



**IFHIMA**

formerly known as IFHRO

# Global News

**International Federation of Health Information Management Associations**

A Non-Governmental Organization in official relations with the World Health Organization (WHO)

## ***The Link for Health Records/Information Management around the World***

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## IFHIMA President's Message August 2012



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Dear Global News recipients,  
my very best greetings to all of you!!

As the current President of IFHIMA, I am happy to reach out to you again, as we are currently 9 months out from the next IFHIMA Congress, the 17th Congress, scheduled in Montreal, Canada on May 13-15, 2013.

Plans are very much underway with significant information already on the IFHIMA web site. I hope you are all making plans in your countries for as many to attend this Congress as is possible.

I have also been continuing to contact some of you relative to your dues payments for 2011 and 2012. Not all countries have paid their dues for these 2 years. Countries not in good standing will not be eligible to vote on issues that come before the Congress, if they have not been a member through the period since the last Congress. Our membership chair, Darley Petersen has worked very hard this year in the membership area, and has sent timely reminders to all regarding dues.

Other requests are that each of you consider contributing to the Global News by sending articles for publication to Angelika Haendel, editor, who has done a fabulous job now for several years in this regard. Our success here is clearly linked to the

contributions from members and countries. Please also visit our web site regularly at [www.ifhima.org](http://www.ifhima.org). Send along to me information for posting to the web site, meetings going on in your countries and the like. We depend so much on the contribution of our members. If you are enjoying this Global News, consider contributing to the next issue.

Registration for the 17th Congress, and the abstract submission process is open. If you go to our web site, there is a link that will send you right to the Canadian site for the latest information. Sponsorship information is clearly indicated as well. You may also go directly to the Congress web site at [www.ifhimacongress2013.com](http://www.ifhimacongress2013.com)

Please plan on arriving in Montreal by Friday May 10, 2013, as there will be meetings, including the Educational Conference, open to all on Saturday, as well as the General Assembly on Sunday. The official opening of the Congress will be on Monday the 13th of May, 2013.

Our work on the board of IFHIMA this year is outstanding. The Europe IFHIMA group, with the good work of past president Lorraine Nicholson, is making great strides on many fronts, including the AHAIIP true European Innovation Partnership focusing on enabling EU citizens to lead healthy, active and independent lives. Ms Nicholson is also making great strides in Africa, and working to establish the HIM profession there. She'll be speaking in Nigeria in the fall as Nigeria has now re-joined as a member of IFHIMA. Welcome Nigeria!! I have been invited to attend the Chinese National Medical Record Management Conference and will be speaking in both Beijing and Guiyang City in September. I'm honoured to have received that invitation. IFHIMA has also been invited by the WHO to contribute to the development of ICD-11. Please email me if you are interested in volunteering in this capacity.

Other directors and board members have been equally as busy - their activities are too numerous to mention in this letter, but please go to the web site to see activities of our executive board in the Western Pacific, Africa and the Eastern Mediterranean, The Americas, and South East Asia. You'll find their names and emails on this letterhead. A big thank you goes out to Angelika, Lorraine, Joon, Marci, Stuart, Yukiko, Sallyanne, and Darley. We could not do what we do without each of you.

Thank you for your contributions to IFHIMA. We are only successful because of

our members, Directors and Executive Board. Please outreach to others and bring them along in our wonderful virtual organization.

Best regards,

Margaret

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**IFHIMA**

International Federation of  
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## The Need for HIM Education and Training in Developing Countries



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The International Educator's Forum held at the 16th IFHRO Congress in Milan on 15th November 2010 supported the development of a uniform standard of Global Health Information Management (HIM) education and training. Keeping up to date on the latest knowledge, skills and professional practices to maintain their level of proficiency is standard for Health Information Managers in developed countries. Up until now developing countries have challenged these basic needs of the HIM profession and the needs for a basic level of education covering necessary areas of the latest HIM knowledge and professional practice. The needs for basic, in-service, regularly updated training and the provision of professional career development are very urgent in developing countries.

"For developing countries to achieve the goal of better health requires better creation, capture and utilization of health information. In turn this requires the right people to be trained at the right time with the right skill sets. Improvement in health information system cannot be achieved unless attention is given to the training and career development of human resources at all levels this results in significant improvement in the quality of data and in the un-

derstanding of its importance by health care workers." (WHO 2008)

Each country's needs are fulfilled by its own HIM policy, plan, programs and short- and long-term strategies. But many developing countries do not have specific programs to address their HIM needs. Firstly there is a need to address the specific country issues of HIM at policy-making level and then secondly, to develop basic update programs for sound medical records management practice in the Hospitals. It is now timely for a review of current HIM systems and practice. In developing countries, Donor recommendations are very important to help to encourage the Ministry of Health to make positive changes that will support and improve the present situation.

As an example, in Nepal after 1993, the HIM function was placed under the control of the management division at the Department of Health. It is established as a section not as a division. There is no current provision for any one Medical Records Officer (MRO) or any medical records staff to work in the Health Management Information System (HMIS) section. The Deputy Director of the management division (who is a statistician), is head of the HMIS section. Staffing includes a statistical and computer officer and a statistical and computer assistant. The section focuses on funded preventative programs but it does not develop specific medical records management programs separately because it does not have skilled medical records human resources.

There is a total of 88 Government Hospitals in Nepal including those in the central regional and zonal and district levels. HMIS data are only collected in a timely way in these hospitals allowing the generation of timely HMIS reports. There are 18 private teaching hospitals and more than 200 private hospitals in Nepal but there are insufficient resources to completely cover the collection, analysis and documentation of the information from private hospitals.

There is no recent information about the contribution of private hospitals but it is felt that their contribution is at a satisfactory level in urban areas in Nepal.

It may not be possible to manage a sound HIM system without the provision of basic HIM education and regular, basic skills update training. The focus at policy-making

level should be to fulfill the current national requirements for HIM. The HIM community in developed countries explores the global issues of the HIM agenda but developing countries do not include the issues in priority level programs. Without these issues being addressed effectively at policy-making level it will be impossible to develop a national standardized HIM system.

### References

World Health Organization (2008) - Framework and Standards for Country Health Information System Strengthening, Health Metrics Network Tool Box <http://www.who.int/healthmetrics/tools/en/>

Abstract book of the 16<sup>th</sup> IFHRO international congress held in Milan 16-19 November 2010

Published annual report 2010, Department of Health Services, Nepal

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## World Health Day 2012 Celebration in Nepal (6 April 2012)

World Health Day (WHD) is celebrated every year as an advocacy tool, selecting key messages related to Global Health issues, highlighting priority areas of concern to the Member States & WHO. First World Health Assembly held in 1948 recommended conducting advocacy programs on the occasion every year on April 7<sup>th</sup>, which is continued every year thereafter. WHD celebration is then taken as a worldwide opportunity to focus on Public Health issues affecting the international community. The events are launched on the 7th day of April every year with different themes, slogans and advocacy programmes continued thereafter. World Health Day 2012 focused on “Ageing and Health” with the slogan “Good health adds life to years”. World health day 2012, was celebrated in Nepal with the organization of various programs at central, regional and district levels and institutes.



