caused both private and public health-care delivery systems to question current policies and to seek more economical methods of achieving their goals.

Despite expenditures, health services are not always used effectively by those who need them, and results can vary widely from community to community. In Britain, for example, between and the death rate fell by 24 percent in the wealthier sections of the population but by only half that in the most underprivileged sections of society. The achievement of good health is reliant upon more than just the quality of health care. Health entails such factors as good education, safe working conditions, a favourable environment , amenities in the home, well-integrated social services, and reasonable standards of living. In the developing countries The developing countries differ from one another culturally, socially, and economically, but what they have in common is a low average income per person, with large percentages of their populations living at or below the poverty level. Although most have a small elite class, living mainly in the cities, the largest part of their populations live in rural areas. Urban regions in developing and some developed countries in the mid- and late 20th century have developed pockets of slums, which are growing because of an influx of rural peoples. For lack of even the simplest measures, vast numbers of urban and rural poor die each year of preventable and curable diseases, often associated with poor hygiene and sanitation, impure water supplies, malnutrition , vitamin deficiencies, and chronic preventable infections. The effect of these and other deprivations is reflected by the finding that in the s the life expectancy at birth for men and women was about one-third less in Africa than it was in Europe; similarly, infant mortality in Africa was about eight times greater than in Europe. The extension of primary health-care services is therefore a high priority in the developing countries. The developing countries themselves, lacking the proper resources, have often been unable to generate or implement the plans necessary to provide required services at the village or urban poor level. It has, however, become clear that the system of health care that is appropriate for one country is often unsuitable for another. Research has established that effective health care is related to the special circumstances of the individual country, its people, culture , ideology , and economic and natural resources. The rising costs of providing health care have influenced a trend, especially among the developing nations, to promote services that employ less highly trained primary health-care personnel who can be distributed more widely in order to reach the largest possible proportion of the community. The principal medical problems to be dealt with in the developing world include undernutrition, infection, gastrointestinal disorders, and respiratory complaints, which themselves may be the result of poverty, ignorance, and poor hygiene. For the most part, these are easy to identify and to treat. Furthermore, preventive measures are usually simple and cheap. Neither treatment nor prevention requires extensive professional training: In the developed countries Those concerned with providing health care in the developed countries face a different set of problems. The diseases so prevalent in the Third World have, for the most part, been eliminated or are readily treatable. Many of the adverse environmental conditions and public health hazards have been conquered. Social services of varying degrees of adequacy have been provided. Public funds can be called upon to support the cost of medical care, and there are a variety of private insurance plans available to the consumer. Nevertheless, the funds that a government can devote to health care are limited and the cost of modern medicine continues to increase, thus putting adequate medical services beyond the reach of many. Adding to the expense of modern medical practices is the increasing demand for greater funding of health education and preventive measures specifically directed toward the poor. Harold Scarborough Administration of primary health care In many parts of the world, particularly in developing countries, people get their primary health care, or first-contact care, where available at all, from nonmedically qualified personnel; these cadres of medical auxiliaries are being trained in increasing numbers to meet overwhelming needs among rapidly growing populations. The patient seeking first-contact care can go either to a general practitioner or turn directly to a specialist. Which is the wisest choice has become a subject of some controversy. The general practitioner, however, is becoming rather rare in some developed countries. In countries where he does still exist, he is being increasingly observed as an obsolescent figure, because medicine covers an immense, rapidly changing, and complex field of which no physician can possibly master more than a small fraction. The very concept of the general practitioner, it is thus argued, may be absurd. The obvious alternative to general practice is the direct access of a patient to a specialist. If a patient has problems with vision, he goes to an eye specialist, and if he has a pain in his chest which he fears is due to his heart , he goes to a heart specialist. One objection to this plan is that the patient

