



PART 2

Read the text below and answer questions 14–26.

THE PROMISE AND PERIL OF ELECTRONIC HEALTH RECORDS

A

Electronic health records (EHRs) are often marketed as a straightforward upgrade from paper: a cleaner, searchable repository that travels with the patient. In reality, digitisation represents a deeper paradigm shift. A paper chart is largely passive; it stores a narrative and can be read in whatever sequence a clinician chooses. By contrast, an EHR is an active tool that structures attention through menus, templates, and prompts, turning the record into part documentation system and part decision environment. This redesign can improve continuity by making prior diagnoses, medications, and test results available across care settings, but only if information is entered consistently and can be retrieved quickly under time pressure. The benefits therefore depend not just on “having a system” but on infrastructure, usability, and organisational routines that treat implementation as ongoing optimisation rather than a one-off installation.

B

The strongest clinical argument for EHRs has been safety. Computerised prescribing can flag allergies, suggest dose adjustments, and warn about interactions. Standardised order sets can reduce omission errors and nudge clinicians toward evidence-based practice. Yet these advantages have a built-in paradox. If alerts are too frequent or too generic, they lose meaning. Clinicians develop alert fatigue, a psychological and behavioural response in which repeated warnings become background noise, leading users to override prompts reflexively. Over time, a tool intended to prevent mistakes can contribute to new errors—either because the “important” alerts are buried among trivial ones, or because the act of clicking through prompts becomes a ritual that competes with clinical judgement. Effective systems therefore require careful tuning: fewer, more precise alerts, clear escalation for high-risk situations, and auditing to ensure that warnings are improving outcomes rather than simply generating clicks.

C

If safety is the promise, interoperability is the persistent failure mode. Many hospitals and clinics still operate as data silos, using different vendors, proprietary formats, and incompatible standards for coding diagnoses, medications, and laboratory results. Even when systems claim to be interoperable, “semantic” differences remain: the same clinical concept can be recorded in multiple ways, making accurate exchange and interpretation difficult. The result is the fax machine paradox. Despite sophisticated digital platforms,



staff may still depend on faxes, scanned PDFs, screenshots, or manual re-entry because these crude methods reliably cross institutional boundaries. This reintroduces fragmentation—the very problem EHRs were meant to solve—while also increasing the risk of transcription errors and consuming staff time that could have been spent on patient care.

D

The clinician experience has become the most politically charged dimension of EHR adoption. Digital records can reduce some forms of duplication, but many systems also expand documentation demands for billing, compliance, and reporting. The day can become a sequence of micro-tasks: logging in, navigating tabs, selecting codes, and completing mandatory fields. Researchers have described the clerical burden in terms of cognitive load—the mental effort required to manage a complex interface while simultaneously making clinical decisions. Anecdotes about “thousands of clicks a day” and prolonged “screen-gazing” capture a real ergonomic problem: attention is pulled away from the patient and toward the machine. For some clinicians, this contributes to burnout, not only through longer hours but through a sense that professional judgement is being crowded out by administrative mechanics. Attempts to reduce the burden—scribes, voice dictation, smarter templates—can help, but they also illustrate how an EHR can shift work rather than eliminate it.

E

EHRs also promise better data for research, quality improvement, and population health, but data quality collides with usability. Structured fields make analysis easier: diagnoses can be counted, medications can be tracked, and performance indicators can be generated automatically. Yet clinical reality often resists neat categories. Nuance—uncertainty, context, symptom evolution—frequently lives in free text, which is harder to search and standardise. Meanwhile, template-driven documentation can encourage copying and pasting, creating long notes that conceal key facts and propagate errors forward. The tension is fundamental: the more rigidly a system forces structure, the more likely it is to misrepresent complex cases; the more it allows narrative freedom, the harder it becomes to compute and compare. Improving quality therefore requires interface design that reduces friction, training that promotes consistent coding, and incentives that reward accuracy rather than volume.

F

Security and ethics have grown more urgent as EHRs have become critical infrastructure. A paper chart can be stolen, but a digital system can be breached at scale. Ransomware attacks illustrate a distinctive vulnerability: external actors can lock access to records,



disrupt scheduling and prescribing, and force hospitals into emergency procedures. Even without outright attacks, weaker points—poor passwords, misconfigured access controls, unpatched software—can expose sensitive information. Ethical questions extend beyond security. EHR data may be used secondarily for research, insurance analytics, or partnerships with technology firms. Although such uses can generate public-health insight, they can also erode trust if consent is unclear or if patients do not understand how their information circulates. Audit trails and encryption reduce risk, but they cannot fully resolve the underlying debate about who should benefit from clinical data and under what conditions.

G

Future improvements will likely come from reframing what EHRs are for. If the record is treated primarily as a billing tool, it will continue to prioritise documentation volume and administrative compliance. If it is redesigned as a clinical aid, the goal shifts toward speed, clarity, and decision support that genuinely reduces cognitive load. This is where artificial intelligence is often invoked: summarising long histories, extracting key changes, and suggesting next steps based on guidelines. Yet AI integration will only help if underlying data are reliable and if interfaces are built around real clinical workflows. More broadly, successful programmes tend to share the same principles: interoperability standards that travel across vendors, security that is planned rather than patched, and implementation that is iterative—co-designed with clinicians and evaluated against patient outcomes, not just installation deadlines.

Questions 14–19

Choose the correct heading for each paragraph.

List of Headings

- i** The safety paradox: how warnings can become background noise
- ii** The argument that EHRs eliminate the need for clinical judgement
- iii** The cognitive burden of administrative mechanics
- iv** Why fragmentation persists despite digitisation
- v** Security risks and the ethics of secondary use
- vi** From passive repository to active decision environment
- vii** The tension between data structure and narrative nuance
- viii** Why paper records are inherently safer than digital systems



ix The myth that implementation is a one-off event

14 Paragraph **A**

15 Paragraph **B**

16 Paragraph **C**

17 Paragraph **D**

18 Paragraph **E**

19 Paragraph **F**

Questions 20–23

Which paragraph contains the following information?

20 a reference to the specific risk of systems being held hostage by external cyberattacks.

21 a description of the conflict between the need for structured data and the complexity of individual cases.

22 a mention of the continued use of obsolete communication methods despite digitisation.

23 a reference to the psychological phenomenon where frequent warnings cause users to ignore safety prompts.

Questions 24–26

Complete the summary below. Choose **NO MORE THAN TWO WORDS** from the text for each answer.

Challenges of electronic health records

While EHRs aim to enhance safety through decision-support tools, an excessive volume of warnings can lead to **24**, causing clinicians to bypass critical checks. A further systemic failure is the lack of **25**, which forces institutions to rely on disjointed data transfer methods. Moreover, the administrative workload associated with documentation can contribute to clinician **26**

Answer Key

14. vi

15. i



16. iv

17. iii

18. vii

19. v

20. F

21. E

22. C

23. B

24. alert fatigue

25. interoperability

26. burnout