## International Examination for Morbidity Coders



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### Background

The World Health Organization Family of International Classifications (WHO-FIC) and the International Federation of Health Information Management Associations (IFHIMA) have been working together to develop an international coder training and certification program. After awarding international certificates to 79 ICD-10 mortality coders in four countries in 2007, the feasibility of awarding international certificates to morbidity coders was explored and a preliminary survey was conducted with positive results. A pilot test for experienced morbidity coders was developed and conducted in Korea in 2010 and repeated in Japan, Jamaica, Sri Lanka and Sweden in 2011. The tests were not for awarding certificates but for getting infor-

mation regarding the international examination for morbidity coders which will be the basis on determining future actions to be taken.

### Process and method

A small group of WHO-FIC Education and Implementation Committee (EIC) was formed to develop a coding exam for experienced morbidity coders that would reflect thorough knowledge of ICD-10. A request for coding questions was issued. Twelve countries sent exam questions which varied greatly in the number of questions and level of difficulty and some of them had to be translated into English. The questions were reviewed and a number of them selected for further consideration. These questions were circulated to the small group for discussion and agreement on the clarity of the questions and answers. The small group members finally selected 20 multiple choice questions, 30 coding diagnosis questions and 15 scenario questions (10 short and 5 long) for which there was agreement. Countries whose native language is not English arranged to have the exam questions translated into their own languages. The small group decided on the following points to be applied in the countries administering the pilot test.

- Marking scheme: number of points allocated to each question by type of question; points to be subtracted for no answer or wrong answer, incorrect selection of the main condition, over-coding
- Exam passing mark: 80% as decided at EIC meeting
- Time allocation for completing of the exam: 3 hours excluding the time for one restroom break and the evaluation of the test by the examinees
- Diagnoses and Scenario coding requirements:
  - Assign and list the main condition first

- All optional codes should be assigned including morphology codes, external cause codes and Z codes.
- All fifth character codes should be assigned, if applicable.

The number and qualification of the examinees in the 5 countries were as follows.

- Korea: 48 practicing coders with more than 2 years coding experience
- Japan: 52 ICD-10 distance training course lecturers and educators including some hospital coders
- Jamaica: 25 practicing coders
- Sri Lanka: 6 practicing coders with more than 6 years coding experience
- Sweden: 28 clinical coders

## Results

The exam scores were pretty low in all countries and the following factors contributed to the low scores:

- Different versions of ICD-10 are being used in different countries and even within the same country.
- Not all countries apply the WHO updates.
- National coding instructions may differ from the international standard guidelines.
- Variations exist in the level of detail used to code external causes.
- Not all components of the classification (e.g., morphology codes) are routinely used.

The following were the cases showing high error rates.

- Incorrect or missing external cause codes, morphology codes, and Z codes
- Incorrect or missing 5th character codes
- Incorrect selection of main condition code
- Incorrect or missing 4th character codes especially .8 and .9

Many other errors were also identified due to the lack of coding skills, for example, the meaning of ◇ mark in neoplasm table, assignment of Z code for aftercare, late effect code, assignment of a combined code versus a separate code for the comorbidity (e.g. hypertension and heart disease), U codes. Lack of knowledge of the WHO definitions and coding rules included in ICD-10 Volume 2 was also observed.

## Lessons we learned

Good communication is essential for both the person administering the exam and the examinees. They need to understand the purpose of the test and requirements for answering the questions given by the small group of EIC. The terms used in the questions should be familiar to them and the instructions should be self-explanatory. The exam questions should be translated into their own language by a person who knows medical terminology and the classification system.

The 3 hour time allocation for completion of the test needs further discussion because many of the examinees evaluated it as short. The starting time needs to take into consideration of the examinees' travelling time and distance from their place to the test site.

Given the issues which showed high error rates on the tests, the EIC members were surveyed and they confirmed the necessity of including the following in the test:

- Using the activity code when coding an external cause
- Using the morphology of neoplasm code for all tumors
- Assigning the additional code whenever ICD includes the instruction “Use additional code if desired.”
- Using a Z code to indicate outcome of delivery (Z37.\_)

### **Benefits we gained**

While the marks were disappointing, the pilot tests provided many benefits. They:

- Identified weak points of morbidity coding
- Provided very good information to set up coding education program (both basic and continuing education)
- Motivated coders to improve their coding skills by which the quality of coding could be enhanced
- Aroused interest for being internationally certified morbidity coder/trainer

### **The way forward**

Participants at the EIC mid-year meeting in March 2012 concluded that international credentialing and certification of morbidity coders are premature this time. It is hard to find resources to administer an international certification program and to maintain a databank of questions and, in certain countries, even to run the exam. While international certification of morbidity coders is not currently feasible, the group believed that the examination should be available to individuals to assess their own abilities. The exam should not be abandoned but rather should continue to be promoted and efforts made to enrich it by soliciting additional questions for future exams. The questions could also be used to support ICD-11 field trials.

Any international exam should reflect the experiences of many countries. All readers can contribute to this effort by submitting coding questions (and answers) to Joon Hong (jh.hong.42@hotmail.com) or Carol Lewis (calewis213@aol.com) for review by the small group and possible inclusion in the question bank.

## Data on a Comparative Study on Health Information Management Education around the World



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The aim of this comparative study on health information management (HIM) education in countries around the world is to contribute to the development of HIM and HIM education in countries around the world by gaining knowledge of the state of education of health information managers and coders as well as of data collection and management methods used in respective countries. Moreover, it is intended to serve as a reference for countries introducing HIM education for the first time, so that health information management education would spread to as many countries as possible.

I am convinced that giving countries the opportunity to compare their state of management and education with those of other countries will lead to further improvement of the quality of health information management and to the development of health information management education.

The study initially started with a survey of 17 countries in 2008 and has since expanded incrementally to more countries. As of now 34 countries are covered. The status of the study has been presented at the WHO-FIC Network's Education and Implementation

Committee by Japan Hospital Association on various occasions.

The items surveyed include mortality and morbidity coding, version of ICD or other classification systems in use, HIM training methods and teaching materials, how to obtain HIM or coder qualifications and the certifying organizations, and existence of professional organizations. The actual survey data can be accessed from the IFHIMA site.

In the hope of making the data available to IFHIMA members and those concerned with health information management, the data is available from the IFHIMA website.

<http://www.ifhima.org/whatsnew.aspx>

As for the method used for the survey, I interviewed or sent questions to those persons engaged in or related to health information management in respective countries. Please note that since the responses are dependent on the status of the respondents or their scope of knowledge, the responses do not necessarily represent the authorized data of the countries. It is intended to regularly update the survey data and include more countries in the survey. Therefore, information for updating or revising the data, information about countries not yet covered by the survey, and comments would be very much appreciated.

We set information gained from the survey on health information management and education in textbooks and lectures for students of health information management in Japan. There is a real sense that when students become more aware that there are many people abroad who, like them, are studying health information management and ICD codes, it substantially increases their motivation for study. I hope that the survey data would be used not only to contribute to improving the quality of health information management in respective countries, but also to significantly stimulate the intellectual curiosity of young people studying health information management around the world.

## Common HIM Job Titles in the US (and How to Achieve Them)



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What's in a name? A job title marks a person's position and duties in a workplace, but it also serves as shorthand for the skills and knowledge he or she brings to the position. In that same vein, the health information management (HIM) field in the United States provides a large selection of job titles in multiple settings - from coders to consultants, and from trainers to transcriptionists. However, some are more prevalent than others, and titles that seem different at first glance are more similar than you'd think.

