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MEDICAL RECORD COMPLETENESS AND INFORMED CONSENT AS INTEGRATED STRATEGIES FOR LEGAL RISK PREVENTION IN A CIRCUMCISION CLINIC

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Abstract
Medical record documentation and informed consent are central components of clinical accountability, patient rights, and organizational risk governance. This study examined how documentation completeness and informed-consent practices operate as legal risk-prevention mechanisms at Rumah Sunat Rizki Clinic, Malang, and identified organizational strategies for improvement. A descriptive qualitative case-study approach was used. Data were generated through semi-structured interviews with 11 purposively selected informants representing clinic management, administration, medical personnel, supporting staff, and an expert informant, together with direct observation and document review. Interview and observational material was coded into categories and eight themes; findings were then synthesized through SWOT and IFAS–EFAS matrices. The clinic had established documentation procedures and generally obtained guardian consent before circumcision. However, variation persisted in the detail of SOAP notes, recording of service dates and times, staff authentication, witness completion, and disclosure of alternative procedures. These gaps were associated with interacting organizational conditions, including fluctuating patient volume, paper-based workflows, limited rechecking capacity, pediatric patient needs, and differences in guardians' understanding. The SWOT coordinates (−0.47, 0.41) indicated a Quadrant III position and supported a weakness–opportunity strategy. The study proposes a two-point verification model before and after procedures, supported by standardized forms, audit-and-feedback cycles, communication training, confidentiality controls, and phased electronic-record implementation. Legal risk prevention is best embedded in routine quality governance rather than treated solely as a response to disputes.

Keywords: clinical documentation; informed consent; legal risk governance; patient safety; electronic medical records

Introduction

Clinical documentation is not simply an administrative record of a healthcare encounter. It is the structured account through which a facility can demonstrate what assessment was undertaken, what clinical decisions were made, which interventions were delivered, who provided them, and what information was communicated to the patient or authorized representative. The

quality of this account depends on completeness, accuracy, consistency, timeliness, authentication, and retrievability. Deficiencies in these dimensions may weaken continuity of care, organizational learning, and the ability to reconstruct events when questions or complaints arise (Bowman, 2013; Weiskopf & Weng, 2013; World Health Organization [WHO], 2020).

The patient-safety literature increasingly treats documentation and information systems as parts of a broader sociotechnical system. Errors rarely arise from one isolated individual action; they may emerge from the interaction of workload, task design, communication, technology, supervision, and organizational conditions (Carayon et al., 2006; Reason, 2000; Sittig & Singh, 2010). Accordingly, incomplete records should be examined not only as individual compliance failures but also as potential indicators of weaknesses in workflow design and control.

Informed consent is similarly more than a signed form. Ethically valid consent requires disclosure of relevant information, comprehension, voluntariness, and authorization by a person with appropriate decision-making authority. The process should enable questions and a meaningful decision rather than reduce consent to a routine administrative signature (Faden & Beauchamp, 1986; Manson & O'Neill, 2007; World Medical Association [WMA], 2015). For pediatric care, the distinction between parental permission and the child's developmentally appropriate involvement is important; the relevant legal and ethical requirements depend on the child's capacity, applicable law, and clinical circumstances (Alderson, 2007; Committee on Bioethics, 2016).

These principles are particularly relevant to circumcision services, where guardians may need to understand the rationale, method, expected benefits, material risks, alternatives, anesthesia, aftercare, and circumstances requiring follow-up. A form may record that permission was given, but it cannot by itself establish the quality of the preceding communication. The documentation should therefore capture both the decision and the process through which the decision was reached.

In Indonesia, the regulatory context makes documentation governance especially salient. Ministry of Health Regulation No. 24 of 2022 requires healthcare facilities, including clinics, to implement electronic medical records and emphasizes security, confidentiality, integrity, and availability of information (Ministry of Health of the Republic of Indonesia, 2022). The regulation also specifies that clinical information should be recorded completely and clearly, with the name, time, and signature of the healthcare professional providing the service. These requirements position record quality as a governance obligation rather than a discretionary administrative preference.

