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CHALLENGES FACED BY MEDICAL RECORDS OFFICER IN MALAYSIA: IMPLICATIONS FOR HEALTHCARE MANAGEMENT AND PATIENT CARE

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Abstract: *The medical records management in Malaysia is undergoing transition from the traditional paper based to electronic medical records (EMR), hospital information systems (HIS), health information exchange (HIE), electronic health record (HER) and other similar terms. This transformation changes the nature of healthcare professionals' work. MRO are the main part of the healthcare system in Malaysia specifically in managing patient information. They must protect patient privacy and confidentiality while providing access to authorized health care providers. This paper discusses the challenges, skills and gaps among MROs in Malaysia and its implications to health care management and patient care. Technology advancement, system interoperability, evolving of coding standard ICD-11 and data privacy issues are some of the challenges. Apart from that, human factor issues such as resistance to change, digital literacy gaps, and insufficient training, kind of adding sauce in the existing problems. Besides these challenges, there is also a significant ability gap due to differences in formal education, practical training, and the absence of comprehensive professional development frameworks. The consequences are significant, including compromised data accuracy, impaired decision making, operational inefficiencies, and compliance risks for healthcare management. From patient care, this will involve compromised safety, delayed diagnoses, reduce quality of care, tarnish trust and often lead to disjointed or incomplete treatment. This paper concludes with recommendations for enhanced training, competency framework development, infrastructure investment, and policy standardization to empower MROs, thus improving healthcare delivery and patient outcomes in Malaysia*

Keywords: *Medical records officer, MRO challenges, skills, gaps, Malaysia*

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Introduction

Medical Records officers (MRO) or sometimes known as medical records professionals are not just important to prepare the patients' records but serve as the crucial caretaker of patient information starts from the creation of records until its documentation. MRO most crucial role and responsibility is collecting and organizing patient information. Patient information contains sufficient information to identify the patient, support diagnosis based on history, physical examination and investigation, and ensure continuity of care provided to a particular patient by professionals and other health care workers (MMC, 2019). Medical records are not just handwritten notes by doctors and nurses; they also include more complicated information like scanned papers, laboratory reports, images, x-rays, recordings, printouts and many more (Abdelrahman & Abdelmageed, 2014). These MROs play a significant role in ensuring doctors can access all the data needed for patients to get the best treatment possible.

In Malaysia, their responsibilities not just focus on the protecting the medical files, but ensure the administrative efficiency, resource allocation, clinical research and acting as the bridge between raw medical data and healthcare institution especially towards interoperability and longitudinal patient information where Malaysia currently implement the concept of integrated health records and "One Citizen, One Record" that strengthened the patient information that can be accessed accurately and quickly (BERNAMA, 2025). As Malaysia integrates more advanced systems like the Malaysia Health Data Warehouse (MyHDW), the MRO's duty of care expands to include cybersecurity vigilance and data privacy management (Rehman, Shaikh, Ayyasamy & Subramaniam, 2025). The accuracy and accessibility of these records directly affect diagnosis accuracy, treatment planning, and continuity of care. In the absence of a proficient MRO officer, the entire healthcare system becomes vulnerable to errors, resulting in erratic policy decisions and diminished patient outcomes (Sameera, Bindra, & Rath, 2021).

In the current environment of healthcare provision, MRO also needs to ensure accuracy and completeness of data and compliance with legal and regulatory requirements. They also need to update the records with new information as needed. This is because the completeness of medical records is an important performance measure in delivering healthcare services in medical facilities (Tola, 2017). Medical record completeness could be assessed using physician notes, physician order sheets, nursing care plans, drug administration sheets, and discharge summaries.

Moreover, patients and the public are increasingly apprehensive about their privacy and the unregulated use and dissemination of their personal health information. Currently, numerous concerns exist around the inadequate management of personal data and data breaches. Fraud and other issues stem from the self-serving sale or dissemination of medical data by individuals. The invasion of individuals' privacy exposes them to the risk of fraud. MROs have a crucial responsibility to protect patient privacy by establishing security measures to prevent unauthorized access. These specialists must understand the information to collect, the methods of handling it, the individuals authorized to access it and adhere to company regulations and national and state legislation (AHIMA, 2024).

The incorporation of technology, particularly in electronic health records (EHRs), has transformed the landscape of these domains. MRO now work with information systems to efficiently collect, store, process, and communicate health data. They have adapted to the changing healthcare environment by assuming greater responsibility in data analysis, information governance, privacy protection, and data standards. Through enhanced data analytics, information governance, and population health management, educational programs

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have been revised to equip professionals with competencies that extend beyond EHR management (Gibson et al., 2015), thus will improve patient care delivery.

