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Research Article

Documentation and Registration as a Tool for Quality Health in Federal Medical Centre, Owo, Ondo State, Nigeria

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ABSTRACT

Introduction: Healthcare facilities have existed for a long time with the responsibility of providing care to patients, which is often documented.

Aim: To determine documentation and registration as a tool for quality health in Federal Medical Centre, Owo.

Methods: The research design employed in this study is a descriptive survey design. The total enumeration sampling technique was used because the population of the focused group is manageable. In all, seventy-three (73) respondents were recruited for this study and a response rate of 100% was achieved. The data were analyzed using both inferential and descriptive statistics using frequency distribution tables and simple percentages, mean, and standard deviation with the aid of Statistical Package for Social Sciences (SPSS) 20.

Results: This study showed that all 100 (100.0%) respondents claimed that quality patient documentation should be accurate, concise, and logical in an organization as it helps to improve the quality of service rendered to patients among health information professionals and that quality patient documentation should be written, legible, reliable and complete. Also, the majority 67 (91.7%) of the respondents strongly agreed that quality patient documentation should be able to inform good decision-making can be drawn out of quality patient documentation. The hypothesis of this study also reveals that the respondent's knowledge does not impact their years of experience or level of their education since the P-value is more than 0.05.

Conclusion: This study concludes that proper documentation has an immense impact on services rendered in healthcare facilities and also enhances adequate planning by the facility.

Keywords: Documentation; Registration; Tool; Quality; Owo

Abbreviations: SPSS: Statistical Package for Social Sciences; MOHLTC: Ontario Ministry of Health and Long-Term Care; OND: Ordinary National Diploma; HND: Higher National Diplomas

INTRODUCTION

Healthcare facilities (hospitals) have existed for a long time with the responsibility of providing care to patients which are often documented. Health records have always been found in hospitals as proof of documentation of a health delivery service to patients [1]. Quality healthcare delivery relies on proper documentation of patients' health records. Without accurate, comprehensive up-to-date, and accessible patient case notes, medical personnel may not offer the best treatment or may misdiagnose a condition, which can have serious consequences [2,3]. Some of the purposes of patients' records are communication of patient information between health care professionals and the patient, and treatment of the patient, it can be used as evidence in a court of law, for billing and medical research [4,5]. Patient records by nature are very sensitive because of their contents and therefore, must be documented. The patient health record should be easy to read and accessible to the healthcare professionals in charge of the patient's treatment. This will ensure the proper identification of problem areas, plan better patient care, and evaluate the care given [6-8].

Documentation of patients' health records is important in the

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healthcare delivery system. The health records in manual or automated form, house the medical information that describes all aspects of patient care. It is an essential tool in running the day-to-day activities of any organization [9]. Health records are written account of a patient's examination and treatment that includes the patient's medical history and complaints; the physician's findings; and the results of diagnostic tests, procedures, medications, and therapeutic procedures [9,10]. A health record can also be defined as a clinical, scientific, administrative, and legal document relating to patient care in which are recorded sufficient data written in the sequence of events to justify the diagnosis and warrant treatment and results. The patient health record is a primary legal record documenting the healthcare services provided to a person in any aspect of the healthcare system [11,12]. The term includes routine clinical or office records, records of care in any health-related setting, preventive care, lifestyle evaluation, research protocols, and various clinical databases. The medical record is a chronological written account of a patient's medical history and complaints, the physician's physical findings, the results of diagnostic tests and procedures, medications, and therapeutic procedures [13,14,15]. The Nigeria health system was established to provide essential health care services to Nigerians irrespective of their locations in any part of Nigeria. Nigeria operates three tiers of a health system: tertiary health care facilities managed by the federal government through the Federal Ministry of Health, secondary health care facilities managed by the state government, and primary health care facilities managed by local government areas health department to ensure the provision of health care services to communities [13,16]. The tertiary healthcare services under the federal government are provided by teaching hospitals and specialist hospitals. The health record department is concerned with the creation, maintenance, and storage of patients' health records, which is pivotal to the effective delivery of healthcare services provided by a team of health professionals. Health Records Management has become an integral activity of hospital management. The department provides multiple benefits not only to the patients but also to running a hospital effectively. Health record officers compile and store patient health information and make it available to the doctor in charge of the patient's treatment [1,17]. A hospital register is an official list where the names and other essential information about patients that have ever come in contact with the hospital services are written or documented. There are various registers used in hospitals such as; outpatient registers, casualty registers, inpatient admission and discharge registers, birth and death registers, and unit numbering, to mention but a few [18,19]. Over the years, improper documentation of patient clinical and health information has been seen as a threat causing various setbacks in the provision of quality health services to patients. Most healthcare professionals (especially doctors and nurses) do not attach much importance to ensuring accurate documentation of their professional rapport but are more concerned with the art of treatment itself [3,8]. However, this may result in o decrease in the quality of care given to the patients not only at present but also in the continuity of treatment as well as services to be rendered by allied professionals. It can also result in incidences of errors, financial losses, diminished patient care, and increased patient waiting time. A critical look at the activities of health records professionals in ensuring proper documentation practice among health care professionals reveals that little or nothing is being done in this regard [20,21]. Shortage of health records staff and use of non-professionals as health records staff among other reasons have been identified as being responsible for the inactivity in the maintenance of proper documentation. Also, observed that laziness and negligence of the health record personnel usually cause improper documentation of patient records and relevant health information [15]. These and other issues prompted the researcher to investigate the proper documentation as an effective tool to improve the quality of health care delivery services among health record personnel in Federal Medical Centre, Owo [22,11,12].

