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Nurses Perception towards the Care of Patients with Terminal Illness in University of Nigeria Teaching Hospital, Enugu State, Nigeria

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Authors' contributions

This work was carried out in collaboration among all authors. Authors PUO, EIO and LA designed the study, performed the statistical analysis, wrote the protocol and wrote the first draft of the manuscript. Authors CE, EIO and CCA managed the analyses of the study and managed the literature searches. All authors read and approved the final manuscript.

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ABSTRACT

Background: Part of becoming a good nurse is being able to understand one's own perception of death and dying, which can affect the quality of care a patient with terminal illness will receive. This study was carried out to assess the nurses perception towards the care of patients with terminal illness in University of Nigeria Teaching Hospital, Enugu State, Nigeria Part of becoming a good nurse is being able to understand one's own perception of death and dying, which can affect the quality of care a dying patient will receive.
Methods: A descriptive survey method was used, and the population of 284 nurses was used, the instrument used for data collection was questionnaire and checklist developed based on the

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objectives of the study. The data collected were analyzed and presented using descriptive statistics of frequency and percentages.

Results: The result of the study revealed that Nurses at UNTH have a positive perception of deaths with the most prevalent nurses perception being death is the cessation of all life processes (100%), In caring for the dying patients; 97.6% agreed that it is a good thing to care for the dying, 98% agreed that the rights of the patients should be protected even till death, 97.3% nurses should aim at achieving a peaceful death in all patients at the end of life and 97.6% agreed that it is good to involve the family members in the care of the dying patient. The study revealed religion (65.8%), belief (84.6%), previous experience with a dying patient (79.1%) and loss of a loved one (79.4%) as personal factors which influenced the perception of nurses towards the care of the dying. Furthermore, 78.7% and 72.8% of the respondents identified Euthanasia and Advance directive as legal and ethical factors influencing the care of the dying (x-0.728 with a p-value of 0.502).Also, in examining the relationship between nurses perception of death and their years of experience the result showed that the years of experience did not significantly influence nurses care of the dying (x=4.653, with a p-value of 0.166).

Conclusion: It is however recommended that basic knowledge and continuing educational program on palliative care should be made available for student nurses and practicing nurses respectively.

Keywords: Nurses' perception; care; terminal illness.

1. INTRODUCTION

Death is a universal reality that affects everyone; it is an inevitable end to life and is one of the most deep emotional experiences that persons encounter. Usually a person is aware of the inevitability of death, how, or when it will occur is not known. Death has been defined as the cessation of all biological functions that sustains a living organism. Despite advances in medical expertise and technology, medicine cannot cure some diseases. Cultural, ethnic and religious beliefs helps to shape people's perception towards death and dying. Death often make people consider some questions like , the meaning of life , the existence of a soul and the possibility of life after death, these questions can only be answered by the individual, relations and family's belief system, regardless of whether death will occur in the hospital or at home. Although, people generally do not develop positive perception towards death, personal factors such as occupations, gender, age, education, personal life experiences, strong religious background and the belief system of family origin are influential [1].In addition, age has a significant influence on nurses perception towards the care of the dying as younger adults tend to report higher levels of death anxiety than do middle aged adults [2]; and older nurses feel more comfortable talking about end-of-life issues than younger nurses [3].

Nurses encounter death and dying in their everyday practice, be it at home, in the hospital, nursing homes or in hospice care settings. When nurses care for dying patients, they must face the reality of death, while supporting and caring for dying patients and their significant others, this means they have to ensure that the common needs of those at the end of life are anticipated and where possible, must be open to responding to individual difference [4].

Every human being has the right to health care and the dying is not an exception. According to the article 25 of the United Nations Universal Declaration of Human Right 1948, states that "Everyone has the right to a standard of living, adequate for the health and wellbeing of himself and his family"; and the dying is not an exception to this law.

Although end - of - life care is a very particular and important part of nursing care, it is both unique and common. Much of the care that people need at this time can be planned for and anticipated. Care of the dying requires an active compassionate approach that treats, comforts and supports individual who are living with or dying from progressive or chronic life threatening conditions Kassa et al. [4]. Comfort care is an essential part of nursing to a dying patient; it is a care that helps or soothes a person who is dying by preventing or relieving suffering as much as possible and to improve quality or life while respecting the dying person's wishes.