often cannot know which organ is responsible for his symptoms, and the most careful physician, after doing many investigations, may remain uncertain as to the cause. Breathlessnessâ€”a common symptomâ€”may be due to heart disease , to lung disease, to anemia, or to emotional upset. Another common symptom is general malaiseâ€”feeling run-down or always tired; others are headache, chronic low backache, rheumatism, abdominal discomfort, poor appetite, and constipation. Some patients may also be overtly anxious or depressed. Among the most subtle medical skills is the ability to assess people with such symptoms and to distinguish between symptoms that are caused predominantly by emotional upset and those that are predominantly of bodily origin. A specialist may be capable of such a general assessment, but, often, with emphasis on his own subject, he fails at this point. The generalist with his broader training is often the better choice for a first diagnosis , with referral to a specialist as the next option. It is often felt that there are also practical advantages for the patient in having his own doctor , who knows about his background, who has seen him through various illnesses, and who has often looked after his family as well. This personal physician, often a generalist, is in the best position to decide when the patient should be referred to a consultant. The advantages of general practice and specialization are combined when the physician of first contact is a pediatrician. Although he sees only children and thus acquires a special knowledge of childhood maladies, he remains a generalist who looks at the whole patient. Another combination of general practice and specialization is represented by group practice, the members of which partially or fully specialize. One or more may be general practitioners, and one may be a surgeon, a second an obstetrician, a third a pediatrician, and a fourth an internist. In isolated communities group practice may be a satisfactory compromise, but in urban regions, where nearly everyone can be sent quickly to a hospital, the specialist surgeon working in a fully equipped hospital can usually provide better treatment than a general practitioner surgeon in a small clinic hospital. Medical practice in developed countries Britain Before , general practitioners in Britain settled where they could make a living. Patients fell into two main groups: In the National Health Service began operation. Under its provisions, everyone is entitled to free medical attention with a general practitioner with whom he is registered. Though general practitioners in the National Health Service are not debarred from also having private patients, these must be people who are not registered with them under the National Health Service. Any physician is free to work as a general practitioner entirely independent of the National Health Service, though there are few who do so. Almost the entire population is registered with a National Health Service general practitioner, and the vast majority automatically sees this physician, or one of his partners, when they require medical attention. A few people , mostly wealthy, while registered with a National Health Service general practitioner, regularly see another physician privately; and a few may occasionally seek a private consultation because they are dissatisfied with their National Health Service physician. A general practitioner under the National Health Service remains an independent contractor, paid by a capitation fee; that is, according to the number of people registered with him. He may work entirely from his own office, and he provides and pays his own receptionist, secretary, and other ancillary staff. Most general practitioners have one or more partners and work more and more in premises built for the purpose. Some of these structures are erected by the physicians themselves, but many are provided by the local authority, the physicians paying rent for using them. Health centres, in which groups of general practitioners work have become common. In Britain only a small minority of general practitioners can admit patients to a hospital and look after them personally. Most of this minority are in country districts, where, before the days of the National Health Service, there were cottage hospitals run by general practitioners; many of these hospitals continued to function in a similar manner. All general practitioners use such hospital facilities as X-ray departments and laboratories, and many general practitioners work in hospitals in emergency rooms casualty departments or as clinical assistants to consultants, or specialists. General practitioners are spread more evenly over the country than formerly, when there were many in the richer areas and few in the industrial towns. The maximum allowed list of National Health Service patients per doctor is 3,; the average is about 2, Patients have free choice of the physician with whom they register, with the proviso that they cannot be accepted by one who already has a full list and that a physician can refuse to accept them though such refusals are rare. In remote rural places there may be only one physician within a reasonable distance. Until the midth century it was not

unusual for the doctor in Britain to visit patients in their own homes. This enabled him to become a family doctor in fact as well as in name. In modern practice, however, a home visit is quite exceptional and is paid only to the severely disabled or seriously ill when other recourses are ruled out. All patients are normally required to go to the doctor. It has also become unusual for a personal doctor to be available during weekends or holidays. His place may be taken by one of his partners in a group practice, a provision that is reasonably satisfactory. General practitioners, however, may now use one of several commercial deputizing services that employs young doctors to be on call. Although some of these young doctors may be well experienced, patients do not generally appreciate this kind of arrangement. United States Whereas in Britain the doctor of first contact is regularly a general practitioner, in the United States the nature of first-contact care is less consistent.

