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KNOWLEDGE, AWARENESS, ATTITUDE, AND PRACTICE TOWARDS MEDICAL RECORD COMPLETENESS AMONG MEDICAL PROFESSIONALS IN TEACHING HOSPITAL

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Abstract

Introduction: Medical record documentation is vital for patient care, effective communication, and comprehensive data collection. It is essential for healthcare professionals to possess adequate knowledge of medical ethics and record-filling guidelines to ensure the thorough completion of medical records. This understanding is significantly correlated with increased record completeness. A positive attitude towards the importance of detailed medical records further promotes diligent documentation practices. However, South Africa and Uganda studies have revealed deficiencies in attitudes, knowledge, and practices among healthcare personnel.

Methods: A cross-sectional study conducted at Shri B. M. Patil Medical College Hospital evaluated the knowledge, awareness, attitudes, and practices related to the completeness of medical records among nursing staff, physicians, and junior residents. The assessment utilized a self-structured questionnaire comprising 27 items rated on a Likert scale, distributed via Google Forms and hard copies.
Results: A survey reveals that 80% of healthcare professionals believe that incomplete medical records can harm privacy, cause legal penalties, and damage credibility. Computerization improves record accessibility and efficiency, while error correction methods are crucial. Secure authentication enhances patient data security, and patient record trackers are beneficial. Practitioners have varied awareness of critical aspects of medical record management, with 47.5%

and 48.5% fully aware of legal implications and consent requirements. Record-keeping is sometimes burdensome, with 41.0% viewing it as a "sometimes" burdensome task. Challenges include meeting deadlines, feeling understaffed, and using approved formats. Despite these, 70.5% fill in identification details, and 43% observe medical record supervision, indicating areas for improvement in practice management.

Conclusion: The study reveals that medical record completeness with Knowledge, ranking as "Average" and Awareness as "Good." Health institutions should focus on improving documentation through workshops and sharing experiences. Attitude is rated as "Good," emphasizing positive attitudes among healthcare professionals. In practice, the challenges are insufficient time for documentation, inadequate staffing, and lack of a computerized system. Strategies include teamwork, electronic medical records, regular supervision, training programs, and accessible guideline formats.

Keywords: Completeness, Medical Records, Knowledge, Awareness, Attitude, Practice

Introduction

Medical record documentation, the systematic creation of a patient's medical treatment history, is of paramount importance. Whether in paper or electronic form, this documentation must prioritize the patient and uphold standards of accuracy, relevance, clarity, permanence, confidentiality, and timeliness (Ehnfors, 1993). Medical records are crucial in enhancing patient care, facilitating communication among healthcare professionals, providing data for audits and research, and potentially serving as evidence in medico-legal situations (Koh & Ahmed, 2021). They are vital tools for administering treatment and prevention and are often regarded as a reflective representation of medical activities within a healthcare institution (Saravi et al., 2016).

Challenges in medical record documentation are prevalent and can arise from various factors, including insufficient training in medical record management. Another issue is that clinicians may not fully comprehend the benefits and purposes of medical records, leading to a gap between the perceptions of physicians who use medical records and hospitals which provide the medical record forms, failing to deliver quality services (Aritonang A, 2011). Reported challenges in documentation include staff shortages (Johnson, 2011, Sum & Chebor 2013), limited awareness of the significance of thorough documentation (Johnson, 2011,6, Kebede et al., 2016, Journals & Taiye, 2015), high patient volumes (Johnson, 2011, Kebede et al., 2016), lack of in-service training (Kebede et al., 2016, Journals & Taiye, 2015), and lack of support (Johnson, 2011).

A previous report by the World Health Organization identified inadequate communication among healthcare professionals as a significant contributor to medical errors (Ente et al., 2010). Additionally, various studies indicate that the quality of medical documentation can influence patient mortality rates (Collins et al., 2013, Li, 2016, Usher et al., 2016). The prevalence of these practices among care providers poses a substantial challenge to the effective evaluation of patient care (Walker et al., 2018, Chand & Sarin, 2019, Lyons et al., 2018).