However, the last thing man like to talk about is death because human can be very reluctant to

accept their mortality. In reality, 100% of terminally ill patients die sooner or later, so nurses must understand how to handle the complex nature of end-of-life. The dying is given holistic care by recognizing that family members and significant others play vital roles in the dying process and are also considered.

2. RESEARCH METHODOLOGY

2.1 Research Design

A descriptive survey research design was used for this study. This is a non-experimental scientific method that involves the descriptions of condition that exists and opinions that are evident without influencing it and it is suited for this study which aims at assessing the influence of nurses' perception towards the care of patients with terminal illness at UNTH.

2.2 Area of Study

The study was carried out at the University of Nigeria teaching hospital, Ituku-Ozalla, Enugu state. The University of Nigeria Teaching Hospital is a federal tertiary institution located between Ituku and Ozalla village in Awgu Local Government Area in Enugu state. The institution consists of professionals such as Doctors, Nurses, Pharmacist, and Engineers etc. and Semi- skilled workers like Drivers and Unskilled workers like Cleaners.

2.3 Population of Study

The target population of the study is 528 nurses from UNTH irrespective of age, tribe or religion.

2.4 Sample Size and Sampling Procedure

The sample size for UNTH was 228 nurses. This was determined using the Taro Yamane formula. The Taro Yamane method for sample size calculation was formulated by the statistician TaroYamane in 1967 to determine the sample size from a given population. Below is the mathematical illustration for the Taro Yamane method:

$$n = N/ (1+N (e)^2)$$

Where:

n signifies the sample size
N signifies the population under study
e signifies the margin error (it could be 0.10, 0.05 or 0.01)
For UNTH
$n = 528/1+528(0.05)^2$
n =528/ 1+528(0.0025)
n =528/ 1+1.32
n =528/2.32
n =227.5
n=228

Convenience sampling technique was adopted for this study to enable the researcher administer the questionnaire to the nurses in their different wards. This method will be in line with the inclusion criteria which include availability of the nurses and willingness of the nurses to participate in the study.

2.5 Instrument for Data Collection

The instrument that was used for data collection was a self-structured questionnaire which was constructed from literature, based on the objectives of the study. The questionnaire was designed in such manner that guaranteed that the process of enquiry to the topic was in logical sequence. This was achieved by arranging the questions in a way that ensured they follow in the order that the respondents saw a natural smooth movement, from item to item and it represented the various aspect of the problem under study. The questionnaire consists of five sections A, B,C,D and E. Section A consists of the respondents socio demographic data and has eight (8) question items. Section B assesses the nurse's perception of death, It consists of (10) question items. It consists of a four point Likert scale of strongly agree (4), agree (3)), disagree (2), strongly disagree (1). Section C, assesses the nurses perception towards the care of the dying and their perception of dying .It consist of sixteen (16) question items .Section D identifies personal factors that influence nurse's perception towards the care of the dying, and consists of eleven (11) question items and section E identifies ethical and legal factors influencing the perception of nurses towards the care of the dying and consists of five (5) question items, among nurses at UNTH.

2.6 Validity of Instrument

The draft copy of the questionnaire was submitted to the project supervisor for face and content relevance of the content after which necessary corrections were made; the

questionnaire was typed and used for data collections.

2.7 Reliability of Instrument

In testing the reliability of the instrument, Cronbach's Alpha model of test internal consistency was used. The entire scale /questionnaire had a Cronbach's Alpha value of 0.837, this being greater than 0.7, indicated the reliability of the test instrument was strong.

2.8 Pilot Study

A pilot study was conducted using 10% of the sample size. The questionnaire was distributed to nurses at the Mother of Christ specialist hospital Enugu, which is not the facility for study.

2.9 Method of Data Collection

Research constructed questionnaire was distributed to the nurses with the help of trained research assistants and collected after being duly filled. 284 copies of the questionnaire were distributed on four different occasions, for a period of four weeks, while only 255 were correctly filled and returned, giving a return rate of 90%.

2.10 Method of Data Analysis

Data were collated, tallied and analyzed with the aid of statistical package for social sciences [SPSS Version 23.0] software. Descriptive statistics was carried out to show the responses, frequency and percentages, mean and standard deviation of demographic data and factors which influence nurses' perception towards the care of the dying were presented in tables. Fishers test was used to test the relationship between nurses' perception of death and their perception towards the care of the dying.