Pinning down the most common HIM job titles in the US is a challenge. AHIMA's own efforts to catalog and analyze job titles have led to interesting results. For example, a casual survey of AHIMA's own membership - a total of 64,000 members overall - reveals a "top 10" list that looks something like the following (note: all titles are self-reported by AHIMA's membership):

- Coders, 7,547
- Students, 3,477
- Coding Specialists, 2,173
- Consultants, 1,761
- Office Managers, 1,755
- Medical Coders, 1,694
- Presidents, 1,538
- Managers, 1,347
- Directors, 1,253
- Instructors, 932

For a more precise assessment, a recent official study of AHIMA membership demographics between 2010 and 2012 revealed that the most common job levels broke down into several positions. For example, more than a quarter (27.9 percent) of AHIMA's membership work as HIM technicians, while 14.6 percent serve in managerial or other supervisory positions. Furthermore, another 10.2 percent hold clerical and administrative positions; 9.6 percent act as directors and officers; 6.1 percent are consultants; 4.4 percent hold technical roles; 3.5 percent are teachers and other educators; and 2.1 percent were hired as clinicians.

One noteworthy trend in the above study was the rise in HIM technician, clerical, and administrative titles. This reflects US Bureau of Labor Statistics data showing that the availability of medical records and health information technician and medical transcriptionist positions are expected to skyrocket between now and 2020, with demand increasing by more than 21 percent as our population ages, demanding more care. Find more information here:

[www.bls.gov/ooh/Healthcare/Medical-records-and-health-information-technicians.htm#tab-1](http://www.bls.gov/ooh/Healthcare/Medical-records-and-health-information-technicians.htm#tab-1)

[www.bls.gov/ooh/healthcare/medical-transcriptionists.htm](http://www.bls.gov/ooh/healthcare/medical-transcriptionists.htm)

Charting common job titles is further complicated by the fact that similar jobs can have slightly different names. You may be a *coder* in one organization while your nearest counterpart elsewhere is an *inpatient coder*, *outpatient coder*, *coder II*, or something entirely different. Supervisory roles also exist, such as *coding supervisor* or *coding manager*, as do specialties such as *coding analyst* and *coding consultant*. Where are the lines drawn? Viewing the topic through the lens of AHIMA certification is one way to parse the choices.

AHIMA credentials favor and cover multiple job settings and titles.

For instance, those who hold the registered health information administrator (RHIA) credential serve across a wide range of settings. RHIAs manage patient health information and medical records, administer computer information systems, and collect and analyze patient data. This suits them for work in continuum of care delivery organizations, such as hospitals, multispecialty clinics and physician practices, long-term care, mental health, and other ambulatory care settings. Titles in these environments include *director, manager, health information manager*, and the like. Comparatively, registered health information technicians (RHITs) mostly work in hospitals, though they also perform duties in healthcare settings such as office-based physician practices, nursing homes, home health agencies, mental health facilities, and public health agencies. Any organization using patient data or health information - such as pharmaceutical companies, law and insurance firms, and health product vendors - would find an RHIT useful in a *technician, IT, health information technician*, or similar position involving oversight of medical records.

Certified coding specialists (CCSs) and certified coding specialists—physician-based (CCS-Ps) have mastered the coding and classification of medical data from patient records. CCSs serve in hospital settings, while CCS-Ps specialize in physician-based settings such as physician offices, group practices, multi-specialty clinics, or specialty centers. Wherever they may work, the data generated by these individuals is shared with insurance companies, the government (in the case of Medicare and Medicaid claims), and researchers and public health officials for use in monitoring the public's health. CCS and CCS-P job titles frequently employ the word *coder or coding*, such as *coding educator, remote coder, director of coding*,

*coding manager*, and, in one exception, *auditor*.

As for the future of a career in HIM, job title variety will continue to grow, inspired or induced by changes brought on by technology, legislation, and education. In anticipation, AHIMA has produced two reports in the last few years seeking to predict the future of the field; the new roles, functions, and opportunities facing HIM professionals; and the preparations they should take to face them.

Last year, the AHIMA Board of Directors drafted the HIM Core Model, proposing five functional areas of health information to focus on, and the HIM professional's role, in the coming years:

- Data capture, validation, and maintenance
- Data/information analysis, transformation, and decision support
- Information dissemination and liaison
- Health information resource management and innovation
- Information governance and stewardship

Exploring subject literature, job postings, and the AHIMA database, the Board compiled an extensive list of potential roles, settings, and their value to the HIM field. (Review the report and lists here: [http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1\\_049283.pdf](http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_049283.pdf))

AHIMA stresses the value of education, having discovered (and outlining in its Vision 2016: A Blueprint for Quality Education in HIM report) the rising importance of higher degrees in HIM. A job analysis conducted by the Association turned up some interesting data about HIM and health information technology (HIT) pros with a master's or higher degree. Of the 609 individuals surveyed the topmost frequently chosen job titles (representing 56

percent of the respondents) included roles as HIM directors, assistant directors, or supervisors. Notably, not all respondents possessed HIM credentials, suggesting (per the Blueprint) the encroachment of non-credentialed professionals from other backgrounds on positions better assumed by those with a proper background and skill set in HIM.

Regarding the rising need for graduate-level HIM professionals and future HIM educators, the trend is encouraging, but work must still be done to promote the pursuit of higher education. Per Vision 2016, 11 percent of AHIMA's membership base (5,600 in total) holds master's level degrees and doctorates, and higher-level positions as directors, managers, and administrative positions at the executive level. In short, those who wish to rise through the ranks must seek graduate level degrees or be left behind. (Read more here: "<http://www.ahima.org/schools/FacResources/RESEARCHVISION.pdf>")

and see AHIMA's Health Information Careers site

<http://hicareers.com/Toolbox/pathways.aspx>

for further information on successful educational pathways.

With an aging population, there's no doubt that work in the HIM field will always be available, with the number of job titles in fact increasing as new specialties develop to accommodate new technology (for example, electronic health records, new legislation, and the inevitable implementation of ICD-10 in the US). Eventually, no job title in HIM will be considered "common." If anything, the variety and range of titles, positions, and other opportunities available to the HIM professional will make every job title extraordinary.

*Lynne Thomas Gordon is the CEO of the American Health Information Management Association. Representing more than 64,000 specially educated health information management professionals in the United States and around the world, the American Health Information Management Association is committed to promoting and advocating for high quality research, best practices and effective standards in health information and to actively contributing to the development and advancement of health information professionals worldwide. AHIMA's enduring goal is quality healthcare through quality information. For more information, go to [www.ahima.org](http://www.ahima.org)*



## Health Information Managers in The Philippines



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There are about more or less one thousand two hundred thirty seven (1,237) Health Records Managers in the Philippines, but the Philippine Medical Records Association (PMRA) has only 180 registered members Health Records Managers, most of these members belong to private hospitals. There is another association by the name of League of Government Health Information of the Philippines in which government health information managers are members.

The association (PMRA) continues to offer training and workshops to all personnel in the field of health records information. We hold a bi-monthly activity for all our members wherein we conduct the following.

