In beginning this article, I pondered the answer to the following question: after 34 years working as a Victorian Health Information Manager (HIM), what have been the standout aspects in my working life? After much thought I was able to distil the answer to two words: ‘change’ and ‘respect’.

Of course, change is an ever-current part of working life for everyone, but it is interesting to stand back and reflect on specific changes in the working life of a HIM that have mirrored those changes taking place in the wider society. I recall the compulsory interview and the compulsory visits to Medical Record departments in 1976, before I was successful in gaining a place in the Medical Record Administration Course at Lincoln Institute, Melbourne. Now, in 2013, it is interesting to note that all universities encourage potential university students to visit workplaces and talk to professionals about their working lives to ascertain if this future employment would be the right match for them. These compulsory visits into the depths of a hospital to actually visit a Medical Record department may be one of the reasons that my graduating cohort has a very high number of still current working HIMs.

Some things change, some remain constant
Every HIM would acknowledge the extraordinary change that the introduction of computers has had on productivity and staff numbers. In my first MRA/HIM position in 1979, I introduced a card index for the collection of disease and operation codes, and when I was undertaking further studies in 1983 my computer classes were still using punch cards for computer programming and the size of the computers would fill rooms, not just one small area. Now we are surrounded by portable computers, the wonders of email and an ability to mine data for many uses. In all this change, there are still some underlying constants. This was illustrated by an article in the *Sydney Morning Herald* (14 December 2012) where Professor Fiona Stanley spoke on the conclusions she has drawn about the effectiveness of schooling in educating children: ‘Children who are born underweight because their mothers smoke or drink in pregnancy or fail to eat well or have sexually transmitted disease when pregnant, are likely to have poor education outcomes regardless of the quality of their schooling’. These conclusions were able to be formulated by linking Western Australia’s birth, health and education records. The ‘constant’ is the role of the HIM in organising databases, educating staff and colleagues on the importance of data, and an unrelenting persistence in ensuring that processes are streamlined to achieve outcomes.

Changes in the working life of a HIM: the 1980s and 1990s
My journey is similar to a number of HIMs who began working in the private sector over 20 years ago. My decision to work in the private hospital sector was based on family responsibilities - I had resigned from a senior full-time HIM role after the birth of my first daughter and did not want to return to full-time work. The private hospital sector offered flexibility in working hours and being close to my home allowed me to combine work and being a mother. I was not alone in this desire and I, and many of my HIM colleagues in other private hospitals, seemed to be the forerunners for the ‘work-life’ balance. I would arrive at work after I had finished the reading-time session in my daughter’s class and return to her school for the afternoon pick-up. I know all working mothers would relate to the stress of watching the clock in the last 30 minutes of work, hoping you would not receive an important task that had to be finished before you left for the school pick-up. This flexibility in working hours has been the major reason I have remained in the private hospital sector. It has allowed me to attend reading sessions at school, craft sessions, sports days, weekly Friday afternoon soccer games, and school plays, and many other such events. Those stressful times of getting daughters ready for school and doing multiple school runs have long gone (although never forgotten!). I am also reminded of the earlier ‘hostage exchange’ that my husband and I undertook every Thursday afternoon, when I was teaching at Lincoln Institute. At 9.00am on a weekday morning, I would be the ‘usual Mum’, in jeans and tee-shirt, dropping off my eldest daughter at kindergarten. By 11.30am I had changed into the ‘corporate clothes’ with the red patent stiletto-heeled shoes (it was the 1990s!). I then drove to West Melbourne, handed over the shopping list and the children to my husband and he gave me his train ticket and his car keys (his car was parked at the suburban train station), and I would then be dropped off in Swanston Street, Carlton, outside the lecture theatre, to continue my multi-faceted day.

As you can see, these changes in our working HIM lives reflected the change in the lives of all women in the latter part of the 20th Century.
Financial responsibility led to increased respect for HIMs

In relation to respect, there was no doubt, even when I graduated, that the role of the MRA/HIM was well respected in the hospital, but this was in the area of the management of a Medical Record department and having influence in the research and quality aspects of the hospital. I had no idea that I would one day find myself in such a crucial role in the financial wellbeing of a hospital.

Responsibility for the financial wellbeing of a hospital began with the introduction of the casemix-based payments for hospital patients in the public and private sectors. This occurred in the Victorian public hospitals in 1993, and was introduced into the private sector in the late 1990s (McDonald 2012). It is not surprising that with financial responsibility came an increased respect for the role of a HIM. This financial responsibility rested on the ability of HIMs to ensure that there was a high quality coding process. However, we also needed to have a detailed knowledge of the diagnosis related group (DRG) system, and the confidence to speak to clinical staff to ensure the maximisation of DRG allocations.