Decision rules were used to analyze the four point Likert scale of strongly agree, agree, disagree and strongly disagree, with positive decision mean of >2.5 and negative decision mean of <2.5.Fisher's test statistics was adopted for relationship testing.

3. RESULTS

Table 1: Above shows that the socio – demographic characteristics of the responses. It shows that 62(31.2%) of the participants were between 30-39 years .Majority, 129(65.2%) of the participants were married .While 78(39.2%) had B.NSc and RN/RM each as their highest level of education. Majority, 121(61.4%) of the participants had special training in care of the dying. About half, 43(53.1%) of the participants had continued training in the care of the dying. The table shows that 80(41.7%) of participants had 6-10 years of experience.

In reference to decision rules on perception of death, the participants from UNTH had positive perception: Death is the cessation of all life processes (mean of 3.74±0.439), Death is the sure end of every man (mean of 3.73±0.559), Death can occur at any age (mean of 3.77±0.445), Death is a transition to a new life (mean of 2.91±0.823), Death is simply a part of the process of life (mean of 3.39±0.713).

While the respondents had negative perception on: It is better to die than live with an incurable disease (mean of 2.32±0.866), It is an escape from the cruelty of this world (mean of 2.35 ±0.902), Death is as a result of sin and curses (mean of 1.73±0.767) Death offers a wonderful release of the soul (mean of 2.48±0.854) and I am afraid of death, so I avoid thinking about it (mean of 2.35+0.873).

In reference to decision rules on perception of death, the participants from UNTH had positive perception on-The respondent had positive perception on the following: it is a good thing to care for the dying (mean of 3.72 ± 0.504);The rights of a patient should be protected even till death (mean of 3.65 ± 0.519) Nurses should aim at achieving a peaceful death in all patients at their end of life (mean of 3.67 ± 0.502) Dying patients do need spiritual preparation according to their belief(mean of 3.58 ± 0.589), Showing love to the dying will help him die a happy death (mean of 3.60 ± 0.541) It is good to involve the family members in the care of a dying patient (mean of 3.60 ± 0.576).

While the participants had negative perception on It is a waste of time and resources to care for the dying, after all they will still die (mean of 1.45 ± 0.634) The length of time spent in care of the dying is frustrating (mean of 1.81 ± 0.695) The dying patient should not be allowed to make decisions about his care (mean of 1.60 ± 0.788), It is difficult to form a close relationship with the family of a dying person (mean of 2.15 ± 0.843).

Table1. Socio-demographic characteristics of participants

Variables	Frequencies	Percentage (%)
Ages	N=199	
20-29 years	34	17.0
30-39 years	62	31.2
40-49 years	60	30.2
50 and above years	43	21.6
Mean(SD)	37.61(10.72)	
Religion	N=195	
Christianity	194	99.5
Islam	1	0.5
Others	0	0.0
Marital Status	N=198	
Single	51	25.8
Married	129	65.2
Divorced	6	3.0
Widowed	12	6.1
Highest level of education	N=198	
RN	16	8.1
RN/RM	78	39.4
BNSc	78	39.4
M Sc Nursing	25	12.6
PhD	1	0.5
Care Unit	N=197	
Medical Wards	35	17.8
Surgical Wards	60	30.5
Emergency	22	11.0
Oncology	20	10.2
Others	60	30.5
Special training in care of the dying	N=197	
Yes	121	61.4
No	76	38.6
Source of training in the care of the dying	N=81	
Basic Training	38	46.9
Continued Education	43	53.1
Years of Experience	N=192	
Less than 5 years	36	18.8
6-10 years	80	41.7
11-15 years	33	17.2
Above 15 years	43	22.3

The Table 4 above shows the personal factors influencing participants on the care of dying.

The participants had positive perception on religion (mean of 2.78 ± 0.976) ; Beliefs (mean of 3.14 ± 0.755), previous experience with a dying person (mean of 3.11 ± 0.802) disease conditions of the patient (mean of 2.47 ± 1.021), loss of a loved one (mean of 2.99 ± 0.795).