At Rumah Sunat Rizki Clinic, internal service records for 2025 indicated 407 circumcision patients, with peaks in June (98 patients) and December (70 patients), as well as 54 follow-up visits involving buried-penis circumcision cases. The supplied preliminary assessment described a predominantly paper-based record system and variable completion of some documentation elements. The reported gaps concerned the detail of SOAP notes, service dates and times, authentication, the depth of information disclosure, witness completion, and recording of the time at which consent was obtained. These are not equivalent to an absence of records; rather, they indicate variation in the reliability of documentation across the care pathway.

Prior research and guidance have addressed medical-record quality, electronic-record implementation, informed consent, patient safety, and strategic management, but these strands are often considered separately. This study brings them together in a single clinic-level analysis. Its contribution is contextual and managerial: it examines how clinical documentation, consent communication, operational constraints, and legal-risk governance interact in a circumcision clinic, and translates the qualitative findings into a staged improvement strategy. The study does not claim to establish causal effects or legal immunity from documentation practices.

The study addresses four questions: (1) How are medical records completed and managed throughout the clinic's service pathway? (2) How is informed consent communicated and documented before circumcision? (3) What organizational and operational conditions contribute to variation in documentation completeness? and (4) What feasible strategies can strengthen documentation governance and reduce preventable legal and patient-safety risks?

Theoretical Framework

Clinical documentation as information quality and accountability

Medical records perform clinical, administrative, informational, and legal functions. Their value depends on whether the record accurately represents the care delivered and can be retrieved by authorized users when needed. Information-quality scholarship distinguishes dimensions such as accuracy, completeness, consistency, timeliness, and accessibility; these dimensions are interdependent rather than interchangeable (Batini et al., 2009; Weiskopf & Weng, 2013). A record may be present but still be deficient if it lacks a clear chronology, provider authentication, or sufficient clinical detail.

Documentation quality also has implications for patient safety. The record supports handovers, follow-up, communication across professionals, and organizational review. However, electronic systems do not automatically guarantee high-quality information. Poorly designed interfaces, fragmented workflows, copy-forward practices, and inadequate training can reproduce or introduce documentation problems (Bowman, 2013; Kruse et al., 2016; Sittig & Singh, 2010). Therefore, digitization should follow workflow analysis, standardization, governance, and user engagement rather than be treated as a stand-alone technological intervention.

Informed consent as communication and authorization

Informed consent is a process through which an individual receives and understands information relevant to a proposed intervention and voluntarily authorizes it. Its ethical foundations include respect for autonomy, adequate disclosure, comprehension, and voluntariness (Beauchamp & Childress, 2019; Faden & Beauchamp, 1986). The quality of consent therefore cannot be inferred solely from the presence of a signature. The information should be tailored to the recipient's needs, presented in understandable language, and include relevant alternatives and material risks (Manson & O'Neill, 2007; WMA, 2015).

In pediatric services, parents or legal guardians generally provide permission in accordance with applicable law, while children should be involved in decisions to the extent appropriate to their developmental capacity and circumstances. Pediatric ethics guidance emphasizes communication that respects the child and family, avoids coercion, and recognizes the child's

developing autonomy (Alderson, 2007; Committee on Bioethics, 2016). In this study, the source data primarily describe communication with guardians; the manuscript does not provide sufficient evidence to assess the extent of child assent.

Legal risk, patient safety, and organizational learning

Legal risk prevention in healthcare should not be equated with preventing all complaints or guaranteeing a favorable legal outcome. Rather, it involves reliable processes that protect patient rights, support safe care, and enable an organization to explain and review its decisions. Patient-safety frameworks emphasize learning from system conditions and strengthening defenses rather than relying exclusively on individual blame (Reason, 2000; WHO, 2021). Documentation and consent contribute to this system when they are integrated with clear responsibilities, review mechanisms, feedback, and corrective action.

Audit and feedback can support improvement when performance information is timely, specific, repeated, and linked to actionable recommendations. Evidence indicates that audit-and-feedback interventions can improve professional practice, although their effects vary by context and design (Ivers et al., 2012). For a clinic with fluctuating patient volume, the audit process should therefore identify recurring omission patterns and the operational conditions associated with them, not merely return individual forms for correction.

SWOT as a strategy-synthesis tool

SWOT analysis can organize internal strengths and weaknesses alongside external opportunities and threats. In healthcare, however, it should not be treated as a self-validating measurement instrument or as a substitute for evidence-based prioritization. Its usefulness depends on transparent factor selection, defensible weighting, stakeholder involvement, and careful interpretation (Helms & Nixon, 2010; van Wijngaarden et al., 2012). In the present study, SWOT and IFAS–EFAS matrices are used as a structured synthesis of qualitative evidence. Their numerical scores represent the study's interpretive weighting procedure and are not inferential statistics.