MATERIALS AND METHODS

Study design

The study made use of a descriptive survey design which involves designing and administration of questionnaires to collect data from respondents.

Study population

The population for this study consisted of Health Information Management staff of Federal Medical Centre, Owo. The study population was seventy-three (73).

Sample size and sampling technique

Total enumeration was used to determine the sample size made up of the total population of the staff (i.e.73 personnel) of the Medical Records Department of Federal Medical Centre, Owo. This is because the population size is relatively small and manageable.

Instrument for data collection

A structured self-administered questionnaire was used by the researcher as the research instrument. The questionnaire consists of 44 questions which are divided into 4 sections as follows:

Section A: Contains Socio-demographic data of respondents,

Section B: Assesses the knowledge of health records professionals on quality documentation of patients' health records in Federal Medical Centre, Owo.

Section C: Determines the attitudes of health records professionals towards quality documentation of patients' health records in Federal Medical Centre, Owo.

Section D: Identifies the barriers militating against proper documentation of patient's health records in Federal Medical Centre, Owo.

Validity and reliability of the instrument

The content validity of the instrument was ensured by seeking the opinion of the supervisor who vetted the first draft of the questionnaire to reduce errors and ambiguous content of the instrument.

Data collection

A semi-structured, self-administered questionnaire was distributed to the respondents. Seventy-three (73) questionnaires were distributed to the respondents at the Medical Records Department of Federal Medical Centre, Owo. They were properly filled in by the respondents and retrieved for data analysis.

Data analysis

The collected data was entered, coded, cleaned, and analyzed using Statistical Package for Social Sciences (SPSS version 20). The data was analyzed and presented using frequency tables and simple percentages. Inferential statistics (chi-square) was used to test for the level of significance between selected independent variables and dependent variables with a P-value<0.05.

RESULTS

Socio-demographic data

The results in Table 1 shows that 15 (20.5%) 0f the respondents fall within the age group of 21-30 years, within 31-40years, 29.0 (39.7%) within 41-50 years, 21 (28.7%) while 8.0 (10.9) fall within 51-60years. The results in Table 2 reveals that 64.0 (87.6%) of the respondents were female, and 9.0 (12.3%) were male. This implies that there are more males in the study area than females involved in documentation. The results in Table 3 shows that the majority 70 (95.8%) of the respondents were Christian, 2.0 (2.7%) were Muslim, and 1.0 (1.0%) of the respondent practice traditional [23]. The results in Table 4 shows that the majority of 72.0 (98.6%) of respondents were Yoruba, and 1 (1.3%) were Igbo. The results in Table 5 shows that none of the respondents working with a secondary education level, the majority 45.0 (61.6%) had Technician Education, 5.0 (6.8%) of the respondents had OND certificate, 21(28.7%) had HND/ B.sc education while 2.0 (2.7%) had M.sc respectively. The results in Table 6 shows that the majority 23.0 (31.5%) of the respondents fell between 0-5years of experience, 7.0 (9.5%) fell between 6-10years of experience, 10.0 (13.6%) fell between 11-15years of experience, 15.0 (20.5%) fell between 16-20years of experience, 13.0 (17.8%) fell between 21-25years of experience, while 5.0 (6.8%) fell between 26-30 years of experience.

