Misinformation In Electronic Medical Records Has Consequences

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Electronic medical records have become an essential backdrop to modern medical practice. Paper charts, not long ago the mainstay of health-care documentation, have become antediluvian. Whereas once doctors used to write notes with pen and paper and insert the paper into a physical binder, doctors now keep track of patients by clicking keys on a keyboard and entering data into a computer software program.

One of the great advantages of the electronic medical record over its ancestral precursor :notes-in-a-binder" is that records are now centralized and can be accessed by multiple authorized care providers, such that it is possible to know what treatment a patient received from any health-care provider working in the conjoined medical system, from primary care visits to hospital admissions. Physicians are less siloed within specialties and more able to share information.

The Science section of the *New York Times* discusses [1] the upsides and the downsides of modern technology in the medical workplace, but one of the downsides that isn't emphasized is the fact that much of the data entered into electronic medical records is being mined to make important decisions about clinical care and health policy. And if data-mining is based on inaccurate information, then the whole operation is a house of cards. Let me cite one example.

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