Adequate knowledge and awareness are essential in achieving thorough completion of medical records. The responsibility of filling out medical records lies with healthcare professionals, and their understanding of the process is crucial. The theory surrounding knowledge-based medical record filling encompasses various domains, including medical expertise, a comprehensive understanding of the health system, familiarity with relevant policies and guidelines, and an awareness of ethical considerations and patient privacy (Junaedi et al., 2024). For instance, research conducted by Althobaiti indicated that a strong understanding of medical ethics and record-filling guidelines was significantly correlated with increased completeness of medical records (Althobaiti et al., 2021). Oliver's study aims to raise awareness of records and record-keeping in the information literacy community. Furthermore, Oliver's study seeks to enhance awareness regarding the significance of records and meticulous record-keeping within the information literacy community. His findings reveal that recognizing the impact of records and record-keeping on individual's lives remains largely overlooked in information literacy research and practice (Oliver. G, 2016).

According to attitude theory, a favourable disposition towards a particular action enhances a person's readiness to engage. A positive attitude towards the significance of complete and precise medical records in medical record-keeping motivates healthcare professionals to fill out these documents with care and diligence. Furthermore, a positive view of the standards and regulations governing medical record completion is crucial for ensuring the completeness of such documents (Junaedi et al., 2024). The meticulous maintenance of medical records allows healthcare providers to efficiently track, evaluate, and make informed decisions based on a patient's medical record (Kasaye et al., 2022). Research conducted in South Africa and Uganda has identified shortcomings in attitudes, knowledge, and practice behaviour related to this matter (Nakate et al., 2015, Health Information Systems in Developing Countries: A Landscape Analysis, 2009).

Numerous studies have assessed the completeness of hospital medical records; however, there remains a lack of research focused on identifying the facilitators and barriers that could enhance the quality of medical record documentation. Conducting such a study is anticipated to aid hospitals in achieving their primary goals of continuous quality improvement and patient safety while offering strategies to rectify existing deficiencies. Furthermore, this research could present a novel perspective for other scholars interested in advancing the quality of medical records (Faraji-Khiavi et al., 2021). Consequently, this study examines the knowledge, practices, attitudes, and awareness regarding medical record documentation among doctors, nurses, and junior residents.

Gap analysis is conducted to provide feedback to medical staff regarding identified deficiencies, which can subsequently enhance their performance (Kern et al., 1990). This process is crucial in ensuring that the highest quality of services is delivered to admitted patients, aligning with the standards set by the National Accreditation Board of Health. The quality of clinical services offered by hospitals is evidenced by the proficient management of medical records (Singh & John,

2017). Furthermore, this analysis aids hospital administrators in coordinating care, identifying areas for enhancement, and guaranteeing the effective and efficient delivery of safe, high-quality healthcare (Holt et al., 2008).

Materials and Methods

A cross-sectional study was conducted at the Shri B. M. Patil Medical College Hospital and Research Centre, accredited by the National Accreditation Board of Health. This research took place over two months in 2024. It examined the knowledge, awareness, attitudes, and practices regarding the completeness of medical records among nursing staff, physicians, and junior residents in surgical and allied departments such as Obstetrics and Gynaecology, General Surgery, Orthopaedics, and ENT. Data were collected using a self-structured questionnaire with a 5-point Likert scale for responses. The source population comprised a total sample of 200 participants, which include 45 Consultants/Physicians, 80 Junior Residents, and 75 Staff Nurses, representing approximately 50% of the total staff available during the data collection period.

The research employed both an online Google Forms questionnaire and printed copies, comprising four sections: ten knowledge questions, five awareness questions, five attitude questions, and seven practice-based questions, totaling 27 items. Additionally, it collected data on the respondent's department, designation, and shift time. The questionnaire received validation from three healthcare quality experts with over ten years of experience, who reviewed it for content validity and suggested improvements, which were then integrated into the final version.

Before data collection, a pilot test of the questionnaire was conducted with ten samples, representing 5% of the total sample of 200. This process assessed the questionnaire's reliability and completeness, leading to refinements in phrasing, and 0.71 was achieved in Cronbach's alpha coefficient, indicating acceptable internal consistency. A P-value less than or equal to 0.05 was declared to be significant. The dependent variable in this study was the completeness of medical records. The independent variables are knowledge, awareness, attitude, and practice as intervening factors.

Knowledge towards completeness of medical records

The study participants' knowledge was assessed using a 5-point Likert scale, incorporating ten questions designed to gauge knowledge. Participants had the option to select multiple responses. Knowledge levels were classified into "Good knowledge" and "Poor knowledge." Individuals who selected three or more options were classified as having "Good knowledge." In comparison, those who chose fewer than three options were deemed to have "Poor knowledge" regarding the completeness of medical records.