Table 1: Frequency and percentage distribution by age group.

S.No	Age group	Frequency (n)	Percentage (%)
1	21-30	15.0	20.5
2	31-40	29.0	39.7
3	41-50	21.0	28.7
4	51-60	8.0	10.9
	Total	73.0	100.0

Table 2: Frequency and percentage distribution by sex.

S.No	Sex	Frequency (n)	Percentage (%)
1	Female	64.0	87.6
2	Male	9.0	12.3
	Total	73.0	100.0

Table 3: Frequency and percentage distribution by religion.

S.No	Religion	Frequency (n)	Percentage (%)
1	Christianity	70.0	95.8
2	Islam	2.0	2.7
3	Traditional	1.0	1.0
4	Others	0.0	0.0
	Total	73.0	100.0

Table 4: Frequency and percentage distribution by ethnicity.

S.No	Ethnicity	Frequency (n)	Percentage (%)
1	Yoruba	72.0	98.6
2	Igbo	1.0	1.3
3	Hausa	0.0	0.0
	Total	73.0	100.0

Table 5: Frequency and percentage distribution of respondents by level of education.

S.No	Level of education	Frequency (n)	Percentage (%)
1	"O" Level	0.0	0.0
2	Technician	45.0	61.6
3	OND	5.0	6.8
4	HND/BSC	21.0	28.7
5	M.sc/PhD	2.0	2.7
	Total	73.0	100.0

Table 6: Distribution of respondents based on years of experience.

S.No	Years of experience	Frequency (n)	Percentage (%)
1	0-5	23.0	31.5
2	6-10	7.0	9.5
3	11-15	10.0	13.6
4	16-20	15.0	20.5
5	21-25	13.0	17.8
6	26-30	5.0	6.8
	Total	73.0	100.0

Analysis of knowledge of health records professionals on quality documentation of patient's health records

The results in Table 7 reveals that the majority (98.6%) of respondents claimed to quality patient documentation should identify the person the record is written about. The majority of (100.0%) respondents strongly agreed that quality patient documentation should be accurate, concise, and logical in an organization which helps to improve the quality of service rendered to patients among health information professionals [24]. Also, the majority of (100.0%) of the respondents strongly agreed that quality patient documentation should be consistent in layout and the size of paper and aids in the continuity of patient care while none of the respondents disagreed. (95.8%) of the respondents strongly agreed that Quality patient documentation should identify the contributors to the records both health information personnel and other relevant health workers which helps to provide relevant answers in research activities while 3.0 (4.1%) also agree. Also shows (94.5%) of the respondents strongly agreed that quality patient documentation should be promptly retrievable when required and presented before the users while (5.4%) respondents agreed. The majority of (100.0%) of the respondents strongly agreed that the quality of patient documentation should be written, legible, reliable, and complete and none of the respondents disagreed with the statement. While (91.7%) of the respondents strongly agreed that quality patient documentation should be able to inform good decision-making, (5.4%) agreed, and (2.7%) disagreed that no good decision can be drawn out of quality patient documentation. The majority (94.5%) of the respondents claimed and strongly agreed that quality patient documentation should improve the quality of health care service delivery, (2.7%) agreed, (1.4%) disagreed while (1.4%) also strongly disagreed that quality documentation cannot in any way improve health care delivery.

Analysis of attitudes of the health information professional/ personnel in quality documentation of patient's health record

The results in Table 8 shows that the majority (97.2%) of respondents strongly disagreed that ensuring quality documentation is not meant for health information managers, (3.7%) disagreed, while none of the respondents strongly agreed. (100.0%) strongly disagreed that it makes their work stressful. (89.0%) strongly disagreed with not liking documentation because it is time-consuming, (1.4%) disagreed, (9.5%) agreed. (91.7%) strongly disagreed that documentation makes them look inferior, (2.7%) disagreed, and (5.4%) agreed. (82.2%) strongly disagreed that they don't feel proud whenever they are documenting manually, (4.1%) disagreed, (9.6%) agreed and (4.1%) strongly agreed. The majority of the respondent (86.3%) strongly disagreed that they don't feel satisfied when performing documentation, (6.8%) disagreed, (2.7%) agreed and (4.1%) strongly agreed respectively. (94.5%) of the respondents strongly disagreed that they don't enjoy doing documentation, (5.4%) disagreed while none of the respondents agreed they don't enjoy doing it. (80.2%) strongly disagreed to prefer electronic means of documentation, (8.2%) disagreed, (9.5%) agreed to prefer electronic means of documentation over manual while (1.3%) strongly agreed on electronic means.