- Medical Records Management
- Lectures on Medico-legal aspects (with focus on patient dead on arrival, privacy and confidentiality and witnessing in court)
- Seminar/ Workshop on birth registration, death certification and other aspects of legal documentation
- Seminar on PhilHealth claims and benefits

- Seminar/ Workshop on the Hospital Statistics
- Seminar/ Workshop on Release of Information (privacy and confidentiality)
- Seminar/ Workshop on International Classification of Diseases -10 in conjunction with Dr. Juan Lopez of the Epidemiology Center Department of Health. Who was trained at Brisbane, Australia.

The association (PMRA) is charging Seminar Fees to the members in order to fund the lectures, venues and other logistics to keep the seminar running. Evidently, private hospitals have more of their budget allocated for these kinds of training.

Both private and government hospitals have the same standards for hiring Health Records Managers – a graduate of any 4-year course – even if the individual has no experience concerning health records, this is for a new built hospital, but in cases of old hospital the health record managers are hired with the required 5 year experience and with a master degree in management or in business administration especially in a tertiary hospital.

Health Records Managers take up their master degree in the field of their own choice since they are required to have a master degree as a hospital standard but unfortunately, the courses they take up are not centered solely on records management due to its unavailability.

It was only three years ago when the NCHFD, with the help of Department of Health and the premier state university in the country, University of the Philippines, offered a certificate course on Health Information Management. There were several Health Record Managers coming from different government and private hospitals, who finished the said course. Sad to say, DOH and UP was unable to offer the course again this year due to lack of finances.

Our Medical Records Adviser from NCHFD also proposed to Department of Health and the Department of Budget and Management five years ago to have a reform in the position of Health Information Managers. The proposal was done in conjunction with the rationalization of the plantilla position of the Department of Health. All Health Records Managers will be con-

sidered and upgraded in their position, with the corresponding increase in their salaries, so as to uplift the morale of all health record practitioners in the country. Hopefully by the end of this year, DBM will release a favorable result to this proposal to further reinforce the role of Health Information Managers to our Health sector.

## HIM in Finland



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### General information

Estimating the number of HIMs (Health Information Manager) is quite difficult because we have many different titles, but there are about 4000 persons who are working as HIM in primary and special health care in Finland. They are called “osastonsihteerit” or “avdelningssekreterare” (Finland is a bilingual country, Finnish and Swedish are the official languages). The title would be directly translated into “ward secretary”. Medical secretaries work in private clinics and occupational health too.

### Training

We have 9-years of comprehensive school for everyone. Most medical secretaries have a commercial education without an orientation to health care after the first 9 years. It is usual that a person is hired after 3-years of commercial education and

it is up to the colleagues to introduce her to the work besides their own daily work.

In some places different actors arrange courses and in these include anatomy, physiology, administration in national health services and laws etc. These courses usually run over a period of months, maybe about 9 months including holidays. The requirements to get in to these courses can vary, usually there are no special requirements, 9 years comprehensive school is enough.

In some areas schools arrange even 3-years' education with orientation to health care: the first two years are together with nurse students and the last year is oriented to customer service and data administration. This education has not been very popular because the students have to choose if they prefer to be a nurse or a medical secretary. There are very few jobs offered, where they can use all their skills. In spite of this, this education is nationwide. Another reason why this education has not been popular could be the title of it: “lähihoitaja”, which could be translated into “basic nurse”. Even though they work as secretary, so there is a dilemma between the title and tasks.

Terveydenhuollon Sihteerit ry (the Finnish national association of secretaries) has in many years tried to get a nationwide education for secretaries without nurse skills. We haven't managed with this yet, but we keep trying, of course. Ministry of Education is planning a new education for medical secretaries and even Terveydenhuollon Sihteerit ry was asked to get a statement about the criteria. Now we are waiting for the results.

### The responsibilities

HIM's responsibilities are almost the same as in Denmark: the visitation procedure, making appointments, sending calls, reception, transcribing dictations and many other texts, coding, updating websites and other office work. The tasks are about the

same in primary, special health care and in private sector. Health Information Managers in Finland can also be attached to the work of the chief doctor or chief nurse.

Automatic Speech Recognition is used in some places, usually on X-ray departments to routine statements.

We don't have any Diploma for Leading Secretaries as we do not have any leading secretaries. Secretaries belong to nurse staff or other staff and department head (nurse) and charge nurse are our superiors. But HIMs work is completely secretarial work.

### Recruitment

A person who has graduated from the 3-years' commercial education (after 9-years' comprehensive school) is a competent HIM in Finland. Nowadays many persons are graduated from university of applied sciences (commercial) and they are, of course, supposed to be more competent because their education is 3 years longer (9 + 3 +3). In the condition of qualification in Vaasa Central Hospital it is "enough" that the person has graduated from the technical college (usually commercial) or university of applied sciences. The demands can vary from hospital to hospital.

The employment situation is not very good. Hiring new personal is very uncommon because there is lack of money. The average age of secretaries is quite high so many of them are retiring within some years.

### Future?

Many people seem to think that after some years medical secretaries are not needed any more because of many robotic systems. That might be a reason for not having visions for our future work. At the time being medical secretaries have so much work to do that they don't have time to make future visions and to find the right channels to the decision-makers.

Electronic health records are implemented in Finland and we will have a national archive even for patients' use after some years – an active patient is desired in the Finnish health care system. Maybe the role of medical secretary could develop to be a coordinator between patient and hospital, but also to be a multidisciplinary contact person. We hope that the employers might see the medical secretary as a resource to the new kind of jobs.



**Terveystuollon Sihteerit ry**

Sosiaali- ja terveystuoltoalalla toimistotyötä tekevien ammatillinen etujärjestö

## Medical Secretaries and Electronic Patient Records: Invisible work and its future?



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**SUMMARY:** The upgrade plan for the new electronic patient record (EPR) was changed by the IT-department a few weeks after taking it into use. It was the first time for the Regional Hospital to implement a comprehensive EPR and unexpectedly medical secretaries, not performance, IT-bugs, or resistance by physicians, were the main challenge. Their functionality for transcription, coding and finalizing patient records was slow, and they could not keep up with the workload. Despite hiring outside help, physicians and nurses at the hospital found themselves lacking updated records and voiced their discontent. Software patches resolving some of the medical secretaries' problems with the EPR were implemented immediately, and the first, planned upgrade of the EPR a month later was changed to focus solely on the remainder of the medical secretaries' problems caused by the new EPR. For a moment, the work of medical secretaries, otherwise often taken for granted, became visible.

It was this experience that led me and my colleagues to focus on medical secretaries and their central role in the work arrangements of hospitals. We were in the midst of evaluating the implementation of a comprehensive EPR [1], when the incident occurred. After having completed the evaluation report, we decided to follow up upon the medical secretaries. Medical secretaries in Denmark and other countries have their own associations and unions to represent them in public and know their

work. However, to our surprise, very little is written about medical secretaries within social sciences and medical informatics, and even less is written about how their role and work changes in connection with implementation of EPRs. With the efforts of developing and implementing EPRs in many countries, and the importance of medical secretaries to healthcare organizations that relative invisibility should, we think, be addressed.

### Medical Secretaries' work with paper records

The work of medical secretaries varies across countries and even within these. In general, Danish medical secretaries can be said to perform a variety of tasks: Code patient records with appropriate diagnoses; ensure patient record data are accurate, updated and complete; transcribe dictates; book appointments; communicate with patients, relatives and various entities internally and externally to the hospitals; and other miscellaneous tasks.

