Evolution of the health information management profession in Australia: from Medical Record Librarian to Health Information Manager

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Introduction

Evolution is defined by the Oxford English Dictionary as the unfolding of events; to evolve is to develop gradually and naturally or to develop from a simple to more complex form (Gwynn 2011). When looking back at our profession it is clear that it did evolve gradually and in most cases the changes were natural and often preceded by an external influence.

In 1949, medical record services in our teaching and district hospitals came under the responsibility of medical record clerks who had not had any formal training. Many had progressed up the ladder of the hospital clerical staff to become the Medical Record Librarian (MRL) in charge of the Medical Record Department, which was responsible for all the services associated with a patient’s medical record.

As well as managing staff, their responsibilities included ensuring that all medical records were complete, accurate and available when required for future care of the patient. They were also responsible for coding, using the Standard Nomenclature of Diseases and Operations (SNDO), and indexing to ensure that medical records required for research could be retrieved for a specific disease or procedure. In addition, they were responsible for medico-legal issues, such as preparing and sending medical records to court when subpoenaed, and overseeing the typing of medico-legal reports as well as discharge summaries. The MRL also liaised with medical staff on matters relating to medical record completion, were members of the medical record committee, and were well respected by both medical and administrative staff.

In 1949 MRLs did not know where their path would lead but pressed forward with determination and commitment to improve the standard of medical records and upgrade the hospitals’ medical record services.

Most of the text below has been extracted from notes used for writing The first fifty years 1949 – 1999: from Medical Record Librarian to Health Information Manager (Watson 2013). I hope readers will find it interesting and consider reading the full history, as there is so much more to tell.

The beginning – who are we and where did we come from?

Our journey began in 1949, when the need to improve medical records and medical record keeping in Australian hospitals was identified by a number of senior medical staff and hospital administrators, who started to search for ways to make improvements to the quality of medical records. With a grant from the Carnegie Corporation in the United States (US) in June 1949 the Australian Hospital Association (AHA) was able to recruit Edna Huffman from the US for six months. Although Mrs Huffman’s main task was to advise on the development of the medical record services at Royal Prince Alfred Hospital (RPAH) in Sydney, she also visited a number of other hospitals and conducted two special training courses: one in New South Wales and one in Victoria. It was her encouragement and support that inspired MRLs from New South Wales and Victoria to establish an association in their state, each with 25 members. This was the beginning of the health information management profession in Australia.

Also in 1949, while consolidating the state associations, interest was roused by the proposed first international congress on medical records to be held in London in 1952. With great excitement seven Australian MRLs were able to attend and also participate in the first business meeting, but as we did not have a national association they did not have a vote. On their return to Australia the need for a national association became paramount if we wanted to participate in the international movement as a member nation. This was the impetus needed for members to go ahead and form The Australian Federation of Medical Record Librarians (AFMRL) in 1955, with the two state associations as members. A National Council was set up as the governing body with two, then three members from each state.

From the beginning, members in both states encouraged persons interested in medical records, not only in the foundation states but also in other parts of the country, to join one of the two state associations. This suggestion was resisted, unfortunately, and with limited numbers and no formal education, medical record workers in the other states found it impossible to form their own state association and wanted to join the Federation as an individual member, which was not possible at the time.

Evolution of the professional – who were we?

We were a small group trying to establish a new profession. There was pride in the accomplishments at state level and a strong desire to maintain an independent state association, while at the same time develop a strong national organisation. Most MRLs worked in the medical record departments of
hospitals in their state and were responsible for the management of the medical record services.

When I joined the profession in 1963 I found an extremely dedicated group of people (all female at that time), who were responsible for the medical record services of large teaching and district hospitals. They were well respected by the general superintendent and hospital administrator, as well as the honorary medical officers and senior nursing staff, and were accepted as important members of the healthcare team.

Over the years, with the many developments in healthcare, a number of the tasks originally included within the role of the MRL started to require a specially designated person within the medical record department. Slowly but surely, the role of the person in charge of the medical record services began to change. In some hospitals medico-legal issues required a full-time manager, as did coding and quality assurance, all of which were responsibilities previously undertaken by the Medical Record Librarian/Medical Record Administrator (MRA), but which have evolved into specialised positions.