Analysis of barriers militating against proper documentation of patients' health records

The results in Table 9 shows that the majority (89%) of respondents strongly disagreed that laziness of health care staff prevents proper documentation, (6.8%) disagreed while (4.1%) agreed that laziness of health care staff could prevent adequate documentation. (83.5%) strongly disagreed wrong data capturing by members of the health care team could the prevention of proper documentation, (5.4%) disagreed, (9.5%) agreed and (1.3%) strongly agreed respectively. The majority (95.8%) of the respondents strongly disagreed lack of appropriate training of staff engaged in the documentation of patients' records prevents proper documentation because of their vast knowledge about documentation while (4%) disagreed. 82% of the respondents strongly disagreed that poor professional training of documenting staff prevents proper documentation, (12%) disagreed while (5%) of the respondents agreed. (86%) of the respondents strongly disagreed that negligence on the part of documenting staff prevents proper documentation, (5%) disagreed, (1.3%) agreed and (6.8%) strongly agreed respectively. (91.7%) of the respondents strongly disagreed that inadequate provision of working materials, such as stationeries prevents proper documentation which carries the majority, (2.7%) disagreed, while (5.5%) strongly agreed. (90.0%) of respondents strongly disagreed with the lack of proper supervision of staff documentation could prevent proper documentation, (8.0%) disagreed while and (1.3%) agreed with it. The majority (97.0%) of the respondents strongly disagreed that the lack of a language barrier between staff and patients prevents proper documentation and (2.7%) disagreed. (75.0%) strongly disagreed that lack of conductive working space prevents proper documentation, (6.8%) disagreed, (10.9%) agreed and (6.8%) agreed respectively. (93%) respondents strongly disagreed that lack of proper co-ordination prevents proper documentation, (4%) disagreed, and (2.7%) agreed inadequate co-ordination prevents proper documentation. The majority (98.6%) of the respondents strongly disagreed that lack of concentration on the part of staff prevents proper documentation and (1.3%) disagreed. (86.0%) of the respondents strongly disagreed that inadequate motivation of staff by hospital administration prevents proper documentation, (4.0%) disagreed, (6.8%) agreed, and the remaining (2.7%) strongly agreed inadequate motivation could prevent proper documentation. (100.0%) of the respondents which show all of them strongly disagreed with the shortage of manpower prevents proper documentation. The majority (84.9%) of the respondent strongly disagreed that illegible handwriting of staff prevents proper documentation, (9.5%) disagreed, (4.0%) agreed and the remaining (1.3%) strongly agreed. (89.0%) strongly disagreed that convergence of rush by patients at the facility could prevent proper documentation, (5.5%) just disagreed, (2.7%) agreed and the remaining (2.7%) strongly agreed. (4.0%) of the respondents agreed on unwholesome attitude from patient to staff prevents proper documentation, (93.0%) strongly disagreed and the remaining disagreed. (1.3%) of the respondents disagreed inexperience of staff prevents proper documentation while the remaining (98.6%) which carries the majority strongly disagreed, which that shows a well-experienced staff will have a positive effect on documentation. (100.0%) which shows all the respondents strongly disagreed with the statement lack of support from management prevents proper documentation. (4.0%) of the respondents strongly agreed that mechanical error from machinery prevents proper documentation, (2.7%) disagreed, (6.8%) agreed and the remaining (86.0%) majority strongly disagreed with the statement. (94.5%) majority of the respondents strongly disagreed that religious restriction prevents proper documentation and (5.5%) disagreed with the statement. (4.0%) of the respondents agreed to cultural restriction prevents proper documentation, (89%) of the majority strongly disagreed, and (6.8%) also disagreed with it.

Table 7: Distribution of knowledge of health records professionals on quality documentation of patients' health records.

