

# Evidenced based medicine and the emr

[Technology](#), [Information Technology](#)



Module 8 DQ1 and 2 John Jones DQ1 To quote Canadian Doctor David Sackett, considered by most to be the “ father” of evidence-based medicine (EBM), its definition is “ the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research” (Duke, 2010). The university breaks EBM down into six step, ASSESS the patient, ASK the right questions, ACQUIRE the evidence from appropriate areas, APPRAISE (evaluate) the evidence, APPLY (confer with the patient) and probably the most difficult of all, do a critical analysis of one’s performance.

Clancy (2013) points to the pharmaceutical drug approval process used in the West as one of the best examples of EBM utilized successfully. Although she makes a valid point of saying that increased direct healthcare spending makes very little impact, the monies spent on research and innovations such as Information Technology. With the average of over ten thousand medical studies at any one time in the US alone, the “ evidence” part of EBM is growing sufficiently enough to make a difference.

Even though it could be argued the US Government has a somewhat prejudiced attitude toward Health Information Technology (HIT), the NIH (2013) gives a refreshingly critical work on EBM. Of course, it highlights the strides the Department of Veterans’ Affairs in combining EBM and HIT. Yet the article states that HIT could be more successful if the VA had kept better clinical statistics concerning those research criteria such as smoking, cancer and patient obesity. Therefore, the answer concerning facilitation is that HIT and EBM should go hand in hand, especially considering the new technology

available.

DQ2

The case of the forty five year old man with the prostate condition gives a very good scenario as to just how confusing the information technology and EHR system can actually be. The person himself would only visit three separate areas of the massive hospital complex (assumed to be admissions, the surgery suite, his room, and discharge and financials area). Yet his records would travel to an astonishing four different places, not including the test results, which travel to still another three places. The IT system seems to be efficient enough but one can quickly see how EHR is a big improvement over paper patient records, which have the chance of being misplaced in each of the different stops along the way.

For instance, the National Center for Policy Analysis (2010) states that “overreliance on the accuracy of EMR’s can lead to grievous errors if a patient record contains false information”. The Doctors who wrote the article seem to be not very sure that HIT is the right approach. Rather, they suggest that corporate America and insurers work with the medical community to find an appropriate solution.

The breakdown in communication would most likely occur in the age-old area where communication has historically been an issue. While the operating room has caught a lot of attention lately over inattention, normally the nurses’ station is where failure to understand one another, either between the doctors and nurses or during shift handoff, can lead to disastrous results. Dingley (2008) reports an almost twofold increase in patient deaths due to failure of communication between physicians and the nursing staff, not to

mention longer hospital stays.

## References

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