Awareness towards completeness of medical records

The awareness level of study participants was evaluated through a 5-point Likert scale, with responses ranging from "Fully aware" to "Fully not aware" across five questions. Awareness levels

were classified into two categories: good awareness and poor awareness. Participants demonstrating options above "neither" on this scale were classified as having good awareness. Conversely, those selecting options at "neither" or below were identified as having poor awareness regarding the completeness of medical records.

Attitude towards completeness of medical records

Study participants' attitudes were assessed through a series of five questions utilizing a 5-point Likert scale that provided a range of response options. Subsequently, the overall attitude level was established by calculating the median score. Participants who achieved a score equal to or exceeding this median were classified as having a favourable attitude toward medical documentation practices. In contrast, those scoring below the median were deemed to possess an unfavourable attitude.

Practice towards completeness of medical records

The assessment of documentation practice utilized seven questions for evaluation. Six of these questions employed a rating scale from "1 = Always" to "5 = Never," while one offered specific choices. Participants whose scores met or exceeded the average for the practice questions demonstrated good documentation practice, while those scoring below the average were deemed to have poor documentation practice.

Results

Table 1: Assessment of Knowledge Level Distribution for Completeness of Medical Records across Departments and Designations

Knowledge-based Questions	Options				
What are the legal implications of incomplete medical records?	Privacy & Patient Confidentiality Violations	Legal Penalties & Disciplinary Actions	Risks Organization's Reputation	Harms Credibility of the Consultant	All the above
	25 (12.5%)	9 (4.5%)	6 (3.0%)	0 (0.0%)	160 (80.0%)
Computerization can help capture medical records more effectively by?	Accessibility & Efficiency	Communication & Coordination	Clinical Decision-Making	Remote Monitoring	Error Free Documentation
	133 (66.5%)	28 (14.0%)	11 (5.5%)	6 (3.0%)	22 (11.0%)
What are the right ways to correct errors in medical records?	Draw A Line Through the Error	Original Entry	Signing After	Not Using Correction Fluid	Not Removing

		Should Be Visible	Correction of Errors		Documents
	137 (68.5%)	28 (14.0%)	3 (1.5%)	23 (11.5%)	9 (4.5%)
Using unaccepted abbreviations in treatment orders and diagnoses may lead to?	Medical Error	Misunderstand Patient's Condition	Difficult In Continuous Treatment	Create Barriers to Future Research	None
	123 (61.5%)	28 (14.0%)	10 (5.0%)	28 (14.0%)	11 (5.5%)
How important is it to check and document vital signs in identifying deterioration/ improvement in a patient's condition?	Identifies Patient Complications	Assess the Improvement	Plan Timely Intervention	Identify Deterioration	None
	95 (47.5%)	20 (10.0%)	47(23.5%)	31 (15.5%)	7 (3.5%)
What are the benefits of secure authentication?	Enhance Patient Data Security	Increase Patient Trust	Improve Regulatory Compliance	Reduce the Risk of Tampering	All the Above
	34 (17.0%)	8 (4.0%)	2 (1.0%)	12 (6.0%)	144 (72.0%)
What is the significance of obtaining LAMA/DAMA?	Assessing Complications of Incomplete Treatment	Identifies The Causes of Lama/Dama	Support Legally	Explains Risk Associated Factors	All the Above
	85 (42.5%)	12 (6.0%)	10 (5.0%)	1 (0.5%)	92 (46.0%)
Poor clinical records lead to?	Mislead Patients & Healthcare Providers	Unnecessary Repetition of Tests	Increase Medico-Legal Risks	Jeopardise Patient Care	All the Above
	35 (17.5%)	7 (3.5%)	0 (0.0%)	10 (5.0%)	148 (74.0%)
How does data collect through the patient record tracker help?	Improve Patient Satisfaction	Identify Gaps	Quality Improvement	All the Above	None
	31 (15.5%)	6 (3.0%)	13 (6.5%)	137 (68.5%)	13 (6.5%)

Inform consent in patient records should include?	Information About Diagnosis	Risks And Benefits of Treatment	How and Who Performs Procedures	Witness Sign	All the Above
	28 (14.0%)	0 (0.0%)	6 (3.0%)	8 (4.0%)	158 (79.0%)

