

The Computerization of the Medical Records in the Hospitals: Be Extra Careful

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Received: December 19, 2017; **Published:** February 01, 2018

In recent years we have seen the progressive computerization of electronic medical records of the Hospitals in our country. Given the magnitude of information required for medical practice, the complexity of the programs developed is quite pronounced, making it difficult to handle with agility. Since hospitalization, evolution, prescription, surgical description and discharge of patients, we are confronted with innumerable steps and shortcuts difficult to remember given the range of possibilities involved in the day-to-day practice of medicine. If, on the one hand, computerization has the advantage of standardizing access to data by all those who work in the hospital, it has the disadvantage that it is difficult for everyone to manipulate platforms with dexterity. Although we do courses and training, we always have a 24-hour helpdesk to resolve any doubts that may arise. We must also take greater care in the requirements in view of the numerous possibilities of medications, doses and routes of administration that are included in the programs. This is another reasoning and responsibility that we have to develop beyond the main one that is the clinical picture and safety of our patient. Maybe over the years we will be able to develop this practice in an automatic way or perhaps even more friendly programs may emerge. While this does not occur we have to be extra careful in our medical practice by using electronic medical records.

Volume 9 Issue 3 March 2018

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