

THE IMPACT OF HEALTHCARE ADMINISTRATORS ON HOSPITAL PERFORMANCE AND PATIENT OUTCOMES A COMPREHENSIVE REVIEW

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ABSTRACT

Healthcare administrators play a critical role in raising the standard of hospital treatment, and in order to carry out these responsibilities successfully and efficiently, their managers need a number of competences. The employment of professional hospital managers should be given greater consideration in the modern day, particularly those with training in health services management. The goal of the current research was to examine how graduates of Health Services administration changed the paradigm of hospital administration in a developing nation. The aim of this research was to determine the need for evidence-based management (EBMgt) training programs and to investigate hospital administrators' attitudes and views towards the use of EBMgt. A non-experimental, cross-sectional design was used. Spearman's correlation and descriptive statistics were used to analyse the survey data. The study's findings demonstrated that hospital administrators' opinions on the use of EBMgt were favourable. The proportion of healthcare management choices made using an evidence-based practice approach and attitudes showed a strong link ($p < 0.01$). The results of the research indicate that hospital managers would probably benefit from EBMgt educational training programs if they used evidence-based practice in management decision-making.

Keywords: *Healthcare, Healthcare administrators, Hospital performance, EBMgt, patient outcomes, Spearman's correlation, descriptive statistics.*

1. INTRODUCTION

Switzerland has one of the greatest health systems in the OECD, but it is also one of the most expensive, according to a worldwide assessment done by the OECD and the WHO. The bulk of the expenses are incurred by the hospital industry, which accounts for around 22.5 billion Swiss Francs, or 36% of all healthcare spending in Switzerland. Acute care was offered by 300 hospitals in 2010 with a total bed capacity of 39,000. Additionally, 1.3 million patients were treated by 185 000 hospital workers. In January 2012, the government implemented a new compensation system based on Diagnosis Related Groups to boost competition among Swiss hospitals due to the continually rising prices. As then, the majority of hospitals have been anxious to be on the officially recognized hospital list, as doing so guarantees public support for around half of their expenses. A hospital's placement on the list is determined by the local governments based on a number of factors, such as quality and cost. The hospitals are under more strain as a result of some significant developments on the demanding side. The need for hospital services is growing as patients' multi-morbidity and chronic illnesses worsen and as Switzerland's life expectancy rises. These elements cause operational capacity limitations. Hospitals have been hiring foreign workers more often than not since it has become very difficult to find fresh professional workers in Switzerland. Furthermore, as patients are no longer restricted by cantonal boundaries when selecting the hospital where they hope to get the finest care, competition across Swiss medical facilities has intensified. Hospitals must adapt to this new reality and strive to remain competitive not just in terms of quality but also in terms of finances.

Health organizations face several obstacles and new regulations, such as disgruntled patients, rising healthcare costs, more competition, and lower service reimbursement. The aforementioned causes compel healthcare organizations to implement a system that can effectively handle ongoing changes, technological advancements, rising health service costs, enhancing their competitive edge, and enhancing client satisfaction. A number of variables influence how satisfied customers are, including: 1 involvement in selecting the kind of health care required 2 raising client knowledge of their health and rights, which acts as a type of health service monitoring. Since the patient is at the centre of all health services, every health system's ability to assess its performance and maintain its competitive edge depends on its ability to satisfy its patients. TQM is a system that can handle all of these difficulties and provide

solutions for the majority of issues that healthcare practitioners encounter. Hospitals used to define excellence as following set criteria, which were first established in 1912 as a peer review by the American College of Surgeons. Peer review was also used by the Joint Commission on Accreditation of Hospitals, an assessment technique that was first implemented in 1950. The procedure grew and was renamed quality assurance later in the 1970s, with an emphasis on the structure, the procedure, and the result. TQM and QA are not the same. In QA, the quality department, for example, employs mechanisms like inspections to satisfy the quality requirements. QA is a reactive method of issue resolution. Total Quality Management (TQM) is a preventative approach that assists in detecting and avoiding mistakes, which in turn includes every person inside an organization. Al-Assaf, Schmele, and Diane Deming predicted that fewer than 15% of work errors are attributed to individual mistakes, for which people are accountable, and that 85% of work errors are referred to as systemic faults, which are basically the management's fault. Al-Assaf and Schmele contended that more income would result from improved quality, which will save expenses and raise customer satisfaction.