The survey results reveal significant insights into medical record management within healthcare. Notably, 160 (80%) of respondents indicated that incomplete records can infringe on privacy, lead to legal penalties, and damage organizational credibility. Additionally, 133 (66.5%) acknowledged that computerization improves the accessibility and efficiency of records. The importance of proper error correction methods was highlighted, with 137 (68.5%) advocating for the visibility of original entries post-correction. Moreover, 123 (61.5%) expressed concerns over unaccepted abbreviations potentially causing medical errors. Furthermore, 144 (72%) affirmed that secure authentication enhances patient data security and trust, while 148 (74%) recognized that poor documentation jeopardizes patient care. 137 (68.5%) of respondents believe that patient record trackers benefit overall care, with 158 (79%) emphasizing the need for comprehensive informed consent. Obtaining LAMA/DAMA is vital for evaluating treatment complications, identifying causes, assessing risks, and supporting legal matters.

Table 2: Assessment of Awareness Level Distribution for Completeness of Medical Records across Departments and Designations

Awareness based Questions	Options				
Are you aware that tampering with the documents in medical records can be legally offensive?	Fully Aware	Aware	Neither	Not Aware	Fully Not Aware
	95 (47.5%)	70 (35.0%)	11 (5.5%)	16 (8.0%)	0 (0.0%)
Are you aware that procedures carried out without the required consent may have legal repercussions for the organizations and practitioners involved?	Fully Aware	Aware	Neither	Not Aware	Fully Not Aware
	97 (48.5%)	78 (39.0%)	8 (4.0%)	11 (5.5%)	6 (3.0%)
Are you aware that failing to update patient reassessment notes might negatively impact the continuity of care for patients?	Fully Aware	Aware	Neither	Not Aware	Fully Not Aware
	78 (39.0%)	99 (49.5%)	8 (4.0%)	9 (4.5%)	6 (3.0%)
	Fully Aware	Aware	Neither	Not Aware	Fully Not Aware

Are you aware that medical malpractice results from incomplete medical records?	80 (40.0%)	82 (41.0%)	10 (5.0%)	19 (9.5%)	9 (4.5%)
Are you aware that handling medical records by many staff compromises patient confidentiality?	Fully Aware	Aware	Neither	Not Aware	Fully Not Aware
	81 (40.5%)	84 (42.0%)	18 (9.0%)	9 (4.5%)	8 (4.0%)

The survey results indicate a varied awareness among practitioners concerning critical aspects of medical record management. While 95 (47.5%) and 97 (48.5%) of respondents demonstrated full knowledge of the legal ramifications of document tampering and the necessity of obtaining consent, awareness of continuity of care related to patient reassessment notes was lower at 78 (39%). Additionally, understanding of medical malpractice due to incomplete records and the influence of multiple staff handling records was at 80 (40%) and 81 (40.5%), respectively.

Table 3: Assessment of Attitude Level Distribution for Completeness of Medical Records across Departments and Designations

Attitude based Questions	Options				
To what extent do you agree that filling up patient records gives you an impression of additional work?	Always	Often	Sometimes	Rarely	Never
	40 (20.0%)	37 (18.5%)	82 (41.0%)	28 (14.0%)	13 (6.5%)
How much do you rate the difficulty level with completing medical records while simultaneously interacting with patients/nurses/physicians?	Very Easy	Easy	Moderate	Difficult	Very Difficult
	30 (15.0%)	9 (4.5%)	107 (53.5%)	34 (17.0%)	20 (10.0%)
To what degree do you understand the significance of obtaining a witness signature in an emergency?	Very Important	Important	Neither	Low Important	Not Important
	122 (61.0%)	52 (26.0%)	17 (8.5%)	9 (4.5%)	0 (0.0%)
Do you agree that investigation reports help in justifying the diagnosis and treatment?	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
	101 (50.5%)	78 (39.0%)	15 (7.5%)	0 (0.0%)	6 (3.0%)
How do you rate the education, competency, and experience level to complete the medical records?	Excellent	Good	Fair	Poor	Very Poor
	65 (32.5%)	99 (49.5%)	25 (12.5%)	8 (4.0%)	3 (1.5%)

The survey shows varied attitudes toward medical record completeness among professionals. Notably, 82 (41.0%) view record-keeping as a "sometimes" burdensome task. About 107 (53.5%) rated "moderate" difficulty completing medical records during team interactions. The critical nature of witnessing signatures in emergencies is recognized by 122 (61.0%) as "very important," while 101 (50.5%) strongly agreed with the role of investigation reports in supporting diagnoses. Furthermore, the majority assess their proficiency in this area positively, rating their skills as "good" 99 (49.5%) or "excellent" 65 (32.5%).