Overview of the digital health adoption

Electronic Medical records (EMR) were created according to current trends and developments that have replaced manual records handling. Previously, the way of handling records was to use file storage. According to Rothenberg (1995), changes in technology and the growing implementation of full EMR are forcing healthcare environments to evolve. As a result of this development in technology, the healthcare environment requires transformation. According to Ismail, Keshta, and Ammar Odeh (2020), an Electronic Health Record is defined as a digital representation of a patient's medical history maintained by a healthcare provider over a specified duration. It encompasses all essential administrative and clinical data pertinent to the care provided to an individual by a specific provider, including demographics, progress notes, medical issues, medications, vital signs, medical history, immunization records, laboratory results, and radiology reports. Years later, technological advancements significantly enhanced the development of electronic health record systems for patients and healthcare providers. By the 2000s, governments and healthcare organizations globally acknowledged the potential of electronic health records and initiated policies to promote their adoption over traditional manual record-keeping methods.

As we know, the development of this system can facilitate many parties not only from medical institutions, but it can provide comfort and convenience to patients and visitors to connect or deal more easily with the medical side about their health conditions without having to take time like before. Rhonda, Victor, and Sherry (2012) stated that EMR facilitates the collection, storage, retrieval, and analysis of medical information. Medical data and subsequent analysis are utilized to advise clinicians, enabling them to pursue optimal treatment and excellent care for the patient. Electronic medical records (EMR) offer numerous alternatives for the collection, storage, access, and analysis of medical data. Through medical data and supplementary examinations, healthcare professionals can acquire information that facilitates the pursuit of the most effective treatment while ensuring high-quality patient care. Furthermore, it can assist with time management. This EMR facilitates time efficiency by providing access to every patient's details within the system. Furthermore, it can diminish the personnel required to locate information within the file. This is due to the potential for electronic medical records (EMRs) to supplant numerous routine administrative tasks, leading to considerable time savings. The technology could streamline the preparation of referrals, prescriptions, and lab orders, among other tasks.

Roles and responsibilities of MROs.

Managing patient records.

The storage of patient information is a fundamental responsibility of a health information professional, who ensures that both electronic health records (EHR) and paper-based data are accurately documented and readily accessible for the benefit of other healthcare professionals. For example, when a patient seeks treatment at a healthcare facility, prior to any procedure or engagement, following a disease diagnosis, or before or after any tests, a health information specialist ensures that records are meticulously updated with comprehensive information, including medical history, diagnosis, treatment options, and test results. This entails ensuring that modifications to a patient's prescription or the initiation of a new prescription are promptly recorded in the EHR to prevent complications such as administering incorrect medication,

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inappropriate dosages, or drug interactions. Accessible patient records are essential for formulating an appropriate treatment plan or addressing emergencies. For example, if a patient arrives comatose due to an automobile accident, healthcare practitioners can promptly consult the EHR to ascertain allergies or any preexisting conditions, thereby expediting the treatment procedure. It also reduces instances of misdiagnosis or inappropriate treatment that compromise patient safety (Harrison, 2020).

Ensuring data privacy and security.

One of the essential responsibilities of health information professionals is to safeguard the privacy of patients and their information. The digitization of patient records has escalated, rendering the safeguarding of sensitive health information against unauthorized access, breaches, or misuse increasingly relevant. The governing boards of organizations that produce electronic health records and other sensitive patient data rely significantly on health information professionals to implement and enforce robust security measures, such as encryption, password protocols, and access controls. They ensure strict adherence to established health norms, including data privacy laws, to safeguard the patient's dignity at all costs. For example, HIM experts mitigate potential data breaches by implementing procedures that restrict access to specific medical information to authorized individuals and by regulating system features to prevent inappropriate behavior. These measures can significantly contribute to maintaining patient trust and justifying access to protected data for enhancing the quality of treatment plans.

Facilitating the use of electronic health records (EHRs)

Health information specialists play a vital role in optimizing the utility of electronic health records in healthcare institutions, as will be established subsequently. Electronic Health Records (EHR) are digital representations of a patient's medical history that may be swiftly accessed by other physicians within an organization to enhance the provision of care. EHR specialists are responsible for managing, coordinating, and tailoring EHR systems to improve usability, mitigate risks, and ensure compliance within the healthcare sector. They instruct clients on treatment teams and health care students on appropriate documentation techniques in EHR systems, including data entry, alteration, or retrieval. Health information management also addresses technological concerns, facilitates communication across various systems, and ensures that data is coded to comply with billing and reporting standards. As HIM professionals persist in their advocacy for EHR, this will result in enhanced efficiency, reduced errors, improved communication, and overall positive outcomes for patients.