While a negative perception was noticed on age of the nurse (mean of 2.12 ± 0.887), age of the patient (mean of 2.12 ± 0.947), disease conditions of the patient (mean of 2.47 ± 1.021), and socio economic class of patient (mean of 1.87 ± 0.931).

The Table 5 above shows the ethical and legal factors influencing care of the dying the respondents had positive perception on Advance directive hinders the delivery of care to the dying (mean of 3.08 ± 0.898); Euthanasia is a moral wrong(mean of 3.31 ± 0.859);Interference of care from advance directives (mean of 2.95 ±0.759).

While they had negative perception on advance directives are time consuming for health professional (mean of 2.32 ± 0.776) and Terminating life at the request of an individual is not immoral because it is the individual's decision to make(mean of 1.97 ± 0.875).

Table 2. Responses to the perception of death by the participants

S/N	Variables	SA	A	D	SD	Mean(StD)
1.	Death is the cessation of all life processes	146(74.1)	051(25.9)	0(0)	0(0)	3.74(.439)
2.	Death is the sure end of every man	151(76.6)	41(20.8)	2(1.0)	3(1.5)	3.73(.559)
3.	Death can occur at any age	153(78.1)	41(20.9)	2(1.0))	0(0)	3.77(.445)
4.	It is better to die than live with an incurable disease	20(10.2)	54(27.6)	90(45.9)	32(16.3)	2.32(.866)
5.	It is an escape from the cruelty of this world	22(11.2)	60(30.6)	79(40.3)	35(17.9)	2.35(.902)
6.	Death is a transition to a new life	49(25.1)	89(45.6)	48(24.6)	9(4.6)	2.91(.823)
7.	Death is as a result of sin and curses	4(2.1)	26(13.3)	79(40.5)	86(44.1)	1.73(.767)
8	Death is simply a part of the process of life.	97(50.0)	81(41.8)	11(5.7)	5(2.6)	3.39(.713)
9.	Death offers a wonderful release of the soul	18(9.5)	82(43.4)	62(32.8)	27(14.3)	2.48(.854)
10.	I am afraid of death, so I avoid thinking about it	17(9.0)	66(34.9)y	73(38.6)	33(17.5)	2.35(.873)

Key: SA-Strongly Agree; A –Agree; D –Disagree; SD –Strongly Disagree; Std – Standard Deviation; Decision rules: Positive perception: mean of above 2.5; Negative perception: mean of less than 2.5

Table 3. Assessment of Participants perception of the care of the dying

Variables	SA	A	D	SD	Mean(StD)
It is a good thing to care for the dying	146(74.1)	48(24.4)	2(1.0)	1(0.5)	3.72(.503)
It is a waste of time and resources to care for the dying, after all they will still die	2(1.0)	9(4.6)	65(33.0)	121(61.4)	1.45(.634)
The rights of a patient should be protected even till death	131(66.5)	64(32.5)	1(0.5)	1(0.5)	3.65(.519)
Nurses should aim at achieving a peaceful death in all patients at their end of life	135(68.9)	58(29.6)	3(1.5)	0(0)	3.67(.502)
The length of time spent in care of the dying is frustrating	5(2.5)	17(8.6)	110(55.8)	65(33.0)	1.81(.695)
The dying patient should not be allowed to make decisions about his care	7(3.6)	16(8.2)	65(33.2)	108(55.1)	1.60(.788)
It is difficult to maintain a good interpersonal relationship with the dying.	30(15.2)	49(24.9)	79(40.1)	39(19.8)	2.36(.967)
Dying patients do need spiritual preparation according to their belief	121(61.4)	72(36.5)	1(0.5)	3(1.5)	3.58(.589)
It is difficult to form a close relationship with the family of a dying person.	15(7.6)	42(21.3)	98(49.7)	42(21.3)	2.15(.843)
Showing love to the dying will help him die a happy death	123(62.4)	69(35.0)	5(2.5)	0(0)	3.60(.541)
It is good to involve the family members in the care of a dying patient	126(64.0)	66(33.5)	3(1.5)	2(1.0)	3.60(.576)

Key: SA-Strongly Agree; A –Agree; D –Disagree; SD –Strongly Disagree; Std – Standard Deviation; Decision rules: Positive perception: mean of above 2.5; Negative perception: mean of less than 2.5

Table 4. The personal factors influencing the perception of respondents towards the care of the dying