S.No	Parameter	SA	A	D	SD
1	Quality patient documentation should identify the person the record is written about	98.6%	0.0%	1.3%	0.0%
2	Quality patient documentation should be accurate, concise, and logical in the organization	100.0%	0.0%	0.0%	0.0%
3	Quality patient documentation should be consistent in layout and the size of paper	100.0%	0.0%	0.0%	0.0%
4	Quality patient documentation should identify the contributors to the records	95.8%	4.1%	0.0%	0.0%
5	Quality patient documentation should be promptly retrievable when required	94.5%	5.4%	0.0%	0.0%
6	Quality patient documentation should be legible, reliable, and complete	100.0%	0.0%	0.0%	0.0%
7	Quality patient documentation should be able to inform good decision making	91.7%	5.4%	2.7%	0.0%
8	Quality patient documentation should improve the quality of healthcare service delivery	94.5%	2.7%	1.4%	1.4%

SA=Strongly Agree, A=Agree, D=Disagree, SD=Strongly Disagree.

Table 8: Attitudes of the health information professional/personnel in quality documentation of patient's health record.

S.No	Variable	SD	D	A	SA
1	Ensuring quality documentation is not meant for Health Information Managers	97.2%	3.7%	0.0%	0.0%
2	I don't like documentation because it is stressful	100.0%	0.0%	0.0%	0.0%
3	Documentation consumes much time	89.0%	1.4%	9.5%	0.0%
4	Documentation makes me look inferior	91.7%	2.7%	5.4%	0.0%
5	I don't feel proud whenever I am documenting manually	82.2%	4.1%	9.6%	4.1%
6	I don't feel satisfied	86.3%	6.8%	2.7%	4.1%
7	I don't enjoy doing it	94.5%	5.4%	0.0%	0.0%
8	I prefer electronic means of documentation	80.2%	8.2%	9.5%	1.3%

SA=Strongly Agree, A=Agree, D=Disagree, SD=Strongly Disagree.

Table 9: Barriers militating against proper documentation of patients' health records.

S.No	Statements	SD	D	A	SA
1	Laziness of health care staff prevents proper documentation	89.0%	6.8%	4.1%	0.0%
2	Wrong data capturing by members of the health care team prevents proper documentation	83.5%	5.4%	9.5%	1.3%
3	Lack of appropriate training of staff engaged in the documentation of patients' records prevents proper documentation	95.8%	4.0%	0.0%	0.0%
4	Poor professional training of documenting staff prevents proper documentation	82.0%	12.0%	5.0%	0.0%
5	Negligence on the part of documenting staff prevents proper documentation	86.0%	5.0%	1.3%	6.8%
6	Inadequate provision of working materials, such as stationeries prevents proper documentation	91.7%	2.7%	0.0%	5.5%
7	Lack of proper supervision of staff documentation prevents proper documentation	90.0%	8.0%	1.3%	0.0%
8	The language barrier between staff and patients prevents proper documentation	97.0%	2.7%	0.0%	0.0%
9	Lack of conducive working space prevents proper documentation	75.0%	6.8%	10.9%	6.8%
10	Lack of proper co-ordination prevents proper documentation	93.0%	4.0%	2.7%	0.0%
11	Lack of concentration on the part of staff prevents proper documentation	98.6%	1.3%	0.0%	0.0%
12	The inadequate motivation of staff by hospital administration prevents proper documentation	86.0%	4.0%	6.8%	2.7%
13	Shortage of manpower prevents proper documentation	100.0%	0.0%	0.0%	0.0%
14	Illegible handwriting of staff prevents proper documentation	84.9%	9.5%	4.0%	1.3%
15	Convergence of rush by patients at the facility prevents proper documentation	89.0%	5.5%	2.7%	2.7%
16	The unwholesome attitude of patients to staff prevents proper documentation	93.0%	2.7%	4.0%	0.0%
17	The inexperience of staff prevents proper documentation	98.6%	1.3%	0.0%	0.0%
18	Lack of support from management prevents proper documentation	100.0%	0.0%	0.0%	0.0%
19	Mechanical error from machinery prevents proper documentation	86.0%	2.7%	6.8%	4.0%
20	The religious restriction prevents proper documentation	94.5%	5.5%	0.0%	0.0%
21	The cultural restriction prevents proper documentation	89.0%	6.8%	4.0%	0.0%

SA=Strongly Agree, A=Agree, D=Disagree, SD=Strongly Disagree.

