Computer- based medical record: The current innovation method of managing patient's data

Angeliki Banousi
Surgical Team Mgr. MSc, PhD©, General Hospital of Athens KAT
Athens, Greece

Introduction: The use of computer technology in computer-based medical documentation and management of medical information regarding patients has significantly changed the way we practice medicine nowadays. The known practical disadvantages of the traditional paper-based medical record and the apparent advantages of the electronically created one have changed the scene. In developed countries it is currently well established for processing and archiving medical information, for performing medical videoconferences and for conducting and performing worldwide multi-centre studies and epidemiological investigations.

Objectives: To highlight the necessity of using the Computer-based medical record (CMR) in Greek hospitals as the main tool for recording, storing and defusing of clinical data, compared to the printed record, highlighting incomplete or incorrect documentation using traditional paper method

Methods: The methodology is based on review of international and Greek literature, and the detailed review of these.

Advantages: Easily import, search, and change data, resulting in more accurate conclusions. Easy inspection and processing of medical images, which ultimately means a more accurate diagnosis. Easier introduction of laboratory test data through the automatic integration of laboratory test protocols Larger ability to analyze patient data.

Disadvantages : There is no protocol to clarify the data to be inserted after the end of the patient examination The information recorded is often dependent on the physician's experience Always introducing new technology is causing concern and embarrassment to nursing staff because many of them are not potential users

Results: CMR reduces the potential errors of manual diagnosis, produces long history of patients and ensures comparable and comprehensive data for different populations. However there is difficulty in formulating clear and precise rules, which could reasonably be determined upon implementation of the electronic file, after the first hospital information systems must ensure consistent, continuous and discrete input and other data should correspond closely to medical terminology, but according to internationally accepted encodings.

Conclusions: Physicians should show particular interest in this method, while the managements to immediately seek its implementation, which involves reducing the cost, accounting patient management, monitoring of the operation of sections and able to conduct quality control of the offered health services.

References

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