Variables	SA	A	D	SD	Mean(StD)
Religion	55(28.2)	64(32.8)	55(28.2)	21(10.8)	2.78(.976)
Beliefs	66(34.0)	95(49.0)	28(14.4)	5(2.6)	3.14(.755)
Previous experience with a dying person	67(34.9)	85(44.3)	34(17.7)	6(3.1)	3.11(.802)
Age of the nurse	20(10.4)	29(15.0)	99(51.3)	45(23.3)	2.12(.887)
Age of the patient	20(10.4)	39(20.2)	78(40.4)	56(29.0)	2.12(.947)
Disease condition of the patient	40(20.7)	46(23.8)	71(36.8)	36(18.7)	2.47(1.021)
Loss of a loved one	49(25.3)	105(54.1)	29(14.9)	11(5.7)	2.99(.795)
Socio economic class of patient	13(6.7)	33(17.1)	62(32.1)	85(44.0)	1.87(.931)

Key: SA-Strongly Agree; A –Agree; D –Disagree; SD –Strongly Disagree; Std – Standard Deviation; Decision rules: Positive perception: mean of above 2.5; Negative perception: mean of less than 2.5

Table 5. Ethical and legal factors influencing the care of the dying

Variables	SA	A	D	SD	Mean (SD)
q38AdvanceDirectives	72(37.3)	79(40.9)	28(14.5)	14(7.3)	3.08(.898)
q39EuthanasiaisMoralWrong	102(53.1)	54(28.1)	29(15.1)	7(3.6)	3.31(.859)
q40Adv.DirectiveTime	16(8.3)	50(25.9)	106(54.9)	21(10.9)	2.32(.776)
q41TerminateLifeatReq	10(5.2)	41(21.2)	76(39.4)	66(34.2)	1.97(.875)
q42InterferenceofCare	43(22.5)	102(53.4)	39(20.4)	7(3.7)	2.95(.759)

Key: SA-Strongly Agree; A –Agree; D –Disagree; SD –Strongly Disagree; Std – Standard Deviation

Table 6. The relationship between the respondents' perception of death and their care towards the dying

Perception of death	Perception of caring for the dying		Total	Fisher's Test(p-value)
	Positive perception	Negative perception		
Positive perception	13	0	13	0.362(1.000)
Negative perception	179	5	184	
Total	192	5	197	

Table7. The relationship between the respondent years of experience and their perception towards the care of the dying

Years of Experience	Perception of caring for the dying		Total	Fisher's Test(p-value)
	Positive perception	Negative perception		
Less than 5 years	34	2	36	2.391(0.512)
6-10 years	77	2	79	
11-15 years	32	1	33	
Above 15 years	43	0	43	
Total	186	5	191	

The Table 6 above examines the relationship between the perception of death and the perception of respondent towards the care of the dying.

Fisher's test statistics was in adopted because some cells in the table above content values less than 5 and therefore did not meet the criteria for chi-square. The result shows that perception of death did not significantly influence the perception of the respondent caring for the dying (X= 0.362 with a p-value of 1.000). So the null hypothesis is accepted that there is no relationship between the nurses' perception of death and their care towards the dying.

The Table 7 above shows the relationship between the respondent years of experience and

their perception towards the care of the dying. The result shows that the year of experience did not significantly influence the perception of respondents care of the dying. (X = 2.391 with a p-value of 0.512), so we accept the null hypothesis between the nurses year of experience and perception of the care of the dying.

4. DISCUSSION

The study revealed that the nurses at UNTH have a positive perception of death. It revealed that the most prevalent nurse's perception of death include: death is the cessation of all life processes (100%), death is the sure end of every man (97.4%), death can occur at any age (99%) and death is simply a part of the process of life (91.8%).

Furthermore, the study also revealed that the nurses at UNTH had a negative perception on: it is better to die than live with an incurable disease (62.2%), it is an escape from the cruelty of this world (58.2%), death is as a result of sin and curses 84.6%), and I am afraid of death, so I avoid thinking about It (56.1%).

The study agreed with the studies by Fadere et al. [5] and Callem and Conigley [6] which revealed that 80.5% of the respondents recognized dying as a normal process, death as the cessation of all life processes and 88% perceived death as a part of life respectively.