**Evolution of the professional association**

The evolution of the professional association was hampered in the early years by the desire to protect the profession by limiting membership to existing members and graduates from formal medical record programs. As mentioned previously, this was a major problem for medical record officers in other states without a state association or any formal medical record education, who wished to be accepted as full graduate members of one of the two existing state associations. This presented a barrier to the early expansion of the national association into all states and territories of the Commonwealth.

From the beginning, the six major areas of concern for the professional association included:
- membership and developing a truly national association
- international recognition and participation
- formal education for medical record/health information personnel
- communicating with members
- our image and recognition as a profession
- changes in health record/information services and external influences.

**Membership**

With only 50 members and a small number of students, the profession grew slowly during the 1950s as Council continued to look for ways and means of increasing membership. Then in the 1960s and 1970s, interest in the profession began to spread, although membership was still restricted with the limited number of formal education programs and eligible personnel in other states. Membership, however, did increase slowly with the two schools accepting more students each year.

In 1977, the constitution was changed at last to include individual membership. In addition, our title was changed to Medical Record Administrator, which described our role more effectively than librarian and tended to change many people’s attitude about the profession. The name of the Federation was also changed to the Medical Record Association of Australia (MRAA). Although we now had individual membership there were still a number of problems unresolved.

In the 1980s, we started to move forward more rapidly, with an increase in the number of members and greater interest in developing formal education programs and setting up branches in other states. An important development in November 1988 was the formation of the Queensland Branch of the MRAA, established as the Queensland Medical Record Association (QMRA). Then in 1991, the long-awaited expansion into all states became a reality. In October 1991, WA was admitted as a branch and, with limited members, official groups were formed in SA, the ACT and Tasmania. In 1992, the name was again changed to the Healthcare Information Management Association of Australia (HIMAA), which placed more emphasis on the information part of our role. This was followed by another long-awaited constitution change in October 1996, when all states and territories could now become true branches of HIMAA, with equal status under one constitution. After 45 years, and a lot of hard work, the profession now had individual membership and a National Council with representation from nearly every state and territory of the Commonwealth.

**International recognition and participation**

From the beginning, AFMRL members were involved in the International Federation and participated in all international congresses. At the Fifth International Congress in 1968, Australia’s representative, Betty James, was elected the first president of the newly formed International Federation of Medical Record Organizations (IFMRO), later changed to International Federation of Health Record Organizations (IFHRO). We were also successful in winning the bid to host the Sixth International Congress on Medical Records, held in Sydney in 1972. The Congress was a great success and sparked renewed interest in the profession, with Council receiving...
many enquiries regarding membership from persons in other states.

Numerous international directors have continued Australia’s representation on the international executive and/or the education committee since IFMRO (now the International Federation of Health Information Management Associations [IFHIMA]) was formed in 1968. The 11th International Health Records Conference was held in Melbourne in 2000 and was again well organised and an outstanding success. Our strong involvement in IFHIMA continues to this day.

**Formal education for medical record/health information personnel**

In the early 1950s, members from both state associations were frustrated with the many delays and setbacks in their efforts to establish a professionally-based medical record course. Then in 1955, after their continued persistence, a basic six-month short course was offered in New South Wales. This was followed in 1956 with a three-year (reduced to two years in 1961) course in New South Wales and a two-year course in Victoria in 1961. Both were hospital-based, with a director of training responsible for the day-to-day operation, curriculum, lectures and examinations and an external advisory committee to advise on student admission, changes to the program and other matters when required. The original courses started at certificate level, and were expanded over the years to diploma level and finally to bachelor degrees in 1983. Another 22 years passed, however, before two more degree courses were established, one in Western Australia in 1982 and the other in Queensland in 1983.