Table 4: Assessment of Practice Level Distribution for Completeness of Medical Records across Departments and Designations.

Practice-based Questions	Options				
Besides regular work, how much time do you have to finish medical records?	0-10 Min	10-20 Min	20 – 30 Min	45 – 50 Min	> Hour
	18 (9.0%)	45 (22.5%)	79 (39.5%)	22 (11.0%)	36 (18.0%)
Do you find it difficult to complete paperwork on time?	Always	Often	Sometimes	Rarely	Never
	35 (17.5%)	30 (15.0%)	90 (45.0%)	27 (13.5%)	18 (9.0%)
Do you have inadequate manpower to complete the medical records?	Always	Often	Sometimes	Rarely	Never
	52 (26.0%)	33 (16.5%)	67 (33.5%)	29 (14.5%)	19 (9.5%)
Are you filling out medical records only in the formats that have been verified and approved?	Always	Often	Sometimes	Rarely	Never
	113 (56.5%)	44 (22.0%)	29 (14.5%)	11 (5.5%)	3 (1.5%)
Does repeating the same data in several formats take up more time?	Always	Often	Sometimes	Rarely	Never
	55(27.5 %)	48 (24.0%)	66 (33.0%)	25 (12.5%)	6 (3.0%)
Are you filling in the patient identification details on each medical record document?	Always	Often	Sometimes	Rarely	Never
	141 (70.5%)	31 (15.5%)	19 (9.5%)	9 (4.5%)	0 (0.0%)
How often is the supervision of medical records conducted?	Always	Often	Sometimes	Rarely	Never
	86 (43.0%)	64 (32.0%)	41 (20.5%)	9 (4.5%)	0 (0.0%)

The survey results reveal various challenges in managing medical records among professionals. Notably, 79 (39.5%) of respondents require 20 to 30 minutes to complete records, while 90 (45%) "Sometimes" struggle to meet deadlines. Additionally, 52 (26%) "Often" feel understaffed, and 113 (56.5%) "Always" use approved formats. Data redundancy affects 55 (27.5%) as "always," contributing to time inefficiencies. Despite these challenges, 141 (70.5%) "Always" fill in identification details, and 86 (43%) "Always" observe medical record supervision, indicating areas for improvement in practice management.

Discussion

Table 5: Evaluation of Average Knowledge Level Distribution for Completeness of Medical Records by Designation

Designation	Average Knowledge					Chi-square test	P value
	No of the respondents chose 1 Option	No of the respondents chose 2 Options	No of the respondents chose 3 Options	No of the respondents chose 4 Options	No of the respondents chose 5 Options		
Junior Resident	0	6	47	25	2	32.701	0.000
	0.0%	26.1%	39.2%	52.1%	66.7%		
Physician/Surgeon	0	0	32	13	0		
	0.0%	0.0%	26.7%	27.1%	0.0%		
Staff Nurse	6	17	41	10	1		
	100.0%	73.9%	34.2%	20.8%	33.3%		
Total	6	23	120	48	3		
	100.0%	100.0%	100.0%	100.0%	100.0%		

A prior study highlighted that creating high-quality medical records necessitates strong knowledge, skilful execution, and dedication to accuracy; inadequate skills result in incomplete and insufficient records. (Debora et al., 2022, Chutwarat et al., 2017).Our study's significant chi-square test result ($p < 0.001$) indicates notable differences in knowledge levels among designations. Junior Residents performed best, with a majority selecting three and four options, reflecting a deeper understanding. In contrast, Physicians/Surgeons showed limited engagement, particularly with higher options. Staff Nurses exhibited foundational knowledge but needed further training. Overall, targeted educational initiatives could address these gaps, fostering more comprehensive knowledge across all roles to improve patient care outcomes because Susanto highlights that the advantages of training and development encompass enhanced productivity in terms of both quantity and quality, improved employee morale, reduced need for supervision, and personal growth (Dwi S, 2018).