DISCUSSION

The study indicates in Table 1 that majority of the respondents 29.0 (39.7%) fall within the age group of 31-40 years. This indicates that the bulk of the professionals among health information professionals falls within this age group. Also, the majority of the respondents 64.0 (87.6%) were female, and the male counterpart was 9.0 (12.3%). This shows that the frequency of female professionals is high. Moreover, the frequency of christianity among the respondents was higher 70.0 (95.8%) compared to 2.0 (2.7 %) practice Islam while 1.0 (1.0%) practice traditional religion. In addition, the study reveals that the majority 72.0 (98.6%) of respondents were Yoruba. this indicates that the location of the Hospital mostly determines the maternity of the Health Workers. The study reveals that 45.0 (61.6%) of the respondents had tertiary education as technicians, 5.0 (6.8%) had OND certificates, 21.0 (28.7%) had HND/BSc, and 2.0 (2.7%) had MSc/Ph.D. education. This indicates that health information officers whose major duty is documentation are of the highest frequency of the respondent and well trained.

The study also reveals that majority 23.0 (31.5%) of the respondents fell between 0-5 years of experience, 7.0 (9.5%) fell between 6-10 years of experience, 10.0 (13.6%) fell between 11-15 years of experience, 15.0 (20.5%) fell between 16-20 years of experience, 13.0 (17.8%) fell between 21-25 years of experience, while 5.0 (6.8%) fell between 26-30 years of experience.

It was shown that the majority of 100.0 (100.0%) respondents claimed that quality patient documentation should be accurate, concise, and logical in an organization which helps to improve the quality of service rendered to patients among health information professionals. This indicates that all the respondents knew the importance of accurate and adequate documentation, this is in the submission of Ontario Ministry of Health and Long-Term Care (MOHLTC), 2012 that says "over the years, improper documentation of patient clinical and health record has been seen as a threat causing various setbacks in the provision of quality health services to patients. For example, when physicians inaccurately document a patient complaint and plan for treatment in the case notes, the next attending physician may come up with a wrong diagnosis and the pharmacist will give the wrong drug or medications to the patient".

Furthermore, the majority of (100.0%) of the respondents claimed that quality patient documentation should be written, legible, reliable, and complete. The details help to give physicians a clear picture of the patient's condition. This gives clearer evidence of the understanding of documentation by the respondents. The hypothesis of this study also reveals that the respondent's knowledge does not impact their years of experience or level of their education since the P-value is more than 0.05. It also shows that (95.8%) of the respondents, which carries the majority strongly agreed that quality patient documentation should identify the contributors to the records both health information personnel and other relevant health workers which helps to provide relevant answers in research activities. In addition, the majority (94.5%) of the respondents strongly agreed that quality patient documentation should be promptly retrievable when required and presented before the users. Likewise (100%) of the respondents agreed that the quality of patient documentation should be consistent in layout and the size of the paper while none of the respondents disagreed with the process, this shows their high level of understanding as regards documentation. The study also reveals majority (91.7%) of the respondents strongly agreed that quality patient documentation should be able to inform good decision-making can be drawn out of quality patient documentation while the majority (94.5%) the respondents claimed and strongly agreed that quality patient documentation should improve the quality of health care service delivery, (2.7%) agreed, (1.4%) disagreed and (1.4%) also strongly disagreed that quality documentation cannot in any way improve health care delivery.

CONCLUSION

The objective of the study was to evaluate the knowledge of health information professionals regarding the importance of proper documentation in healthcare settings. The findings of the research indicate that proper documentation has a significant impact on the services provided in healthcare facilities. Accurate and comprehensive documentation ensures that patient information is readily available, facilitating effective communication and coordination among healthcare providers. This, in turn, enhances patient safety, as critical information is not lost or misinterpreted during care transitions. This research emphasizes the significant role of proper documentation as an effective tool to enhance quality health delivery in the Federal Medical Centre, Owo. By recognizing the importance of documentation, healthcare providers and administrators can work together to improve patient care, foster better communication, support evidence-based practice, and ensure compliance with regulatory standards.

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DECLARATION

Conflicts of interest

No competing interest to report, the authors declared no potential conflicts of interest concerning the research, authorship, and/or publication of this article.

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