

Chapter 8

Are Electronic Medical Education and the EHR Helping or Hurting the Quality of Medical Education and Patient Care? Taming Medicine's Leviathan

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ABSTRACT

This chapter addresses some of the negative aspects of both electronic medical education and the electronic health record. This includes the dilution of the doctor/patient interface, the emphasis on documentation rather than on learning the healing arts, and the intellectual dishonesty that arises from the use of templates and automated fillers. The authors address concerns about the dehumanization of medicine, starting with the style of medical education carrying through to the style of function within the clinical environment.

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INTRODUCTION

In recent decades, researchers have noted how the swift emergence and growth of digitized innovation, particularly in the healthcare and medical education sectors, has left little opportunity for end-users (medical students, residents and attending physicians) to reflect on how to best utilize these new technologies, or to question if they should be used in certain instances at all. Yet, our healthcare systems eagerly continue to employ these new innovations without much forethought. Right or wrong, technological innovations are now equated with greater efficiency, expediency and cost savings, though one can make a convincing argument that rather saving money with new educational technologies, we have actually shifted the costs – now hidden behind the electronic grid – with all the human support it actually entails. Technology is expensive – it just appears affordable when fewer people are standing in the room. While the bottom line will always be the bottom line, as a physician and educator, I can't help wondering at what cost?

It is important to bear in mind that technological innovations are not new, as noted by world renowned bioethicist and co-founder of the Hastings Center, Dr. Daniel Callahan. He reminds us how:

The culture of technological progress has a long history, going back to the Industrial Revolution, gathering more speed in the nineteenth and twentieth centuries, with Silicon Valley as a high point going into the twenty-first century. 'Innovative technology,' the marketing brand of Silicon Valley, is simply the older model of progress in new clothes, but moving faster and faster." Indeed, I would go a step further and argue that it is moving far more rapidly than we can possibly understand. (Callahan, 2017, pp. 169)

As a more senior physician, I acknowledge that I'm still working from an older model of healthcare education that was taught in the seventies, and that I'm also somewhat rebellious against the newer model of medical education for a variety of reasons I consider valid. For instance, it is difficult to understand how the continuous streaming of medical education via digitized informational formats on a computer screen is an intelligent approach to medical education, particularly in a field that requires contextualization, understanding the complexities of team work and, most importantly, up-close and consistent engagement with the patient. Coordination of care is highly complex and requires a sophisticated 'human' infrastructure for the most efficient communication between team members. These communications are often highly nuanced. Important cues and clues can be easily missed or misinterpreted if the medical student, resident or attending physician is not in the room with the patient or has his/her back to the patient, typing. However, some researchers are now

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