The reading and lecture discuss about the disadvantageous and advantageous of replacing traditional medical paper records with electronic version of them. The reading believes that electronic medical versions are far beneficial than traditional formats, while the professor describes that there is uncertainty on the benefits mentioned in the reading.

First of all, the reading asserts that the electronic records can reduce cost due to no need of storing space and easy transferring medical records. The professor, however, mentions that the cost reduction is not significant since the doctor who adopt to use the electronic records continue to use the paper versions in order to back up their prescription. Hence this condition discredits the reading's claim of not needing to storage space. Besides, the need to sign the prescription forces doctor to use the paper records. As a result, this plan increased the doctor expenses because they had to pay extra charge for the electronic records.

Secondly, the writer avers that the electronic records impede possible error due to illegible handwriting, misinterpretation and nonstandard organization of paper records. The speaker refutes this claim by mentioning that the electronic records do not eliminates mistakes due to improper handwriting or misreading of the medical records. She elaborates on this point that during diagnosing disease, doctor use their pen and paper to take note of disease's symptoms, and they later hand over these notes to their staffs to enter them in the electronic data base. As a consequence, there is always a possibility of making mistake by their staff due to a misconstruing the notes by the doctor's staff.

Finally, the author claims that the electronic records aid research by providing collective data with ease. The professor repudiates this claim by stating that researchers have difficulty to get stored data because these records are subject for strict privacy rules if patients wish stringent rules. Therefore, the researchers have to follow prohibitive rules to get that information and sometimes reaching to the records are not granted. For example, some patients block their medical records for other uses unless they be used for patient's own treatment.