Information Overload For Doctors Increases Malpractice Risk

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I have used the electronic medical record (specifically EPIC) since 2004. I have grown accustomed to its nuances, benefits and quirks. There are parts about it I really like. There are parts of it I'd like to do without but accept that they are necessary evils in our current health care climate. I know that there will always be parts of any modified computer system that will suffer growing pains. For any new and adapting technology this is understandable.

But there is a little-appreciated issue that I see brewing: doctors (and maybe even patients) are quietly being buried by electronic information overload. As a result, I believe doctors are being placed at an increased liability risk.

Let me explain.

In the past era of medicine, nothing happened without a doctor's order. Nothing. If you wanted a medication, lab test, invasive procedure, opportunity to participate in rehab classes – anything – you needed a doctor's order. For the years of paper records and independent doctors offices, this work flow assured that doctors (1) knew what was happening with their patients, (2) saw their patients, (3) prescribed the proper therapy, and (4) assumed the risk for the intervention or treatment prescribed. Information proceeded in a logical linear fashion and the doctor was always at the head of the information line.

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