This quality of confidence reminds me of the time I taught public speaking in the Department of Health Information Management at La Trobe University. The course was developed to instil confidence in students by having them speak on a topic that they were passionate about and engaging the student audience. Among the many memories I have of teaching this course are of presentations on Star Trek episodes, seaside holidays, dress-making, cooking, car maintenance, and beloved pets. All of these presentations were accompanied by many colourful Powerpoint presentations, handouts and hands-on experience. The standout of the hands-on experience for a student presentation was one by a group of male HIM students, who gave a very learned presentation on stacking an ‘Esky’. The class was educated on the history of the Esky, provided with a diagram on the correct stacking of the beer into the Esky, the correct amount of ice to an Esky, carrying the Esky and correct removal of bottles from the Esky. All of this was done with the Esky, ice and the beer bottles! At the end of the lecture, while helping to put away the unopened beer bottles, I dropped one onto the tiled floor. I had to ring the University’s cleaning staff and apologise to the next lecturer for the smell of beer in the lecture theatre, and as I made my way to my next lecture I was a bit concerned about the reputation of the HIM students throughout the University and wondered if this incident might end my teaching career. Thankfully, it seems that La Trobe University must have experienced worse situations than spilt beer in lecture theatres, as this incident was unremarked upon by my fellow teaching colleagues.

Looking back, I hope that those public speaking classes did assist those HIM students to build up the confidence they would need to exhibit in their future careers as HIMs, to motivate, educate, and sometimes plead with clinical staff for increased documentation in the medical record. In the private sector, it is not the medical residents or registrars with whom I need to discuss medical record documentation; it is senior consultants, who expect HIMs to have the clinical and coding/DRG knowledge to outline a very succinct argument for increased documentation. The knowledge that HIMs possess and the confidence they have in the value of what they know, has generated an increased respect for the role of the HIM in hospitals. In many of the large private hospital corporations, the HIM conducts a session in the hospital orientation program to outline the financial structure of the hospital, the role of the HIM, the understanding of the DRG process, and the staff’s role in ensuring the financial viability of the hospital. Hospital staff are always most interested in this virtually ‘unknown’ aspect of hospital life and the fact that it allows everyone to be a part of the financial viability of the hospital. I still have senior hospital accounting staff wanting to see me ‘for just 15 minutes’ to go through the coding/health fund contracts/DRG process! After that ‘15 minutes’ has turned into 60 minutes they always leave with a new respect for the abilities of a HIM. It is unfortunate that many senior staff still believe that the expertise to influence the financial wellbeing of the hospital lies with the billing/accounts/health fund contract departments and not the Health Information Services area. It is up to us to ensure that the value that a HIM can bring to a hospital in terms of financial wellbeing is fully recognised.

Many previous contributors to the Professional Profile section of HIM-I have commented on the privilege of working for the Health Information Management Association of Australia (HIMAA), and I have been extremely fortunate to have been Chair of the HIMJ/HIM-I Editorial Board since August 2004. It all started with ‘a coffee’ with Kerin Robinson, Head of the Department of

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Health Information Management (who had forgiven me for the beer-spilling episode!) and asked me if I would like to take on the role of Chair of the Editorial Board. Kerin, who at that time was the Editor of HIMJ, had been 'sounding out' likely candidates for that role, on behalf of the Members of the Editorial Board, and I was delighted to say 'yes' to the proposal. Again, this role has been involved in a change process. In August 2004, HIMJ was only published in an electronic format on the HIMAA website due to financial constraints but HIMAA members had repeatedly asked for a paper-based journal. There was keen debate that this could be a backward step for an organisation that wished to be part of the health informatics community but many members believed that a paper-based journal would have increased readership due to ease of access and thereby increased contributions from the HIMAA community. The Editorial Board worked with the HIMAA Board to begin the dual paper-based and electronic journal, which was published for the first time in this format in March 2006. Again, change occurred with the introduction of HIM-I in March 2011 to give a professional practice journal to HIMAA members and to allow HIMJ to be a highly regarded peer-reviewed journal. For me, it has been a truly exciting time being part of this very experienced Editorial Board and one of the highlights of my professional life.

I have been so lucky to have selected a career that has allowed me to develop my teenage wish to be part of a hospital environment and to then allow me to combine a fulfilling job with family commitments and, above all, to have a highly respected position in my working environment.

References


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