Another important component that affects healthcare management is patient participation. The main goal of that specific therapy will not be achieved if the doctor fulfils the prerequisite and the patients disregard his or her advice. The degree of collaboration between the nurse and the patient usually determines the intended therapeutic results. Given their knowledge of the medication's effects, people should follow their doctor's advice if they are told not to consume a certain meal. When a patient and doctor work together well, quality healthcare management is possible.

Lastly, the nature of the patient's ailment may have an impact on the standard of healthcare administration. Certain illnesses need the nurse's full-time monitoring. For example, most physicians experience stress connected to their jobs at cancer hospitals. The physicians' psychological stability is impacted when they see young kids fighting illness and losing the battle for life. Severe diseases can cause a rise in the frequency of fatalities. When a specific Oklahoman hospital is on the verge of closing, the healthcare administration system is deficient.

2. LITERATURE REVIEW

Simone, De (2013) The implementation of a regulatory oversight system is necessary for clinical governance, as it serves as the foundation for clinical audits, risk management, and overall service quality improvement. The control system seeks to provide a robust regulatory framework with the goal of delivering 33 high-quality services and fostering clinical excellence. The connection between clinical governance and quality assurance is the risk management system. Safety and quality are integral elements that no company can separate from one another. For this reason, developing an extensive reporting system-based corporate safety culture is essential.

Zhan et al in 2005 confronted the dearth of scientific classification and widely used terminology. Adverse events, medical mistakes, medical injuries, iatrogenic disorders, sentinel events, risks linked with health care, and hazards are only a few of the terminology used to describe accidental damage that occurs to patients when they receive treatment in hospitals. As to NQF (2004), mistakes and failures may be further classified based on their domain, which encompasses a range of healthcare providers and situations. The following phrases are used to identify the underlying causes of patient damage or harm.

Fallowfield(2004) proposed that medical mistakes are distinct from carelessness or malpractice since the former are intentional transgressions of a law or code of behaviour, while the latter two are not. Furthermore, patients may not always suffer obvious consequences as a result of medical mistakes.

Romano et al., 2003 The Organization for Healthcare Exploration and Quality (AHRQ) made principles for contrasting gamble changed hospital rates for various preventable unfavourable occasions in research utilizing regulatory information, particularly information utilized according to the Healthcare Cost and Usage Task (HCUP), to address the requirement for normalized patient wellbeing result measures. Twenty hospital-based parameters for clinical conditions and surgeries make up these patient safety indicators (PSIs). It has been demonstrated that the rates of adverse events for these conditions and surgeries vary significantly between hospitals, and there is evidence to suggest that these rates may be linked to inadequacies in the clinical care delivery system. Essentially, each of the twenty recognized

PSIs has a specific list of possible safety-related incidents that are thought to be detectable using administrative data, suitably tagged in previous investigations, and sufficiently sensitive to the standard of care.

Merwin 2006, Patient safety research employing administrative data entered a new phase with the introduction of the AHRQ's Patient Safety Indicators (PSIs), notwithstanding its drawbacks. Government or administrative agencies, as well as lone academics, have created the metrics for use in their 40 separate research. His study is supported by the need for an early assessment of the reliability and validity of the metrics created and used in patient safety research. To validate the effectiveness of nurse sensitivity measures and other patient safety indicators in detecting mistakes resulting from subpar hospital care, further study is needed. Hospital Quality Alliance research using data from the National Reporting System showed that performance differs across hospitals and metrics.