With the expansion of medical record education in Australia, the need for standards to be set, programs accredited, and graduates registered continued to be raised by members of MRAA/HIMAA councils. After many years of negotiations, course accreditation became a reality in 1992, when the School of Health Information Management in NSW was surveyed with the recommendation that approval be given for both the Bachelor of Applied Science (HIM) and the Graduate Diploma of Applied Science (HIM). Council accepted the recommendations, accomplishing the first formal accreditation process for education of MRAs and HIMs in this country. The accreditation of all other programs followed.

During the 1970s, members of the Education Committee assisted with the development of a correspondence course for medical record clerks in conjunction with the College of Technical and Further Education (TAFE). This was quite controversial as it would not be under the control of the MRAA and many members were concerned as to whether it would produce a ‘second level’ MRL. It took some years before it was introduced in 1977. With many changes since then, the course continues today with particular attention given to training clinical coders.

From the beginning, our education set us apart from nurses, librarians and other allied health professionals. It is the **Health and Management** aspects of our knowledgebase that sets us apart also from persons with health informatics and information technology backgrounds, business administrators, and librarians. Our basic knowledgebase and competencies have not changed substantially and it is this that makes us who we are.

**Communicating with members – national conferences**

Communicating with members was important from the beginning. As well as formal programs, short courses and seminars, national conferences have been extremely important, not only to all councils and boards but also to members.

The first medical record educational conference and exhibition was held in September 1961, with 121 members and visitors from all states of the Commonwealth. The papers at the conference reflected the ever-evolving role of the profession. Speakers such as Dr Edgar Thomson, General Superintendent and Chief Executive Officer, RPAH, who was a great supporter of the profession and the MRL, spoke at a number of our conferences. His comments at the first conference were extremely interesting.

He spoke on **What the Medical Administrator expects from the Medical Record Department**. His advice was that MRLs must be adviser, confidante, watch dog, detective, and nagger. The MRL must be prepared to be unpopular and that technical competence, managerial ability, supervisor ability, leadership and loyalty were all considered to be attributes without which the MRL would fail to be effective. He also emphasised that the MRL must be ready to take advice and to face up to criticism from their superiors, be patient and understanding with her colleagues and with her subordinates. She must always show personal consideration, courtesy and kindness without favouritism (see Watson 2013). How would these words fit into our role today?

Another speaker, Professor John Griffith, Professor of Hospital Administration, University of New South Wales, Sydney spoke on Hospital Administration and Medical Records and made some very interesting observations regarding the limited number of qualified MRLs at the time. He cautioned that in our personal as well as professional interest we would do ourselves a disservice if we ‘hived off’ into a ‘watertight’

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completely independent compartment of hospital work. He believed that MRLs had done a great deal to put medical records ‘on the map’ and that medical records should be a specialised branch of administration rather than an independent profession. He believed that if the profession could achieve such integration it would improve the attractiveness of medical records as a career and would improve recruitment and training potential (Watson 2013). We listened, but stayed with the health sciences in NSW and Victoria. However, the program in Queensland did develop originally within the strand of hospital administration. At the second AFMRL Conference, Dr Roderick McEwan spoke on The Medical Record Librarian and the Medical Superintendent and questions he posed were thought provoking and included: What do we want the MRL to do? Should her role be more clearly defined? Is the MRL rightly named to carry out the function we want of her? Is her job still the proper maintenance and organisation of patients’ records? Or is she the passive custodian of the record? (Watson 2013).

Dr McEwan went on to outline the importance of MRLs and the need for qualities in three areas, which included: personal qualities that allow the MRL to lead a group; organisational qualities that allow the MRL to analyse, plan and organise the activities of a group; and technical ability. These qualities are still important today as we continue to evolve and, as identified by Dr Thomson, the future would see the introduction of computerisation and with the introduction of computers there would be demand for more skilled MRLs in greater numbers.

The encouragement from people such as Dr Thomson and Dr McEwan provided the MRAA the impetus to change the name and push forward with changes to the constitution and eventually to individual membership.