## Chapter 4 : Medicine meaning in Hindi - Meaning of Medicine in Hindi - Translation

*Medical affairs, in addition to the license to operate function, provided mostly on-demand medical information services, as well as support on an adhoc basis in key external experts' engagement and internal and external medical education.*

The power of external cues to trigger craving and drug use, as well as to increase the frequency of engagement in other potentially addictive behaviors, is also a characteristic of addiction, with the hippocampus being important in memory of previous euphoric or dysphoric experiences, and with the amygdala being important in having motivation concentrate on selecting behaviors associated with these past experiences. These manifestations can occur compulsively or impulsively, as a reflection of impaired control. This can be triggered by exposure to rewarding substances and behaviors, by exposure to environmental cues to use, and by exposure to emotional stressors that trigger heightened activity in brain stress circuits. People with addiction often manifest a lower readiness to change their dysfunctional behaviors despite mounting concerns expressed by significant others in their lives; and display an apparent lack of appreciation of the magnitude of cumulative problems and complications. The profound drive or craving to use substances or engage in apparently rewarding behaviors, which is seen in many patients with addiction, underscores the compulsive or avolitional aspect of this disease. Addiction is more than a behavioral disorder. Behavioral manifestations and complications of addiction, primarily due to impaired control, can include: Cognitive changes in addiction can include: Emotional changes in addiction can include: The emotional aspects of addiction are quite complex. The state of addiction is not the same as the state of intoxication. After such an experience, there is a neurochemical rebound, in which the reward function does not simply revert to baseline, but often drops below the original levels. This is usually not consciously perceptible by the individual and is not necessarily associated with functional impairments. Over time, repeated experiences with substance use or addictive behaviors are not associated with ever increasing reward circuit activity and are not as subjectively rewarding. Once a person experiences withdrawal from drug use or comparable behaviors, there is an anxious, agitated, dysphoric and labile emotional experience, related to suboptimal reward and the recruitment of brain and hormonal stress systems, which is associated with withdrawal from virtually all pharmacological classes of addictive drugs. Simply put, addiction is not a desired condition. As addiction is a chronic disease, periods of relapse, which may interrupt spans of remission, are a common feature of addiction. It is also important to recognize that return to drug use or pathological pursuit of rewards is not inevitable. Clinical interventions can be quite effective in altering the course of addiction. Close monitoring of the behaviors of the individual and contingency management, sometimes including behavioral consequences for relapse behaviors, can contribute to positive clinical outcomes. Engagement in health promotion activities which promote personal responsibility and accountability, connection with others, and personal growth also contribute to recovery. It is important to recognize that addiction can cause disability or premature death, especially when left untreated or treated inadequately. The qualitative ways in which the brain and behavior respond to drug exposure and engagement in addictive behaviors are different at later stages of addiction than in earlier stages, indicating progression, which may not be overtly apparent. As is the case with other chronic diseases, the condition must be monitored and managed over time to: In some cases of addiction, medication management can improve treatment outcomes. In most cases of addiction, the integration of psychosocial rehabilitation and ongoing care with evidence-based pharmacological therapy provides the best results. Chronic disease management is important for minimization of episodes of relapse and their impact. Recovery is available even to persons who may not at first be able to perceive this hope, especially when the focus is on linking the health consequences to the disease of addiction. As in other health conditions, self-management, with mutual support, is very important in recovery from addiction. May 01, , Revised: December 01, Explanatory footnotes: The neurobiology of reward has been well understood for decades, whereas the neurobiology of addiction is still being explored. Most clinicians have learned of reward pathways including projections from the ventral tegmental area VTA of the brain, through the median forebrain bundle MFB , and terminating in the nucleus accumbens Nuc Acc , in which dopamine neurons are prominent. Current neuroscience recognizes that the