The study revealed that the nurses at UNTH had a positive perception towards the care of the dying. The study revealed that the prevalent perceptions among nurses in UNTH include: it is a good thing to care for the dying (98.5%), nurses should aim at achieving a peaceful death in all patients at their lifetime (100%); it is good to involve the family members in the care of a dying patient (97.5%) and the rights of the patient should be protected even till death (99%).

Furthermore, the nurses at UNTH had negative perception on: dying patients should not be allowed to make decisions about their care (88.3%) and it is a waste of time and resources to care for the dying, after all they will still die (94.4%).

The positive perception of these nurses can be attributed to their level of exposure both academically and in clinical specialization.

The above findings lend support the interpersonal relation in nursing theory and the humanistic theory, which showed that connected and trusting interpersonal relationship in a palliative care environment led to improvement in patients physical and emotional states, facilitated their adjustment to the illness, decreased pain and ultimately led to a good death experience. Moreover, the theory emphasized the importance of including the family in the care plan of the patient, which is of utmost importance in caring for patients that are dying in order to help them come to terms with the imminence of death. The humanistic theory places emphases on relating ,dialogue, communication and presence of the nurse in a caring situation as important for effective palliative care practice, It also lend support to Henderson's theory of the definition of nursing which states "The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death), that he would perform unaided, if he had the necessary strength, will or knowledge". Thus, the duty of care is not just an obligation to nurse to recovery, but also to nurse unto a peaceful death.

In addition, nurses are uncomfortable with the notion of talking about death and dying with the terminally ill patient.

The study also revealed that some personal factors influence the perception of the nurses at UNTH towards the care of the dying. They include beliefs, previous experience with a dying person, disease condition of the patient and loss of a loved one. However, the study also revealed that nurses in UNTH were not influenced by the age of the nurse, age of the patient and socio economic class of the patient.

According to Abdel-Khalek and Al-Kandari [2], age has a significant influence on nurses' perception toward the care of the dying. It was found that younger adults tend to report higher levels of death anxiety than do middle-aged adults, and older nurses feel more comfortable talking about EOL issues than younger nurses [3].The findings also agreed with the study by Brzostek et al. [7], that the belief factor was the highest ranking factor and a study by Karadog et al. [1], that personal factors such as strong religious background and the belief system of family origin were influential.

The study revealed that there were legal and ethical factors that influenced the care of the dying among nurses in UNTH and include: advance directive hinders the delivery of care to the dying, euthanasia as a moral wrong and interference of care from advance directives, but disagreed that advance directives as being time consuming and terminating life at the request of an individual is not immoral because it is the individuals decision to make.

This findings lends support to the assertion of Cabe and Coyle [8], on ethical and legal issues in palliative care, which revealed that euthanasia and advance directives are the main source of ethical and moral concern, which influence the care of the dying. Moreover, the needs, preferences, and values of the patient and family will continue to be at the core of palliative care [9].

Due to the mixed feelings which accompany the topic of death, nurses should be prepared for this journey from their school days. The curriculum for nurses should include matters that have to do with death and dying and to emphasize the need for the legal implications of advance directives and euthanasia.

5. CONCLUSION

Based on the findings of the study, the following conclusions were made. Some of the perception of the nurses in UNTH towards the care of the dying include: it is a good thing to care for the dying; the rights of the patient should be protected even till death, etc. The nurses in UNTH had a good perception of death. Furthermore, they disagreed that death is a result of sin and curses; it is an escape from the cruelty of this world. The personal factors that influence the care of the dying in UNTH include the religion of the nurses, their beliefs, previous experience with a dying person, etc. The legal and ethical factors that had influenced the care of the dying in UNTH include advance directives, terminating life at the request of the patients, etc. and nurses at UNTH disagreed with the argument that terminating life at the request of an individual is not immoral.

CONSENT AND ETHICAL APPROVAL

An identification letter was obtained from Enugu study center, Director of the National Open University of Nigeria .A research proposal and questionnaire was forwarded to the University of Nigeria Teaching Hospital; Health Research Ethical Committee and Ethical Clearance Certificate obtained, principle of confidentiality, anonymity and voluntary participation was applied.

Permission was obtained from the Chief Medical Director, Director of Nursing Services and the ADN's in charge of the various wards, after which the questionnaires was distributed to the nurses following oral consent and then oral appreciation while returning the questionnaire.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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