Shojana et al., 2001 The state of hospital systems and procedures, whether directly or indirectly related to adverse events, such as staffing shortages in the units, a blame culture, a lack of formal quality improvement programs, a risk management framework, the presence of patient safety committees, etc., must be taken into account in relation to the patient safety concept. Planning patient safety solutions requires careful analysis and comprehension of the relationships between hospital systems and procedures, especially when evidence of the adoption of different safety measures comes from non-health sectors.

Thornlow, 2007 Many structural and organizational factors have been shown to be correlated with patient safety outcomes; nevertheless, the majority of the research on this topic in the literature does not show a correlation with teaching status, morbidity, or mortality.

Baker's (2002) An analysis of the link between hospital ownership and patient outcomes revealed a conflicting and ambiguous association between hospital ownership and mortality, morbidity, and access to treatment. Research has shown that there is no consistent correlation between the hospital's location (rural vs urban), mortality rates, and clinical outcomes.

Blegen et al 2003 As "a global phenomenon [that] encompasses the norms, values, and basic assumptions of an entire organization," "safety culture" was described extensively in 2003. However, "safety climate" is more focused and describes how staff members see various facets

of the company culture. The IOM encouraged all healthcare institutions to establish safe cultures. "The result of individual and gathering values, mentalities, capabilities, and examples of conduct that decide the obligation to, and the style and capability of, an association's wellbeing and security programs" is the definition given to a safety culture.

Clarke, 2006 The history, purpose, and objectives of an organization, as well as its leadership over the years, all influence its culture. Positive safety cultures, according to Gadd and Collins, are defined by communication that is steered by mutual trust, a common understanding of the importance of patient safety, and assurance that error-preventing measures will be successful. Climate and culture are terms that are often used synonymously. The term "organizational climate" describes the general attitudes and viewpoints that employees have about their workplaces, which are connected to employee motivation and satisfaction on both an individual and group level. The atmosphere of an organization is defined by a dynamic collection of views on working circumstances.

Zohar et al., 2008 Furthermore, units and organizations with subpar safety cultures had higher error rates. A small number of researchers found that medication errors were predicted by the safety climate, that the safety climate was correlated with both the hospital-wide and unit-specific climates, and that a unit's positive safety climate could offset the negative consequences of a low hospital-wide climate.

3 RESEARCH METHODOLOGY

3.1 Study Design

This research used a descriptive, non-experimental, cross-sectional methodology to find attitudes and beliefs among hospital administrators in Idaho as well as the need for an EBMgt training program.

3.2 Study Population

All hospital administrators who were people from the Idaho Hospital Connection were associated with the investigation people. Manager practical authorities, supervisor cash authorities, head nursing authorities, and Chiefs of hospitals were among the members.

3.3 Instrumentation

Research on hospital administrators' perspectives and perspectives about the utilization of EBMgt is not many. A couple of distributed examinations on medical care suppliers' very own perspectives and mentalities toward proof-based medication (EBM) and proof based practice (EBP), including specialists, actual specialists, and dieticians, are uncovered in the writing. Based on the goal of the study, we created a new survey instrument after reviewing the previous research.

Health care administrators' professional judgments and the literature study served as the foundation for establishing content validity. Six hospital managers who worked in healthcare administration outside of Idaho participated in a pilot study. Survey items were changed or removed in response to input from the pilot research.

We used a test-retest method with ten healthcare management experts nationwide to ascertain the consistency and reliability of the instrument. The instrument's consistency and reliability were 81%, according to the findings. To evaluate the internal consistency of the survey's belief and attitude-related questions, Cronbach's alpha analysis was done. A good level of correlation between the survey questions was shown by the Cronbach's alpha analysis findings (0.94).

3.4 Administration of Survey

The Human Subjects Board at Idaho State College gave its endorsement to a proposition before the study was regulated. The examiners satisfied the important prerequisites by finishing the Cooperative Institutional Preparation Drive's (CITI) online seminar on human subject security. In July and August of 2013, data was gathered using the Qualtrics® online survey program. The study's goal was communicated to the hospital administrators by email, along with information on their freedom to withdraw from the survey at any time and for any reason. Potential participants received three emails serving as reminders. Participants in the online poll took an average of seven minutes to complete it.