Communicating with members – national newsletter and journal
As well as national conferences, the need to communicate with all members in between conferences influenced the move to publish a national newsletter in 1971. The first newsletter was prepared on a stencil and reproduced using numbers. As the profession developed and evolved, the Journal continued as an important communication tool for members and the National Council. An Editorial Board was established in mid-1987 and the Journal upgraded to refereed status. This was implemented to generally oversee and guide the development of the Journal. Also at this time, the Australian Medical Record Journal, as it was named at the time, was changed to A4 format and a completely revamped style. The Journal today, now the Health Information Management Journal, continues to be an important communication tool with a strong international image.

In addition, the profession began to produce documents such as The role of the Medical Record Administrator, Quality of the Medical Record for Medical Care Evaluation Programs and Organisation of a Medical Record Department, which included the General function of a Medical Record Department. Informative publications have continued to be produced over the years to meet the needs of members for information and continuing education.

Our image and recognition as a profession
By the end of 1959 the profession was well established in NSW and Victoria. The organisation of a national association also contributed to achieving recognition for MRLs as professionals in Australia. In 1974, with developments in community health that included the introduction of community health centres, day hospitals, day care centres, rehabilitation centres, hostels and domiciliary health services around the country, MRLs were being sought to help develop medical records and medical record services.

The role of the clinical coder began to change in the 1970s when state-wide morbidity collections began. Most hospitals changed the coding system they used to the International Classification of Diseases eighth revision (ICD-8), which was considered more up-to-date and was already used in some Australian hospitals. Hospital MRLs/MRAs were no longer coding mainly for research but were expected to supply the government with much needed morbidity statistics. Mortality statistics were not a major problem as data had been collected using a variety of ICD publications for many years.

In the 1980s and 1990s coding quality, although a concern within the profession for many years, became an issue of major concern around the nation. With the establishment of the Casemix Development Program in 1988, greater emphasis was placed on coding and coding quality by the hospital administration and state and national governments. With the changes that followed, positions such as clinical information coordinator, clinical documentation analyst, clinical data administrator and clinical coding educator became available. Interest in coding quality continued to accelerate into the 1990s and 2000s, with coding becoming a major topic of discussion within and outside the profession and institutions offering health care delivery services.

During the 1970s and 1980s there was an acceleration of interest in the profession and in the employment of medical record professionals. Our image was strong, as was the professional recognition of our education and our graduates.

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1 In 2011, the Association launched a second journal, HIM-Interchange, with a mission to publish shorter articles of interest and immediate relevance to Australian HIMs working in professional practice. For a detailed discussion about the two HIMAA journals, see Jennie Shepheard’s article in this issue of HIM-Interchange, ‘Professional Journals for our Profession’. 
Changes in health record/information services and external influences

The healthcare system
Changes within the Australian healthcare system also had a marked influence on the profession and its development. The introduction of hospital accreditation in the 1970s was an important external influence for both the individuals and the profession over the years. More health professionals and healthcare administrators as well as state and national governments were becoming aware of medical records, their place in healthcare delivery and the role of medical record professionals.

Technology
By the late 1960s it was clear that computers would play a major role in medical record management in the future. The introduction of computerised patient administration systems in earnest in the 1970s and 1980s had a marked effect on the profession and the individual MRL/MRA. The fact that the medical record would be linked with the computer was undeniable and some parts of the record, particularly those in research institutions, were already being computerised.

Development of the profession
With the profession expanding rapidly, with great anticipation Council was able to lease an office in Fitzroy, Victoria, from the Hospital Administrative Officers Association of Victoria in 1985. However, limited funds and other pressing issues meant that the Association was unable to continue the lease after a couple of years. Then, in a great leap forward, Council appointed Anne Irwin the first Executive Officer in June 1994 and, in October 1994, under a Casemix Education, Information and Study grant from the Commonwealth Department of Human Services and Health, Council leased an office in North Ryde, New South Wales.

After members having worked for nearly 40 years in an honorary capacity, and with meetings held at hospitals where the President or another member of the executive worked, the Association now had a permanent address and paid staff. The present National Office was officially opened on 8 May 1995. Council proceeded to recruit, select, and appoint staff and centralise operations of the resource centre and membership processing procedures.