Challenges faced by MROs

Digital transition, HER/EMR interoperability

While the Ministry of Health rapidly implemented cloud-based systems and electronic health platform, the digital landscape still remains scattered. Although the government has introduced one patient one records, but there is no standardization and centralization of data. Manys hospitals and clinics use standalone elevctronic medical record (EMR) or HIS. This lead to the repetition of procedure when patient want to get a treatment, for example during the registration process. A lack of standardized data formats and low interoperability also often leading to duplicated test and data tracking (Abdullah, Abdul Aziz, Sodri, Mohd Hanafiah, Ibrahim, Johari, 2020; Quek, 2016).

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Evolving coding standards (ICD-11 Adoption)

As Malaysia systematically transitions to the technology wise, MROs face steep learning curve with the evolving of ICD-11 (International Classification of Diseases, 11the Revision). They need to abreast with the advanced medical classification that requires extensive, continuous retraining, adding an intellectual and operational to their daily task loads. Although the objective is to reduce the burden and standardized the coding, however as mentioned by Ooi, Isa, Manaf, et al. (2024) it becomes burden to most of them that already get used with the manual book and need to adapt with the new system.

According to Fenster (2022), the entry of categorization codes based on a patient's medical problems, conducted tests, and suggested treatment plans constitutes a responsibility of health information management. Medical records professionals are essential for the coding and billing system, particularly for diagnoses, treatments, and services reflected in invoices. They employ systems like the International Classification of Diseases (ICD) to get this precision. The ICD enables the systematic recording, analysis, evaluation, and comparison of mortality and morbidity statistics across different regions and countries (World Health Organisation, 2023).

Legal, privacy and ethical issue

Study by Ibrahim, Abdel-Aziz, Mohamed, Zaghamir, Wahba, Hassan, Shaban, EL-Nablaway, Aldughmi, & Aboelola (2024) stated that the digitization of health records presents considerable privacy issues, heightening the likelihood of unauthorized access and data breaches. Despite the benefits of EHR, the are many potential risks associated with the introduction of it such as data leaks and commercial exploitation (Tan & Mukhriz, 2023)

Recommendations

Keeping up with technological advancements.

A significant difficulty confronting MRO is the necessity to adapt to rapid technological advancements in the healthcare business since the environment has changed considerably especially from MROs work with EMRs, electronic coding, data extraction, health information systems, interoperability and digital information governance. Few things can happen with this implementation.

Firstly, inaccurate information in data quality that comes out of errors during entering the data. This happens because the healthcare professional enters the data without referring to the standards and guidelines, which will result in inaccurate data that is not in line with the patient's information. Healthcare professionals assign the wrong diagnosis to patients, which leads to transaction inaccuracies

In addition to their other responsibilities, medical records professionals play a crucial role in coding and billing. They assign precise codes to diagnoses, procedures, and treatments using standardized coding systems (Sujith, 2023). These codes contribute to correct billing and compensation for healthcare supplied by hospitals, clinics, and other healthcare organizations. Healthcare organizations can obtain proper service payment if their medical data is coded accurately. It is a critical activity that helps ensure the financial aspects of healthcare are functioning efficiently.

As stated by Ondongan (2023), this entails ensuring the integration of systems with pre-existing frameworks, diagnosing and resolving issues, and overseeing data security. As organizations

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transition to digital records, HIM professionals are increasingly assuming cybersecurity duties to ensure the integrity of patient data. Moreover, the modifications guarantee that professionals stay educated via ongoing training to facilitate adaptation to new technologies, regulations, and practices.

Not only that, Hawthorne & Richards (2017) also state that lack of trust in the healthcare professional due to physical and cognitive ability, fear of using technology, insufficient access, inadequate health literacy, and lack of computer and internet skills. In the age of modernization, some people are afraid to explore new things, such as the advancement of technology, due to a lack of skills. Healthcare professionals are not well-trained in using technology, and they prefer to use manual medical records. Especially the senior generation, think that technology is dangerous and more complex, and it will lead to data breaches. Without sufficient training in managing the technology, healthcare professionals are unable to navigate handling and troubleshooting the system. This requires HIM professionals to adapt their conduct on patient data protection in response to evolving laws and regulations.

Navigating legal and ethical issues related to patient data.

Protecting patient privacy and confidentiality is vital for medical records professionals. All patient information details are also the responsibility of the medical records professional, as the information is considered private. Protecting patient privacy is their responsibility as it is an essential ethical and legal issue for medical record professionals and an essential component of patient care. According to MMC (2019), with the advancement in technology comes the new development of Electronic Medical Records (EMC). Consequently, the patient record will also be recorded in an electronic form. This reform also needs to be emphasized by medical records professionals to ensure that no patient information leaks occur.