Integrated analytical framework

The study uses an integrated framework in which documentation quality and consent quality are core governance processes; organizational conditions (workload, staffing, form design, manual or electronic infrastructure, supervision, and guardian understanding) shape their consistency; and audit, feedback, training, and information-security controls support improvement. Legal-risk prevention is treated as an organizational outcome that is strengthened by reliable, traceable processes, not as a directly measured or guaranteed result.

Research Method

Research design and participants

This study used a descriptive qualitative case-study design to examine documentation and informed-consent practices within their operational context at Rumah Sunat Rizki Clinic, Malang, Indonesia. A case-study approach is appropriate for investigating a bounded organizational process through multiple sources of evidence (Yin, 2018). The analysis focused on the clinic's service

pathway, documentation practices, consent communication, organizational constraints, and feasible improvement strategies.

Informants and sampling

Eleven informants were selected purposively because of their involvement in, or knowledge of, the clinic's service and documentation processes. They comprised one clinic director (DIR), one person in charge of services (PJP), two administration and finance staff members (ADM-1 and ADM-2), five medical-service personnel (MED-1 to MED-5), one medical-support staff member (PNJ), and one expert informant (EXP). Purposive sampling is appropriate when participants are selected for their ability to provide information relevant to the research questions (Patton, 2015; Malterud et al., 2016).

Data sources and collection

Primary data were collected through semi-structured in-depth interviews and direct observation. Secondary sources comprised available medical records, informed-consent forms, service reports, and documentation checklists. The interview and observation focus included role allocation, record completion, the sequence of consent communication, authentication, retrieval and storage, supervision, and perceived barriers.

Analytical procedures

The source manuscript reports an iterative process in which interview and observational meaning units were coded, grouped into categories, and synthesized into eight final themes. The analysis involved data reduction, organized presentation, and conclusion drawing, consistent with qualitative analytic procedures described by Miles et al. (2014). The eight themes concerned: (1) policies, SOPs, role allocation, and documentation governance; (2) registration, documentation, storage, and retrieval; (3) content completeness, authentication, and timeliness; (4) information disclosure and informed consent; (5) human resources, workload, manual systems, and guardian understanding; (6) supervision, compliance audit, and corrective action; (7) documentation as legal protection and patient safety; and (8) improvement strategy and phased digitalization.

The qualitative findings were subsequently organized into internal and external factors for SWOT analysis. IFAS and EFAS weights were informed by cross-informant support, relevance to documentation completeness and legal risk, and observational confirmation. The source manuscript reports the resulting subtotals and coordinates. Because the original scoring sheet and item-level weights were not included in the supplied document, the current report preserves the reported aggregate scores but does not claim independent recalculation or statistical validation.

Trustworthiness and reporting

The source manuscript reports source triangulation across management, administration, medical personnel, supporting staff, and the expert informant, as well as technique triangulation across interviews, observation, and document review. These procedures support credibility by examining whether interpretations converge across participants and evidence types. Further reporting could be strengthened by documenting the researchers' roles and reflexivity, the coding structure, examples of discrepant cases, the audit trail, and any participant validation procedures. COREQ provides a useful reporting framework for interview-based qualitative studies (Tong et

al., 2007), while Lincoln and Guba (1985) provide established criteria for credibility, transferability, dependability, and confirmability.

Results

Clinic profile and service volume

The clinic's service pathway included registration, examination, preparation, information disclosure, consent, circumcision, post-procedure education, and follow-up. Internal service records for 2025 recorded 407 circumcision patients. June accounted for 98 patients and December for 70 patients. The source manuscript additionally reports 54 follow-up visits involving buried-penis circumcision cases. These figures indicate variation in service volume and provide operational context for the reported pressure on documentation and verification. They should not be interpreted as a direct measure of documentation error rates.