We offered participants the opportunity to get the survey in hard form by mail in order to boost the response rate. An additional motivation to engage was the drawing of participant names for

rewards. In the primary researcher's office, the survey data were stored in a locked file cabinet for privacy.

3.5 Data Analysis

After the survey was finished, IBM Statistical Package for the Social Sciences (SPSS) 21.0 was used to gather and analyse the data. Analyses of frequency and descriptive statistics were conducted. The data was analysed using means and standard deviations. To find any connections between participant demographics, attitudes, and the proportion of choices taken utilizing an EBMgt approach, Spearman's correlation was used.

4 RESULTS & DISCUSSIONS

4.2 General Survey Information

IHA members received 200 surveys by mail and the Internet. The surveys were submitted by 100 hospital administrators, representing a 45% response rate. Following a two-mode survey distribution strategy, 60 respondents responded online (or 60%) and 40 by mail (or 40%).

4.3 Demographic Information

Among the 100 respondents, 60 (or 60%) held executive positions as presidents or chief executive officers in hospitals and multi-hospital health systems; 23 (or 23%) held chief financial officer positions; and 25 (or 25%) held positions as chief operational or chief nursing officers. 29% (29/100) of the responders were female, and 71% (71/100) were male. In terms of educational attainment, 17 percent (17/100) had bachelor's degrees, 75 percent (75/100) held master's degrees, and 6 percent (6/100) held a doctorate or medical doctorate. The participant's academic level elicited no response. Six (6%) of the respondents said they had worked in senior healthcare management for more than 30 years; 17 (17%) said they had worked in the field for 20 to 29 years; 9 (19%) said they had worked in the field for 10 to 19 years; and 16 (33%) said they had worked in the field for less than 10 years. Regarding views regarding the practice of EBMgt, no significant relationship was found with any of the demographic variables (e.g., age, education, and years of management in health settings).

Of the participants, fifty (50%) said their hospitals were not run for profit, seven (7%) said they were, sixteen (16%) said they were government owned, and one (1%) said they were of a

different kind. A total of 85 out of 100 participants said that general health services were offered by their institutions. The relationship between attitudes, hospital ownership, and the kind of healthcare services was not statistically significant.

4.4 Beliefs and Attitudes

Members in the survey were asked to answer inquiries on their own assessments of the utilization of EBMgt in healthcare the board. Members were requested to rate their perspectives and perspectives on the training from EBMgt utilizing a seven-point Likert scale. The four review questions relating to perspectives and mentalities were recoded into a spurious variable, for example, positive or negative convictions and perspectives, after the response frequencies were inspected. The respondents' opinions and thoughts on the use of EBMgt were generally favourable. For a complete breakdown of participant answers about their attitudes and views towards the practice of EBMgt, refer to Table 1. The study's conclusions were not in line with those of Kovner and Rundall's (2006) investigation. Health care managers had a low propensity to utilize EBMgt, according to their findings. This target research population seems to embrace the use of EBMgt in managerial decision-making. Our objective is that hospital managers would employ an evidence-based decision-making approach more often as a result of the results of this research and other relevant EB Mgt work

Table 1: Beliefs and Attitudes toward the Practice of EB Mgt (N=100)

Beliefs and Attitudes	% of Positive Beliefs and Attitudes	Number of Participants
I accept that healthcare administrators really should settle on choices in view of the most ideal that anyone could hope to find proof.	94%	94/100
I support the reception of EBMgt in healthcare the board.	96%	96/100
Utilizing EBMgt works on my association's performance.	92%	92/100
Proof based dynamic expands the nature of my healthcare the board choices.	96%	96/100

4.5 Percentage of Major Decisions Made Using an EB Mgt Approach

What proportion of the participants' significant choices were made using an EBMgt approach was posed to them. 10% (10/100) said they used an evidence-based management strategy for 78–100% of their significant decisions. Eighteen individuals made 52–77 percent of their significant decisions using an EBMgt strategy. Fourteen people used an EBMgt strategy in 28–52% of the choices, whereas fifteen persons used it in less than 27%. The percentage of choices made utilizing an EBMgt approach and attitudes about the practice of EBMgt were statistically significantly correlated. The proportion of choices taken using the EBMgt strategy increases with positive sentiments (Spearman's $\rho=0.45.2$; $p<0.01$).