In a social science perspective, medical secretaries can be said to be information gatekeepers in the sense that they are central for communication between staff within and between departments, and with patients. They take calls to the department and if they cannot provide answers themselves, they know whom to direct the call to. They are also articulation workers in the sense they coordinate, align, and put together the various non-clinical tasks around patient treatment and care and patient records. They coordinate bookings; inform physicians and nurses about scheduled examination so these can plan their rounds and care accordingly, etc. Furthermore, a central concern in their work ethos is carefulness: Ensuring that data in patient records are updated, complete and accurate. Whereas they are not interested in the substantive content of

records, they are keenly concerned that the records' formal aspects are correct, so that it may work properly for physicians, nurses, hospital management and reimbursement objectives. In lack of a better sociological concept, they are also record trimmers in the aeronautical sense of leveling an airplane to ensure smooth flight, or in the nautical sense of distributing the load and adjusting the sails of a ship, to reach optimal speed and stay on course. 'Trimming' stresses the dynamic and directional aspects of the work, in contrast to 'upkeep' or 'maintenance', which suggest a more static extension of a given state. Medical secretaries ensure the record is trimmed so that treatment and work trajectories are kept on course.

#### **..... and with EPRs**

Implementing the EPR at this hospital entailed several changes. The most obvious change, of course, was that the medical secretaries did not have to print out transcribed dictates and put them into records, nor did they have to spend time requesting and returning records to the archives, or locating records around departments. Transcriptions were entered directly into the EPR, which was accessible from any computer. However, transcription also became more cumbersome, since the new functionality required more clicks, made work processes more rigid, and the new requirement of uploading digital physician IDs slow them down. This was what the software patches and first upgrade of the EPR were to remedy. Hence, though physicians might enter short notes into the EPR themselves, transcribing took longer for medical secretaries.

Since all professions used the EPR, work became more tightly coupled. A benefit of this was the immediate availability to everyone of information as soon as it had been entered into the EPR, but there were also disadvantages. For example, physicians often dictated their discharge sum-

mary before the nurses had completed their documentation of a patient's care, and while the secretaries could write the summary, the work flow embedded in the EPR prohibited them to send the summary to the general practitioner until the nurses had completed their documentation, and registered the patient in the EPR as discharged. A prohibition that the paper record did not have. Hence, they had to check the EPR repeatedly to see whether this had occurred, which entailed a bit more work for them. In this and other ways, the tighter coupling of tasks sometimes slowed work down. Moreover, medical secretaries still found themselves occupied with 'trimming' records, ensuring records were complete, updated and accurate. They were still the ones making the final check as to whether tasks in the problem list had been terminated and results from examinations signed off (for a more detailed description, see [2]).

The changes mentioned above depend to some degree on the specifics of the EPR and hospital in question. For example, in the case of hybrid EPRs, scanning paper documents and entering them into the EPR is a new, major task. In the USA, the tasks performed by the Danish medical secretaries is delegated to more specialized professions such as health information managers, clinical coders, transcriptionists, and chart completion. Even so, we suspect that the tasks and work of medical secretaries or their equivalent specializations changes significantly when EPRs are implemented.

#### **Medical Secretaries in Sociology and Medical Informatics**

While the journals of medical secretaries' association in Denmark and of, for example, the American Health Information Management Association pay considerable attention to EPRs and their members' work, the interest paid to that work is very scarce in the European-based Internation-

al Journal of Medical Informatics, in its American counterpart Journal of the American Medical Informatics Association, and more broadly within social sciences. Browsing the former two, we found one paper focusing on medical secretaries [3], and few papers in other journals where medical secretaries are included as one of several groups in evaluations of EPRs [4, 5]. We also found one sociological paper comparing medical secretaries' work with bank tellers in Sweden [6].

Although, we have not conducted a survey of all relevant journals within sociology and medical informatics, results from Google Scholar are revealing: A search for scholarly articles mentioning medical secretaries in the title results in 41 hits, whereas the results for physicians and nurses respectively provide 35,900 and 54,600 hits. While this reflects the predominance of the latter two professions, the relative invisibility of medical secretaries seems nonetheless puzzling, since they are central to the working arrangements of hospitals, and since that work most likely will change with the implementation of EPRs. Both issues ought, we think, to be of interest to sociologists interested in work studies and to scholars within medical informatics, but little is found.

The invisibility of medical secretaries may have several, partly overlapping explanations. As for the social sciences and medical informatics, private and public efforts to digitize health care have until recently focused on physicians and nurses, and researchers may have followed this trend. However, we suspect that other factors could be significant. First, as a kind of administrative service work, medical secretaries may suffer from the same relative sparse attention paid to similar service jobs such as bank tellers and post office cashiers. Second, as part of organizational infrastructures, their contribution tends, when well-functioning, to sink into the background as a taken for granted part of the infrastructure around the work physi-

cians and nurses perform and which is commonly perceived as the core of healthcare: treating and caring for patients. Only in break-down situations, such as in our case, is their work foregrounded. Third, work organizations are despite often assumed otherwise gendered, and organizational studies have a not so benign neglect of occupations where most staffs are women, which is the case for medical secretaries in Denmark, England and the USA, for example. Finally, what medical secretaries do is often opaque to others, and as a result they are perceived as merely persons in white coats with props in their ears writing dictates for the physician (Photo 1).

Even in a Danish context where most medical secretaries are organized in a national association, their experience is not to be seen by management, who, according to the medical secretaries, do not know their competencies and may talk about replacing them with general, office secretaries. For the same reason, their union funded a study that described their various tasks [7]. Similarly, in the UK in 2004, the union launched a campaign to bring attention to the "hidden workforce" of the National Health Service, and to counter a public image of clerks and medical secretaries as overpopulating and bringing no extra value to healthcare. A series of case studies was also launched in order to foreground medical secretaries' work.

### **IT future**

The future for medical secretaries working with EPRs is uncertain. The development from punch card work, data processing to computing in the first part of the 20th century shows a pattern of women repeatedly being shedded off into the less-skilled, less remunerated jobs. In the 1980s, the digitalization of office work led to deskilling, up-skilling, and as well to a status quo for clerks and secretaries' work position and remuneration. However, EPRs may strengthen medical secretaries' position: The emergence of infrastructures

such as EHRs is also part of an increasing demand for accountability to other parties, such as management and health care authorities. This will demand continued effort, to ensure the accuracy, completeness, and integrity of data. Since clinicians are costly, on call, and prefer clinical tasks to administrative ones, this is an opportunity for medical secretaries. In Denmark and the UK, the unions of medical secretaries have pointed out their expertise upon data quality when nurses and physicians complain about doing too much documentation. Much depends on the ability of medical secretaries to influence the process of change set off by the implementation of EHRs and entailed abolishment and drift of some tasks and emergence of new ones. We hope researchers within social sciences and medical informatics will engage and contribute to medical secretaries' work gaining attention and visibility in their disciplines and in the public visions of digitized healthcare.

PS: We would be happy for references to other studies of medical secretaries, or related professions, working with paper-based records or EPRs.

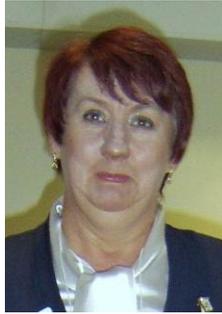
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Photo 1. Danish medical secretaries are most often identified by the public with one of their tasks: Transcribing, alone in their office, and apparently not part of the hospital's work arrangements

## Medical Secretarial Training in Cameroon



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The British Society of Medical Secretaries & Administrators (BSMSA) was asked if it could help to set up a brand new training course for medical secretaries in Cameroon, West Africa. The Society was approached by the St Francis School of Health Sciences which, with the support of the Department of Employment and Vocational Training in Cameroon, was setting up this new project.