Table 1. Clinic Service Volume and Follow-Up Indicators in 2025

Service indicator	Reported value	Interpretation
Circumcision patients in 2025	407	Annual service volume reported by the clinic
June 2025	98 patients	Highest monthly volume reported
December 2025	70 patients	Second reported peak month
Follow-up visits involving buried-penis cases	54 visits	Follow-up activity reported separately

Medical-record workflow and completeness

The clinic had an established pathway for creating, returning, storing, and retrieving medical records. Patient identity, diagnosis, procedure, and treatment were generally documented. Greater variation was reported in detailed SOAP notes, service dates and times, printed names, and signatures or initials. The findings therefore distinguish the existence of a record from the completeness and traceability of its contents.

The paper-based system generally enabled retrieval, but additional time was sometimes required when records had not been returned to storage, had been misfiled, or contained inconsistent patient-name entries. These observations indicate that retrieval depended substantially on orderly physical movement and filing. The source material does not provide measured retrieval times or a quantitative audit of the proportion of incomplete records.

Informed-consent implementation

The reported consent process occurred before circumcision. Medical personnel explained the patient's condition, procedure method, anesthesia, benefits, risks, post-procedure care, and provided an opportunity for guardians to ask questions. However, the depth of disclosure was not always consistent, particularly regarding alternative procedures. Some administrative elements, including staff or witness signatures and time recording, could be completed later.

The findings reveal two distinct dimensions: the communication process and the documentary evidence of that process. A guardian's signature records authorization, but the completeness of the consent record also depends on documenting what was explained, who

provided the explanation, whether alternatives were discussed, whether questions were invited, and whether consent preceded the intervention.

Organizational and operational constraints

The reported constraints were systemic and interrelated. First, fluctuations in patient volume increased pressure on staff time and the capacity to recheck records. Second, paper-based workflows required physical movement, filing, and manual retrieval. Third, pediatric patients who were frightened, crying, or difficult to examine could require additional time for assessment and preparation. Fourth, guardians differed in their prior knowledge and understanding of risks and aftercare. Finally, supervisory review existed but could become faster or sample-based during high-volume periods.

Table 2. Summary of Qualitative Themes, Core Findings, and Operational Implications

Theme	Core finding	Operational implication
T1. Governance and role allocation	Policies, SOPs, and responsibilities were available	The control framework exists but requires consistent execution
T2. Record pathway	Registration, documentation, storage, and retrieval functioned through paper files	Physical movement and filing create retrieval dependencies
T3. Completeness and authentication	SOAP detail, time, printed names, and initials were variable	Traceability may be weakened by repeated omissions
T4. Consent communication	Pre-procedure disclosure occurred, but alternatives and timing were inconsistent	Consent quality requires communication and documentation controls
T5. Systemic constraints	Workload, manual systems, pediatric needs, and guardian understanding interacted	Process redesign is preferable to individual blame
T6. Supervision and audit	Review and correction existed but capacity declined during peaks	Audit frequency and reviewer allocation need to match workload
T7. Legal protection and safety	Records support accountability when authentic, complete, and traceable	Documentation is a governance safeguard, not a guarantee against disputes
T8. Improvement strategy	Checklists, standardization, training, audit, confidentiality, and digitalization were prioritized	Improvement should be staged

SWOT synthesis

The reported IFAS analysis produced a strengths subtotal of 1.59 and a weaknesses subtotal of 2.06, yielding an internal coordinate of −0.47. The EFAS analysis produced an opportunities subtotal of 1.98 and a threats subtotal of 1.57, yielding an external coordinate of 0.41. The resulting coordinate (−0.47, 0.41) placed the clinic in Quadrant III and supported a weakness–opportunity (WO/turnaround) strategy.

Table 3. IFAS–EFAS Results and SWOT Strategic Position of the Clinic

SWOT component	Score	Interpretation reported in the source
Strengths	1.59	SOPs, role allocation, and an established consent process
Weaknesses	2.06	Paper-based records, inconsistent completeness/authentication, limited checking capacity
Opportunities	1.98	Digital technology, regulatory direction, and professional training
Threats	1.57	Patient surges, varying guardian expectations, complaints/disputes, and information-security risks
Coordinates	−0.47; 0.41	Quadrant III; WO/turnaround strategy

The SWOT scores are reproduced as reported. The manuscript should be accompanied by the original IFAS–EFAS worksheet, including factor definitions, weights, ratings, and calculation steps, so that readers can assess the transparency and reproducibility of the strategic synthesis.