neurocircuitry of reward also involves a rich bi-directional circuitry connecting the nucleus accumbens and the basal forebrain. It is the reward circuitry where reward is registered, and where the most fundamental rewards such as food, hydration, sex, and nurturing exert a strong and life-sustaining influence. Alcohol, nicotine, other drugs and pathological gambling behaviors exert their initial effects by acting on the same reward circuitry that appears in the brain to make food and sex, for example, profoundly reinforcing. Other effects, such as intoxication and emotional euphoria from rewards, derive from activation of the reward circuitry. While intoxication and withdrawal are well understood through the study of reward circuitry, understanding of addiction requires understanding of a broader network of neural connections involving forebrain as well as midbrain structures. Although these characteristic features are widely present in most cases of addiction, regardless of the pharmacology of the substance use seen in addiction or the reward that is pathologically pursued, each feature may not be equally prominent in every case. The diagnosis of addiction requires a comprehensive biological, psychological, social and spiritual assessment by a trained and certified professional. In this document, the term "addictive behaviors" refers to behaviors that are commonly rewarding and are a feature in many cases of addiction. Exposure to these behaviors, just as occurs with exposure to rewarding drugs, is facilitative of the addiction process rather than causative of addiction. The state of brain anatomy and physiology is the underlying variable that is more directly causative of addiction. The anatomy the brain circuitry involved and the physiology the neuro-transmitters involved in these three modes of relapse drug- or reward-triggered relapse vs. Reward-triggered relapse also is mediated by glutamatergic circuits projecting to the nucleus accumbens from the frontal cortex. Relapse triggered by exposure to conditioned cues from the environment involves glutamate circuits, originating in frontal cortex, insula, hippocampus and amygdala projecting to mesolimbic incentive salience circuitry. Relapse triggered by exposure to stressful experiences involves brain stress circuits beyond the hypothalamic-pituitary-adrenal axis that is well known as the core of the endocrine stress system. There are two of these relapse-triggering brain stress circuits â€" one originates in noradrenergic nucleus A2 in the lateral tegmental area of the brain stem and projects to the hypothalamus, nucleus accumbens, frontal cortex, and bed nucleus of the stria terminalis, and uses norepinephrine as its neurotransmitter; the other originates in the central nucleus of the amygdala, projects to the bed nucleus of the stria terminalis and uses corticotrophin-releasing factor CRF as its neurotransmitter. Pathologically pursuing reward mentioned in the Short Version of this definition thus has multiple components. It is not necessarily the amount of exposure to the reward e. In addiction, pursuit of rewards persists, despite life problems that accumulate due to addictive behaviors, even when engagement in the behaviors ceases to be pleasurable. Similarly, in earlier stages of addiction, or even before the outward manifestations of addiction have become apparent, substance use or engagement in addictive behaviors can be an attempt to pursue relief from dysphoria; while in later stages of the disease, engagement in addictive behaviors can persist even though the behavior no longer provides relief.

## Chapter 5 : Medicine | Define Medicine at blog.quintoapp.com

*medication Any chemical substance, which may be natural or synthetic, that has a medical or pharmacologic effect on the body. medication Drug Theraeutics Any chemical substance, which may be natural or synthetic, that has a medical or pharmacologic affect on the body.*

## Chapter 6 : Medical Encyclopedia: MedlinePlus

*Medical definition is - of, relating to, or concerned with physicians or the practice of medicine. How to use medical in a sentence. of, relating to, or concerned with physicians or the practice of medicine; requiring or devoted to medical treatment.*

## Chapter 7 : medicine | Definition, Fields, Research, & Facts | blog.quintoapp.com

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## Chapter 8 : Medical Board of California

*medical definition: 1. related to the treatment of illness and injuries: 2. an examination of a person's body by a doctor in order to discover if that person is healthy, sometimes done before a person can be accepted for a particular job: 3. of or relating to medicine, or for the treatment of.*

## Chapter 9 : Medical | Definition of Medical by Merriam-Webster

*Medicine is the science and practice of the diagnosis, treatment, and prevention of blog.quintoapp.comne encompasses a variety of health care practices evolved to maintain and restore health by the prevention and treatment of illness.*