4.6 Interest in EB Mgt Training

Of the 100 participants in this survey, 83% said they had never attended an official EBMgt training session before. Of the participants, 77% (77/100) expressed interest in obtaining EBMgt training. Of those interested in training, 67% (67/100) said they would want to learn about EBMgt principles; 56% (56/100) said they would like to learn about EBMgt implementation; 46% (46/100) said they would like to learn about assessing the quality of evidence; and 27% (27/100) said they would like to learn about information searching. For a summarize version of participant answers about their attitudes and views towards the interest in learning EBMgt, refer to Table 2.

This research has applications in the real world. First off, evidence-based medicine (EBM) served as the inspiration for the first notion of EBMgt, and the movement officially got underway in 1998. After interviewing 68 health managers, Kovner and Randall discovered that these managers had negative sentiments about EB Mgt. Their findings and the findings of this investigation were not the same. The respondents in the current survey were mostly in Favor of using EBMgt. It seems that participating hospital managers have adopted the EBMgt practice. The area of health care management is dynamic and ever-evolving. An increasing number of hospital managers are seeing the value of applying evidence-based practice to administrative decision-making, thanks to the movement of evidence-based medicine and evidence-based practice. Making choices just on the basis of intuition and past experiences is

not a smart move. Personal judgments are the root cause of many medical mistakes. Accountability for patients and healthcare organizations is a need for hospital administrators. Notwithstanding the hospital administrators' own administration encounters, choices should be founded on the most ideal that anyone could hope to find logical data, authoritative information, partners' interests, and values.

We also found that there is a strong demand in this research for hospital managers and health executives to get EBMgt training. Of the participants, 77% (77/100) expressed interest in obtaining training in EBMgt and learning about its guiding principles, as well as how to look for evidence, assess its quality, and put it into practice. According to some academics, EBMgt would increase decision-makers' incentive to use more scientific approaches and their skill in healthcare management decision-making (Kovner and Rundall 2006; Pfeffer and Sutton 2006). Hospital administrators must understand the concepts and procedures of evidence-based medicine (EBMgt), hone their information-searching abilities, assess the quality of the evidence, and use the evidence to drive their decisions on healthcare management in order to provide high-quality patient care and save healthcare expenditures. Giving hospital administrators EBMgt training would improve their understanding of the concept and their ability to make sound decisions for healthcare organizations. They will be better ready to track down the most ideal that anyone could hope to find proof and apply it to their decision-production for both patient consideration and hierarchical performance on account of the data and abilities they have gained through instructive preparation.

Table2: Beliefs and Attitudes toward the interest in learning EB Mgt training (N=100)

Beliefs and Attitudes	% of Positive Beliefs and Attitudes	Number of Participants
I have never attended EBMgt training.	83%	83/100
I have interest in obtaining EBMgt training,	77%	77/100
I am interested in training and would like to learn about EBMgt principles.	67%	67/100

Beliefs and Attitudes	% of Positive Beliefs and Attitudes	Number of Participants
I would like to learn about information searching.	27%	27/100
I would like to learn about assessing the quality of evidence.	46%	46/100

5 CONCLUSION

A supported EB Mgt preparing program for Idaho hospital administrators has been laid out in light of the exploration discoveries, and the program's outcomes will be assessed. The primary target of the EBMgt preparing program is to build hospital's comprehension administrators might interpret the ideas and techniques of EBMgt to support the utilization of proof-based administration in direction. Hospital administrators will be better prepared to pursue choices on healthcare the board by utilizing the most ideal that anyone could hope to find proof thanks to the information and abilities they have mastered.

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