Proposed strategic priorities

Table 4. Proposed Strategic Priorities for Strengthening Medical Record and Informed Consent Governance

Time frame	Priority	Actions proposed in the source	Intended operational result
0–3 months	Process control	Two-point checklist; designated reviewer; standardized mandatory fields	Identity, procedure, consent, time, and authentication checked before filing
3–6 months	Competence and supervision	Routine audits; feedback; disclosure training; documentation of	Recurring deficiencies identified and corrective action targeted

		education and complaints	
6–12 months	Phased digitalization	Electronic patient index; mandatory-field reminders; EHR integration; access rights; audit trail; backup and retention	Improved retrieval, traceability, confidentiality, and continuity

Discussion

Documentation completeness as a governance capability

The findings show that the clinic's central challenge is not the absence of a documentation pathway but the uneven execution of its required elements. This distinction matters because the mere presence of a form does not establish that the record is sufficiently complete to reconstruct the care process. Documentation quality is multidimensional: clinical content, chronology, provider identification, authentication, and retrievability must work together (Weiskopf & Weng, 2013). The observed variation in SOAP detail, dates and times, printed names, and signatures therefore represents a governance issue as well as an administrative one.

This interpretation is consistent with sociotechnical approaches to patient safety. When workload rises, paper forms require manual completion, and verification is concentrated at the end of the pathway, the system becomes vulnerable to omissions. Such omissions should be understood in relation to the design of tasks, tools, people, and organizational controls rather than attributed automatically to individual negligence (Carayon et al., 2006; Reason, 2000; Sittig & Singh, 2010).

Consent quality requires more than a signature

The clinic's reported practice of explaining the procedure and obtaining guardian authorization before circumcision is an important procedural strength. Nevertheless, the variation in explaining alternatives and recording the information provider and timing indicates that the quality of consent documentation is not yet fully standardized. Ethical accounts of informed consent emphasize that authorization is meaningful only when supported by adequate disclosure and understanding (Beauchamp & Childress, 2019; Faden & Beauchamp, 1986; Manson & O'Neill, 2007).

For pediatric services, the record should identify the legally appropriate decision-maker and document the information communicated to that person. Where clinically and developmentally appropriate, the child's involvement or assent should also be considered. The current data, however, do not establish whether assent was sought or how children's views were incorporated. This should be acknowledged as a limitation rather than inferred from the existence of guardian consent.

Workload and workflow as interacting risk conditions

The reported patient-volume peaks, pediatric-care demands, and manual record system appear to interact. A high-volume period may reduce the time available for explanation and verification; a paper-based workflow can add retrieval and filing tasks; and pediatric distress may

extend the clinical encounter. These conditions can compound one another. The finding supports a systems-oriented response: adjust reviewer capacity and task allocation during peak periods, place verification at critical workflow points, and simplify forms without removing essential clinical or legal information.

Interpreting the WO strategy cautiously

The Quadrant III position indicates that the source analysis identified more prominent internal weaknesses alongside available external opportunities. The WO strategy is therefore logically directed toward using regulatory and technological developments, as well as training opportunities, to address paper-based processes and inconsistent completion. However, SWOT is a synthesis aid, not proof that a particular strategy will produce a measurable reduction in legal risk. Its credibility depends on transparent factor selection and scoring (Helms & Nixon, 2010; van Wijngaarden et al., 2012). The original scoring worksheet should be provided as supplementary material or retained for audit.

A two-point verification model

The study's principal managerial proposal is a two-point verification model. The pre-procedure checkpoint should verify patient identity, relevant clinical assessment, guardian identity and authority, information disclosure, opportunity for questions, and consent before intervention. The post-procedure checkpoint should verify the procedure note, date and time, responsible provider's authentication, post-procedure education, follow-up instructions, and completion of required fields before the record is stored. This distributes control across the care pathway and reduces dependence on a single end-of-process review.

The model is a practice-oriented proposal derived from the case findings; it has not yet been tested for effectiveness. Its implementation should therefore be monitored through process indicators, such as the proportion of records with complete mandatory fields, the proportion of consent forms documenting alternatives and timing, audit completion rates, and median retrieval time. These indicators are proposed for future evaluation and were not measured in the present study.