It was my pleasure to be the one to take on this project. I love to travel but have to admit it was with some trepidation that I agreed to do this so I asked if my son could accompany me and the relevant parties agreed. Having been jabbed several times with a very sharp needle, swallowed countless tablets and sprayed myself with what is the mosquito equivalent of CS spray, I was ready for the adventure to begin!

We arrived in Douala, Cameroon at 9pm on Saturday night and found that it was 32C. We were met at the airport by three gentlemen bearing a piece of board with my name on it. We had a two and a half hour journey by road to Buea on unlit roads and we arrived at our hotel at 11.30pm - to say we were a little travel weary would be an understatement!

The following day I went to St. Francis School of Health Services and met the rest of the team. We had a short briefing session and it was explained to me that the medical care in Cameroon is delivered in hospitals and polyclinics and it is on a fee paying basis. There are no GPs or health centres and if a person cannot pay then generally they cannot be treated. There are one or two free hospitals operating throughout the country.

On the first working day I met with the Founder of St Veronica's School of Nursing and Midwifery and St Francis School of Health Sciences, Dr. Biaka, and his wife who holds the post of Hospital Administrator. I was then taken to meet the Delegate for the Department of Employment and Vocational Training. He and his staff were very enthusiastic and supportive of the project and once it is underway in the Buea region he is prepared to take it to the Minister for Employment to try to roll out the courses throughout Cameroon.

We next met with the first batch of medical secretaries who were trained in 2010-2011. It was interesting to learn what their current roles were and how they themselves felt they could be developed. They felt that they should receive some basic clinical training to enable them to be more flexible in their work.

Following this we were taken to meet the Delegate for the Department of Employment and Vocational Training. No work can go on in Cameroon without the blessing of various departments involved. The Delegate made us feel very welcome and is very much in favour of St Francis' School of Health Sciences becoming the flagship for delivery of Medical Secretarial Training throughout Cameroon in due course. He is hopeful that once the courses are being satisfactorily run in Buea then the programme could be rolled out throughout Cameroon.



Mr. Maboh Nkwati,  
Registrar, St. Francis School of Health Sciences



The secretaries are currently commercially trained and have no medical administration training. When I asked them if they felt the new course would be beneficial to them they all agreed that it would.

I delivered a presentation on BSMSA's course materials and the way the City and Guilds courses are delivered. There is interest only in City and Guilds accredited courses and this presentation was observed by two officers from the Ministry of Employment. After the presentation there was an open forum for discussion on the contents of the City and Guilds courses.

For the next three days I worked with the team from St. Francis to draft programmes for three courses. The first is suitable for ward clerks, receptionists and appointment clerks. The second course will be a 2-year course for medical secretaries and the third course will be a Degree course for Medical Administrators who would be Senior Managers in the hospitals. The outline for the 3-year programme for medical secretarial training is as follows:

- Year 1 - City and Guilds Level 2 Certificate/Diploma in Medical Administration. This will be the equivalent of an ONC level in Cameroon. All of the courses must fit in with the education framework of the country.
- Year 2 - City and Guilds Level 3 Certificate in Medical Administration or the Diploma for Medical Secretaries and this will be an HND equivalent.
- Year 3 – it is envisaged that this part of the course will be delivered with the support of Buea University and it will be a BA degree course using materials from BSMSA's Level 5 Practice Manager qualification.

Work continued and the curricula were finalised ensuring that there was the correct content and combination of credits so that City and Guilds certification could be achieved. The Registrar of the School, Mr Maboh Nkwati, will be meeting with staff at Buea University to seek support and to ensure that the level that the courses are pitched at is acceptable at Bachelors level.

I was also taken out to visit other hospitals, Buea General Hospital and Limbe General Hospital, where I met senior management staff and the secretaries currently working there.

I had been asked to give a presentation to visiting dignitaries and hospital chiefs from around the region during my visit. This was an unusual event in that the St. Francis' Choir and the St. Francis' Dancers entertained us both before and after the presentation. The choir were fabulous and I only wish I had been able to tape their singing and bring it home with me!

A seminar had been organised for my penultimate day and I was advised that I would be the main presenter on the "Role of the Medical Secretary in Cameroon" and also the 3-year BA Course for Medical Secretaries. Delegates had been invited to the seminar from several Ministries in Cameroon, all of the Regional Hospitals, the newly trained medical secretaries and the present medical secretarial and nursing students. The seminar was very well received and several senior hospital managers advised that they would certainly look at employing one or two qualified medical secretaries in the future. The seminar was filmed by the local TV station and

after my presentation I was interviewed by the TV station about the purpose of my visit to Buea and about the BSMSA and the role of medical secretaries. I did a live radio broadcast, which was a frightening new experience for me! The Delegate for the Ministry of Employment gave very public and emphatic support at the seminar and made his views well known on TV and the radio.

On my final day I was given a fabulous send off. A farewell ceremony was held in our honour and the choir of St. Francis' sang for us and local dancers gave a wonderful display of their talents.

My visit to Cameroon was a fantastic opportunity both for me and for BSMSA and I enjoyed every minute of it. The visit and the opportunity to input to course development at St. Francis School of Health Sciences would not have been possible if I had not been a part of the BSMSA.

Since I returned to the UK I put Mr. Nkwati in touch with BSMSA's Special Projects Manager, Lorraine Nicholson, who is also Immediate Past President of the International Federation of Health Information Management Associations (IFHIMA), so that he could find out how IFHIMA could also support the School.



St. Francis' Choir



St. Francis' Dancers

## Health Information Managers (HIMs), Medical Secretaries



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In Denmark approximately 10,000 persons are working as Medical Secretary in the field of health record management, primarily in public hospitals, but General Practitioners and Specialists, and private hospitals takes the second lead. Other areas like medical industry, insurance companies and electronic data industry take a minor part of our group. In Denmark all categories are titled Medical Secretary.

Since 1960 professional training has existed in Denmark. First as private schools offering 9 month courses to achieve an authorization to work as a Medical Secretary. After a decade, students were trained in hospitals given theoretical training parallel with practice in different departments.

The training has following concept:

### Admission requirements for students:

- Commercial school: 2 years  
 Theoretical education: Languages (Danish and English), Economics, IT, Social studies, and Commercial

After commercial school the persons are entitled to apply for practice school - in hospitals or at GP's practice.

Schools start every year in August and last 2 years

In total the educational Program for Danish Medical Secretaries runs over 4 years.

During practice supervision of all students is based in students' educational department in each hospital. Through this department, the students have been chosen qualified for entering the practical period of the education.

In each department, the student refers to a Medical Secretary assigned as Students' Coach. This person supports the students on a daily basis. The educational program in each department has been set up in cooperation between the students' educational department and the Student's Coach.

During the practical period of 2 years, each student must work obligatory in departments of surgery, medicine, and service departments.

Theoretical training throughout the period takes place in commercial schools over 5 periods, in total 18 weeks. These semesters include: Anatomy, Physiology, Pathology, Administration in National Health Services, Management, and Administrative law.