Therefore, medical records professionals need to ensure that their security is not easily hacked or interfered with by any party who wants to hack their systems and establish stringent security protocols to safeguard patient data while guaranteeing accessibility for authorized workers as required.

Ensuring interoperability between different health information systems.

Another responsibility of health information professionals is to promote and establish interoperability among various health information technology. Given that numerous health organizations utilize a comprehensive array of electronic data storage for patient information, it is imperative that these systems be integrated with one another. These HIM professionals are responsible for ensuring that information is accurately and securely transmitted across various systems, including EHR, laboratory platforms, installs, and pharmacy databases. This encompasses addressing the technological challenges associated with various data formats and systems. The improved interchange of data enhances patient care quality by minimizing errors, as information technology grants care providers free access to patient data.

Continuous education and training.

Training and educating these health information workers will achieve two goals; increased productivity from the improved trained parallel health workers as well as the parallel health improvement to provide a better efficacy towards the accomplishment of the points above. As best practices and regulations advance, and new technologies emerge, HIM professionals must remain abreast of trends and innovations. This is accomplished through frequent training sessions that familiarize workers with legislative changes and data management procedures, as well as the proficiency in new technologies such as Electronic Health Records. The existing

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educational framework promotes the effective management of patient information, adherence to legal standards, enhancement of patient care, and improvement of healthcare efficacy.

Implementing robust data governance policies.

It is imperative that data governance standards are established to protect private health information and limit its utilization. Initially, it is crucial to establish an efficient governance framework that specifies the diverse data management functions and responsibilities within the organization, including the processes related to the selection of the governance board and the involvement of data stewardship personnel. The establishment and compliance with rigorous standards for data ensure precision and comprehensiveness throughout its lifecycle. Compliance with regulations such as HIPAA or GDPR is required. It requires meticulously organized methods that guarantee privacy while safely facilitating data access (Syed F.M., 2018). Education and training programs are crucial, allowing personnel to comprehend the fundamental principles of ethics and integrity in data management. Moreover, enhanced security measures will be implemented to prevent health information from being compromised by unauthorized access or breaches. The organization should establish effective rules for data sharing to enhance collaboration among departments while safeguarding data privacy. Ultimately, fostering a culture of continuous improvement via regular assessments and revisions of the governance policy enables organizations to adjust to evolving regulatory mandates and advancements in emerging technologies, thereby addressing changing healthcare demands, enhancing patient outcomes, and improving overall operational efficiency.

Encouraging collaboration between IT and healthcare staff.

The collaboration between IT and healthcare personnel will optimize the HIM system's efficiency. It will ensure that IT solutions are beneficial for the healthcare provider and enhance systems and interfaces to improve clinical operations and patient outcomes. The involvement of healthcare professionals in the planning and implementation phases of the IT system will facilitate both teams in acquiring the necessary information to ensure the system is operational, secure, and accurately represents data. It facilitates the effective use of technology by the staff through ongoing training, sharing, and improved feedback on digital tools from health professionals; similarly, it enables the IT staff to comprehend clinical requirements, thereby strengthening the coherence of the entire health system.

Conclusion

The role of Medical Records Officers (MROs) in Malaysia is undeniably critical to the functioning of its healthcare system, serving as the backbone for effective healthcare management and quality patient care. However, as this paper has elucidated, MROs in Malaysia face a complex interplay of operational, technological, and human factor challenges that significantly impede their effectiveness. These challenges contribute to discernible skill and ability gaps, which in turn have profound implications for the entire healthcare ecosystem. These responsibilities may appear easy to understand, but they carry a huge amount of responsibility for ensuring that the contents of the patient record are not misunderstood. This is clear because medical records are designated as "confidential" papers as proof of effective medical practice, and the information contained within them is referred to as "personal" under health ethics guidelines. In other words, the medical record is an essential record that describes the patient's medical history and their current health condition. Medical records contain some of the most private information in a person's life.

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These challenges directly contribute to an ability gap, where the existing competencies of MROs often fall short of the diverse and sophisticated skills required in a modern, digitalized healthcare environment. This gap is caused by lacking in formal education, a lack of comprehensive practical training, the rapid obsolescence of skills due to technological shifts, and a notable absence of robust continuous professional development programs and a standardized competency framework for MROs in Malaysia.

Those issues discussed have significant implications for several aspects of healthcare management, such as translating into compromised data accuracy and integrity, leading to flawed decision-making, operational inefficiencies, and significant compliance risks. For patient care, the consequences are even more direct and severe, including compromised patient safety due to incomplete or inaccurate records, delays in diagnosis and treatment, reduced quality of care, erosion of patient trust, and fragmented continuity of care. Ultimately, the ability of Malaysia's healthcare system to deliver efficient, safe, and high-quality services is intrinsically linked to the competence and support provided to its MROs.

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