Audit, feedback, and organizational learning

The clinic already returned incomplete records for correction, but the reported decline in checking capacity during busy periods suggests that a reactive review process may not be sufficient. Audit-and-feedback can support professional practice when feedback is specific, timely, and connected to feasible improvement actions (Ivers et al., 2012). The clinic could classify deficiencies by type and service stage, discuss recurring patterns with relevant staff, and monitor whether corrective actions reduce repetition. This approach shifts audit from individual correction toward organizational learning.

Phased electronic-record implementation

Indonesia's Regulation No. 24 of 2022 requires healthcare facilities, including clinics, to implement electronic medical records and emphasizes confidentiality, integrity, and availability (Ministry of Health of the Republic of Indonesia, 2022). This provides a regulatory basis for the clinic's digitalization priority. Yet evidence on electronic-record adoption indicates that

implementation is shaped by organizational readiness, workflow fit, training, leadership, infrastructure, and user acceptance (Boonstra & Broekhuis, 2010; Cresswell et al., 2013; Kruse et al., 2016). Digitalization should consequently be phased: first standardize data fields and responsibilities; then introduce an electronic patient index and mandatory-field controls; and finally develop interoperable records with role-based access, audit trails, backup, retention, and security governance.

Electronic records also introduce risks, including inappropriate access, inaccurate data entry, system downtime, and unsafe workarounds. These risks reinforce the need to treat information technology as part of the clinical work system rather than as a purely technical solution (Sittig & Singh, 2010). The clinic's digital transition should therefore include staff participation, clear procedures, data-protection controls, and contingency planning.

Theoretical and practical contributions

The study contributes a contextual account of how documentation completeness, informed-consent communication, and organizational controls intersect in a small specialized clinic. It extends a fragmented discussion by treating record quality and consent quality as mutually reinforcing elements of a single service-governance pathway. Its practical contribution is the two-point verification proposal and a staged WO strategy that links immediate workflow controls to longer-term digitalization. These contributions are analytically derived from one case and should not be generalized statistically to all clinics.

Conclusion

Medical-record management at Rumah Sunat Rizki Clinic had an established procedural foundation, but completion remained inconsistent in detailed SOAP notes, service dates and times, printed names, and signatures or initials. Informed consent was generally obtained before circumcision and included communication with guardians; however, disclosure of alternatives, identification of the information provider, witness completion, and timing documentation required greater consistency. The reported constraints were systemic, involving fluctuating workload, manual record handling, limited rechecking capacity, pediatric patient needs, and differences in guardians' understanding.

The SWOT synthesis placed the clinic in Quadrant III (−0.47, 0.41), supporting a WO/turnaround strategy. The study proposes a two-point verification model before and after procedures, standardized forms, audit and feedback, communication training, confidentiality safeguards, and phased electronic-record implementation. The central contribution is to position documentation and informed consent as connected governance processes embedded in routine service quality and patient safety. Future research should test the proposed controls using prospective process indicators and include patient or guardian perspectives.

Limitations and Recommendations for Further Research

Several limitations should be considered. First, the study concerns one clinic, limiting transferability to settings with different service volumes, staffing, and regulatory arrangements. Second, the supplied manuscript does not report the number of records reviewed, an item-level documentation audit, or measured retrieval times; consequently, the study cannot estimate the

prevalence or magnitude of incomplete documentation. Third, the manuscript does not provide interview dates, duration, transcription procedures, or a detailed coding audit trail. Fourth, the IFAS–EFAS calculation is reported only in aggregate, preventing independent verification of the weighting. Fifth, the study does not include patient or guardian interviews, so the quality of consent is interpreted primarily through staff accounts, observation, and available forms. Finally, ethics approval and informant consent details are absent from the source document and must be clarified by the authors.

CRediT authorship contribution statement

Septrienda Juwita: Conceptualization; Methodology; Investigation; Formal analysis; Writing – original draft. **Vip Paramarta:** Supervision; Methodology; Writing – review and editing. **Rahadian Malik:** Supervision; Validation; Writing – review and editing.

Declarations

Ethics approval: The source manuscript does not include an ethics approval number or a formal decision from an institution.

Informed consent: Not applicable to the analysis of publicly accessible online reviews, while adhering to the ethical requirements of the relevant institution and journal.

Data availability: The dataset of reviews can be obtained by contacting the author via the provided email address.

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Use of artificial intelligence (AI)

The author declares that generative AI was used during the manuscript editing process to improve language, structure, and clarity. AI was not used to generate empirical data, interview evidence, observations, or research findings.

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