With the need for the professional Association to become more involved in coder training, the MRAA Council established an MRAA Distance Education Project and was contracted by the private sector casemix unit of the Commonwealth Department of Health to conduct accelerated training of coders in response to the need for more qualified coding staff throughout the country. In 1990, the Queensland Branch of the MRAA had established a correspondence course in ICD-9-CM, which was an educational and financial success. The MRAA Council subsequently purchased the QMRA course, which they modified to suit the national perspective and began training coders by distance education. The project was renamed the HIMAA Education Centre and relocated to the HIMAA office on 8 May 1995, and HIMAA continues to offer coder training today.

The professional Association not only has a permanent office, an executive officer and other paid staff but also offers a distance education course, something we tried to do without success in the 1970s!

From my point of view, although the early years were extremely important in our professional development, it was not until the 1980s and 1990s that we achieved many of our early aims. During this time we became a truly national association with individual membership from all states and territories, two more MRA/HIM courses were introduced and all four courses offered bachelor degrees, and course accreditation became a reality. In addition, we established an Editorial Board and published a refereed journal. External influences included an expansion of quality assurance activities, the introduction of hospital accreditation, more computerised medical record services and the employment of MRAs in non-traditional roles. We also experienced increased interest in the quality of coding in all states. The introduction of casemix and DRGs in 1991 had an enormous influence on the development of the profession, particularly in Victoria, where MRAs/ HIMs were again faced with enormous changes and challenges. Many more developments will continue to challenge us into the future.

Who are we now?
As the years passed and the role continued to evolve, we were, and still are, responsible for medical record/health information services in hospitals and other healthcare facilities, although we no longer only work in medical record departments of public hospitals.

As a result of the transformation from manual medical record systems to computerised hospital information systems and the proposed introduction of electronic health records, the medical record/health information professional needs to remain alert to the changing environment in healthcare. Tasks have developed to include the maintenance of quality electronic data and controlling the accessibility of users of

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Today, HIMs are employed in many different areas and new job titles have emerged, varying from health services administrator; health information manager and data administrator; to medico-legal manager. Other roles include quality assurance educator; information security officer; cancer registration services manager and many more according to the healthcare services or organisation within which they work.

The change of direction for many MRAs/HIMs over the years is also reflected in changes seen in the activities of the professional Association. Seminar and conference presentations have been broadened to encompass a wider range of topics and activities. There was now an identified problem outside the profession relating to the standard of documentation, subsequent standard of coding and lack of qualified coders. This was particularly so in the private hospital sector. Dealing with different groups, such as information technologists and healthcare providers to ensure that all patient health information is accessible, understandable and organised efficiently has been, and still is, the biggest challenge we face during our working life. The expansion of job opportunities has led to the need to ensure that our graduates are prepared to meet the current changes and challenges and also ones they will face in the future. With all the changes since the inception of the profession in 1949, however, the underlying aims of the profession and the professional remain the same.

**Conclusion**

As we move further into the twenty-first century, we must not forget the important role undertaken by members over many years in developing medical record services and the evolution of the profession and the professional Association. The expected expertise of graduates has increased and in some cases taken a different direction but our basic knowledge and skills are still the same. The hospital-based MRA/HIM remains the backbone of the profession. The demand for efficient and effective management of medical record services, the accurate classification of diseases and the protection of a patient’s right to privacy, may seem to have become more important in many ways, but has not changed per se. They are all still an intricate part of the role of all HIMs.

Today the future of the profession is in the hands of our young graduates. This profession has given me a great deal of pleasure and satisfaction as well as life-long friendships, not only in Australia but throughout the world. I have had the pleasure of being part of its evolution from a simple state association to a strong national one and believe that as professionals we still have a great deal to offer within the healthcare delivery arena. We need to continue to maintain the standards set over the years and to evolve at the right level, and move forward to greater heights in the future. We are still a small profession by many standards but nevertheless a strong one, as long as all members work together to maintain our professional status. The electronic patient record is our future and we need to embrace it with all our knowledge, expertise and commitment.

**References**


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