The reading passage explores the topic of changing the way of doctors recording data from writing on a paper to saving into an electronic device. The professor's lecture deals with the same topic. However, she holds the view that recording the data onto computers does not offer the benefits as what are state in the reading passage. In order to support her point, the professor uses 3 specific examples.

First, the professor argue that since most doctors keeps the record for legal reasons, many doctors will still hand write a record even though they are required to record them on the computer, which contradicts to the statement in the reading passage that a lot of paper will be saved by recording the record onto the computer.

Moreover, even though the reading passage suggests that by recording the data on the computer, nonstandard organization of record will be reduced, the professor contends that this will not help. She points out that many doctors use pen and paper while they are facing the patient. It is the staff who later on record the handwriting into the computer. So, medical errors will still occur if the stuff cannot interpretate what the doctor wrote on the paper.

Finally, the professor asserts that in the USA, gathering large amount of data from the patient record is subjected to the privacy laws. The researchers can only use the patient record after many procedures and get the permissions of every patients. It made using the patient data to aiding research un realistic.

In conclusion, the professor, clearly identifies the weakness in the reading passage and convincingly shows that the central argument in the reading is incorrect.

 In the lecture, the professor casts doubt on the reading passage’s idea that storing patients’ medical records in electronic databases has several advantages over traditional paper-based record keeping. The professor asserts that the benefits are actually uncertain.

　 To begin with, according to the reading passage, electronic medical records will reduce costs of storing and transferring.

　 The professor argues that the cost savings are unlikely as the reading suggests. He says that the doctors just keep the paper records as an emergency backup and most doctors who adopt electronic record keeping still have to pay storage costs associated with paper-based record keeping.

　 On top of that, the reading passage claims that the use of electronic medical records will help reduce the chances of medical errors. On the contrary, the professor rebuts that the electronic records cannot eliminate the possibility of errors. She says that doctors still use pen and paper while examining patients. It is usually the office staff of a doctor who will enter the information at a later time from the handwritten documents into electronic systems. So poor handwriting can still lead to errors.

　 Lastly, the professor rebuts the reading’s point that electronic medical records will be beneficial to medical research through obtaining a great amount of data from patient records by stating that medical research would not necessarily benefit from electronic record keeping. The professor points out that access to all medical information is subject to strict privacy laws in the United States. Researchers who want to collect data from electronic medical records have to follow strict and complicated procedures and obtain many permissions including patient permissions along the way. Often such permissions are not granted.