In the study conducted in Southern Ethiopia, among 413 respondents, 177 (43%) demonstrated strong knowledge of nursing care documentation. Notably, 243 participants (59%) acknowledged that documentation should align with established guidelines. Additionally, 280 respondents (67.8%) identified completeness as a crucial principle for documentation, while 317 (76.8%) recognized that effective documentation enhances the quality of care. Furthermore, 270 (65.4%) believed that patient assessment data is essential to record, 236 (57.1%) indicated that inadequate documentation hampers the nursing profession's advancement and 243 respondents (58.8%) asserted that healthcare providers themselves should document the care given (Ayele et al., 2021).

Our study shows no significant difference in awareness across departments or designations. A study conducted at State University Mindanao revealed that participants possessed awareness regarding records management within their roles. Notably, Indicator 1, which assesses staff awareness of the records management system and its significance, received the highest mean score of 4.11. However, the overall finding indicates a general lack of awareness and knowledge, highlighting organisations' need to enhance efforts in educating their personnel, as successful records management depends on informed staff (Pangcatan, 2020). Regular briefings can help foster this awareness and responsibility among employees (Marwiati & Komsiyah, 2017, Hidayat et al., 2018).

Attitude is a crucial factor influencing medical record completeness, as observed in this study (Kasaye et al., 2022, Wubante et al., 2023). The University of Gondar Hospital study assessed attitudes toward nursing care documentation, revealing a mean attitude score of 28 (SD = ±5.21). Notably, 60.7% of participants exhibited a positive attitude (Kebede et al., 2016). The findings indicate that health workers with a favourable attitude towards medical documentation tended to practice better documentation than those with an unfavourable attitude. This aligns with similar research conducted in Uganda (Nakate et al., 2015), Dire Dewa (Tamir et al., 2021), Hawassa (Ayele et al., 2021), and Tigray (Tasew et al., 2019). Such favourable attitudes may enhance service providers' motivation to document medical care, and the educational habits of workers likely contribute to recognizing the significance of documentation as esteemed professionals. However, our study found no significant differences in average attitudes across various departments or designations.

Previous evidence indicates that medical documentation is a critical care activity that is often neglected. (Kebede et al., 2016, Tasew et al., 2019, Abdulkadir et al., 2011, Mohammad, 2014). The study conducted in Northwest Ethiopia showed that out of 284 respondents, 133 (46.8%) demonstrated good medical documentation practices. Notably, 81 (60.9%) of those with good practice were male, and 115 (86.6%) held bachelor's degrees. Additionally, 117 (87.9%) within the inpatient department. Regular supervision and feedback contributed to good documentation practices, with 70 participants (52.6%) demonstrating this effect. Furthermore, 118 respondents (88.7%) utilized a standardized documentation sheet (Kasaye et al., 2022). Overall, the study highlighted significant deficiencies in documentation practices, enhancing organizational structure and adopting electronic health systems could improve documentation practices (Wang et al., 2013,

Wang et al., 2013). In contrast, our study revealed no significant differences in average documentation practices across different departments or designations.

Conclusion

The findings indicate that knowledge of medical record completeness is rated as "Average," while awareness is "Good." Health institutions should focus on enhancing documentation knowledge through training, workshops, and shared experiences. This study indicates that the completeness of medical records regarding Attitude is rated as "Good." It emphasizes the importance of fostering positive attitudes among healthcare professionals to improve record completeness. Strategies should include patient safety policies, quality improvement initiatives, continuous learning, and a supportive work environment.

In conclusion, the assessment of medical record completeness practice is rated as "Average," primarily due to insufficient documentation time, inadequate staffing, and a lack of computerized systems. To overcome these challenges, fostering teamwork, implementing electronic medical records, providing regular supervision, and offering accessible training programs are vital. Enhancing knowledge, awareness, attitude, and practice is essential for improving patient care quality and achieving optimal health outcomes.

Ethical Considerations

Ethical clearance and approval for this study were obtained from the BLDE (Deemed to be University) Ethical Review Committee with reference number BLDE (DU)/IEC/ 806/2022-23. The confidentiality of patient information was strictly maintained throughout the study period.

Declaration of competing interest

The authors declare no conflicts of interest.

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