The remaining time of practice school is dedicated Training in different departments in hospitals and/or at GP's practices taking part in functions with Medical records, - design and use of medical terminology – IT, Administrative means, Communication, and Management.

Practice school ends after 4 years in a project proving technical knowledge. After that the Medical secretary is qualified for a job within hospital departments or GP's practice.

### Variation of employment in hospitals:

The biggest variation of jobs for Medical Secretaries is found in Danish hospitals. Each department has a professional staff with qualifications concentrated on the actual special tasks. In a university hospital it is not possible to exchange jobs without supported training. Therefore each

department has designed an instruction plan for all new employees.

The variety of jobs in hospitals could be:

- Special secretaries connected to a department - responsible for the visitation procedure, calling in patients and pre hospital examinations.
- During hospital stay secretaries are connected to chief MD's, taking care of their calendars, supporting patient work and plans for lecturing the medical staff.
- Other secretaries update the patients' health records on a daily basis, and are responsible for coding systems and discharge letters.
- Another group of secretaries are connected to the department administration, the chief doctor and chief nurse, - to which the leading secretary refers. Also economic procedures are located in this leading secretariat.
- If the department has a Unit of Clinical Research and Development, there will be special tasks for secretaries connected to this.
- All technical departments in the hospital i.e. Department of Mammography, Department of Radiology, Department of Biochemistry, Pharmacology and Genetics etc. have secretaries with specialist functions.

**Postgraduate education and certificates:** To specialise the Medical Secretaries within individual areas, there is a great number of offers for postgraduate education given either as internal or external courses or seminars. The courses are primarily targeted special groups of professionals, but interdisciplinary courses are also set up.

Before implementation of new technology, each hospital offers education within the area, i.e. booking systems, economic systems, electronic patient record, DRG doc-

umentation, classification systems etc. This kind of course is free and takes place during working time.

The department of postgraduate education in each university hospital covers one or several hospitals, and a catalogue is published every half year and distributed to the staff.

Postgraduate education is formed as seminars lasting from half a day to several days, or as a full week. Also weekly lessons over a period of months can be followed. Almost all courses are paid by the delegate's employer, but unfortunately the economic resources available make it impossible to cover the amount of applications.

Courses take place within working time as well as after working time, and are located in lecture rooms in hospitals or in conference centres.

Also postgraduate education is offered by individual professional organisations. These courses are basically for members only, but might be open for other professionals within the health sector.

Certificates are given after these courses, and generally they are used as documentation in job applications or as documentation for a higher salary.

**Diploma for Leading Secretaries:** Qualifications to become include the general basic and postgraduate education. On top of that it is well seen, if a diploma from business school is achieved. This diploma is documentation for a high school based education on subjects like personal management, organization items, and economic management. Before starting high school, time and money must be granted from the hospital. The period for achieving the diploma is generally 3 years with one weekly day in class. A diploma from high school leads directly to a higher salary.

The latest development for post educational courses is possibilities to study for a Bachelor's Degree.

## Medical Secretaries in Greenland



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The Health Record Professionals in Greenland are called Medical Secretaries.

At this time being 32 Medical Secretaries are occupied in hospitals located in 5 towns: Nuuk, Narsaq, Maniitsoq, Sisimiut and Ilulissat.

5 students, two in 4th semester and three in 1st semester are at the time being in educational period.

The educational programme is very connected to Denmark as students follow the Danish graduation programme.

Queen Ingrid's Hospital in Nuuk makes every year announcements for students; these announcements appear in national newspapers. Other hospitals do not advertise. The Leading Secretary at Queen Ingrid's Hospital announced, that many unsolicited applications for a student's job were available this year, so no advertisement was done.

The students' theoretical education takes place in one of the commercial schools in Denmark (Odder Business School) 4 times during 2 years period. The students find accommodation in the school. During weekends, when Danish students return to their homes, students from Greenland

have an opportunity to stay in a house next door to the school.

The period of practice will be organized to take place in the hospitals in Greenland, which are found qualified for performing the students program. It means that only hospitals with a professional staff of Medical Secretaries, i.e. Secretaries having performed a full students programme themselves, are certified to supervise students. These hospitals are in Nuuk (capital of Greenland), Maniitsoq, Sisimiut and Ilulissat. Narsaq can also have a student, but never receives any applications.

The 32 professionals within the health information management area do seem a small number compared to the huge country, but doctors practising in smaller towns and areas all perform documentations in patients' health records by own hand.

Medical Secretaries are on a daily basis mainly occupied with writing after dictation in health records, writing letters, and admission papers for treatment of patients in Danish hospitals. Discharge letters are made in national language as well as in English due to foreign tourists or sailors – mostly from Canadian trawlers. Cancer registration is done in Queen Ingrid's Hospital as adjuvant therapy also is given in Greenland in stead of sending patients to Denmark.

Normally we are short of hands as our salary is below the standard given in Denmark. This means that persons from Denmark who seek job in Greenland often resign because of low salary. There are hopes that new negotiations will raise the standard of salary, this will happen in May 2012.

Postgraduate education normally takes place in Denmark.

As Chairman for the national association I have the possibility to join meetings every year at the Nordic Conferences within the professional area such as meetings planning the Nordic Congresses which are held every three years. The Nordic countries send one or two persons as representatives and the location change from congress to congress.

In 2013 Iceland will be the host of the Nordic Congress. Two members of the

Greenlandic board will join the congress together with other interested Greenlandic Medical Secretaries. Before registration for participation, approval is needed from the hospital as it is mandatory that the department can manage without the delegates during the period. - Unfortunately the Nordic Congress is going to be held in the same month as IFHIMA 17th World Congress in Montreal, Canada.

## WHO Family of International Classifications (WHO-FIC) Meeting March 19-21, 2012

Margaret Skurka, Joon Hong, Yukiko Yokobori and Marci MacDonald, attended the WHO-FIC meetings March 19 – 21, 2012, in Washington, DC., USA. Carol Lewis, a former IFHIMA President, also attended and continues to lend her expertise and support as an engaged WHO-FIC committee member.

The WHO constitution mandates the production of international classifications on health so that there is a consensual, meaningful and useful framework which governments, providers and consumers can use as a common language.

Internationally endorsed classifications facilitate the storage, retrieval, analysis,

and interpretation of data. They also permit the comparison of data within populations over time and between populations at the same point in time as well as the compilation of nationally consistent data.

The purpose of the WHO Family of International Classifications (WHO-FIC) is to promote the appropriate selection of classifications in the range of settings in the health field across the world.

IFHIMA is pleased to support and serve on this WHO Committee, and has been instrumental in the advancement of an ICD-10 on-line training tool. Please look for a link to this Committee on both the IFHIMA and WHO websites. In addition, please visit the WHO-FIC Training Tool Reference Group, which has been created to assist those utilizing the tool, who may have queries and require support.



*From left: Sue Walker (Australia), Rita Scichilone (USA), Margaret Skurka (USA), Kathy Gianangelo (USA), Carol A. Lewis (USA), Joon H. Hong (Korea), Yukiko Yokobori (Japan), Marci MacDonald (Canada)*

## World Health Day 2012 Theme becomes sensational News for the Media



*Reproduced from the WHO (Africa Regional Office) website for Tanzania*

<http://www.afro.who.int/en/tanzania/press-materials/item/4525-world-health-day-2012-theme-becomes-sensational-news-for-the-media.html>

Tanzania like other WHO Member States has commemorated the World Health Day (WHD) 2012. The WHD 2012 was deferred as it coincided with Easter. Hence the Tanzania Government decided to postpone the WHD Occasion to 17th April in order to give it due prominence. The main planned activity was stakeholders' advocacy and information dissemination. A Media advocacy session was organized on 17th April 2012 and it attracted larger than expected participation of the Media.

While 30 were invited 58 members of the Media attended and fully participated in the outlined activities to celebrate the WHD. The event was chaired by the Hon. Minister of Health and Social Welfare who was represented by the Commissioner of Social Services who delivered his speech. The RD's Message was delivered by the WR Tanzania, Dr. Rufaro Chatora who was represented by Dr. Martins Ovberedjo.

The WR congratulated the Government of Tanzania, for high level political commitment and support for health, acknowledged achievements in the health sector including caring of the older population. He said the African Region has witnessed a rapidly increasing number of elderly persons aged 60 years and above since 1985 and that the elderly challenges are related to the changes in the social, political and economic conditions of society. The occasion continued with presentations of four

panellists from various institutions dealing with the old age population. These include the Social Security Regulatory Authority which represented all Insurance Institutions and commented on retirement Issues and challenges and solutions; A representative from Helpage International talked on Ageing Issues and Challenges and possible solutions; Social Services Commission talked on vast experience in dealing with old age population and finally a representative from the Old Age Association namely Tanzania Legion & Club who made a number of observations related to care, respect and commitment for services for old age population in the country.

The presentations stimulated several responses from the audience. The role of the Media in educating the community was highlighted. Participants were also informed that the Insurance Funds serve only 4% of the Tanzanian old population who were once employees and the remaining 96% of the old population remain without being covered by any such service. The Government, on its part is coming up with policies addressing issues and challenges of the old age population. Other activities for this year included printing of advocacy materials with the WHD2012 messages. These included Posters, Street Banners, T-Shirts and Caps which were used to further disseminate the message.

### WHD 2012 activity at WCO

The World Health Day 2012 commemoration was extended by conducting a mini function at the WCO whereby the staff shared information on the occasion. Finally each staff member was presented a mug with WHO Emblem and the WHD 2012 message on it.



The Commissioner of Social Services delivering the speech of the Hon. Minister of Health & Social Welfare at the opening of the Media Advocacy session. (R) Dr. Martins Ovberedjo representing the WR

## 68<sup>th</sup> National Congress of the Korean Medical Record Association



Joon H. Hong  
Past president of KMRA  
IFHIMA Regional Director of  
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Committee member [jh.hong.42@hotmail.com](mailto:jh.hong.42@hotmail.com)

The 68th KMRA National Congress was held at KOEX Convention Center in Seoul on April 27th. The theme was "Management of health record information for performance improvement in healthcare." More than 900 members attended at the congress.

The keynote speaker, Dr. Yoon Kim, the professor of Seoul National University, gave a lecture with the title "The role of health information managers in the revolution of healthcare." After the comparison of healthcare policies suggested by political parties for the coming presidential election which will be held in November this year in Korea, he presented the desirable way of healthcare revolution and emphasized the importance of the role of health information managers, quality managers, information technologists and health related research experts. He also emphasized the necessity of widening and integrity of health record professionals' knowledge, and cooperation with other health related professionals.

There were five concurrent sessions in the afternoon for the following subjects: Electronic health record, Management of health record information, Privacy and security, Management of health record in

the medium sized hospitals, and free subject presentation. The tutorial was held for "Implementation of cancer audit system based on the information of cancer registry." with the lecture of clinical knowledge regarding hepatoma and the blood cancer. KMRA checked the attendees' ID with their pictures at the registration table because Ministry of Health and Welfare requested KMRA to manage the continuing education for the members strictly as a warning for the government new law of recertification of health record professionals which will be effective from 2014.

KMRA opened IFHIMA booth for promotion of IFHIMA and 2013 Montreal Congress. IFHIMA related posters were put on the wall, and IFHIMA brochure and application form for IFHIMA associate member were distributed to the visitors at the booth. KMRA sold handbag hooks for IFHIMA fund raising, and donated the profit US\$580 to IFHIMA.



## 65<sup>th</sup> WHO World Health Assembly



Angelika Haendel, M.A.  
IFHIMA President-elect

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The 65th WHO World Health Assembly (WHA) was held in Geneva from May 21-26, 2012. The participation at this event takes place upon invitation and is being reserved to the representatives of the 194 WHO-Member states and NGO's (Non-Governmental Organization) representatives that are in official relation with WHO.

IFHIMA is a NGO and since 1979 in official relations with the World Health Organization (WHO) and therefore received an invitation. Angelika Haendel, IFHIMA pres-

ident-elect, followed up on this invitation to attend this year's WHA in Geneva.

In addition to the plenary session (The World Health Assembly) which has the authority to adopt resolutions and binding international regulations there were a large number of smaller sessions. Especially the session eHealth Facilitating Active and Healthy Ageing met IFHIMA interests.

The focus of this session was at which extent eHealth can help to enable an active, autonomous life in old age.

Dr. Peteris Zilgalvis, head of information and communication technologies (ICT) for Health of European Commission presented the project "European Innovation Partnership on Active and Healthy Ageing" initiated by the European Union. This European Innovation Partnership on Active and Healthy Ageing will be realized step-wise in the next years. For more detailed information visit the following official EU-website

[http://ec.europa.eu/research/innovation-union/index\\_en.cfm?section=active-healthy-ageing](http://ec.europa.eu/research/innovation-union/index_en.cfm?section=active-healthy-ageing)



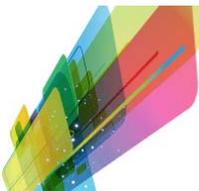
**SIXTY-FIFTH WORLD HEALTH ASS**  
Geneva, Switzerland  
21-28 May 2012



## Calendar of Events

- 27th – 30th August 2012  
Annual Scientific Conference/Seminar of The Health Records Managers Association of Nigeria (HIMAN) – “Enriching Accountable Healthcare: Opportunities and Prospects for Managing Health Information”, Sickle Cell Foundation, Surulere Lagos, Nigeria. 10:00 am daily.  
E-mail: [infor@the-himan.org](mailto:infor@the-himan.org) Web: <http://www.the-himan.org>
- 20<sup>th</sup> – 21<sup>th</sup> September 2012:  
12. National Conference of DVMD Braunschweig, Germany  
<http://www.dvmd-tagung.de/>
- September 26 – October 4, 2012:  
AHIMA National convention, Chicago, Illinois, USA  
<http://www.ahima.org/events/convention/default.aspx>
- October 29 – 31, 2012:  
HIMAA National Conference, Gold Coast, Queensland, Australia  
<http://himaa2.org.au/conference/?q=node/1>
- 13<sup>th</sup> – 15<sup>th</sup> May 2013:  
17th IFHIMA Congress Montréal, Canada  
<http://www.ifhimacongress2013.com/>

17th IFHIMA Congress  
Health Information Management  
Making A World of Difference  
May 13-15, Montréal Québec Palais des congrès



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## Call For Abstracts

April 30 - September 28, 2012  
Notification of Acceptance: October 30, 2012  
Confirmation Deadline: November 16, 2012



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