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ORIGINAL RESEARCH: EMPIRICAL RESEARCH – QUALITATIVE

Nurses' and midwives' experiences and views about responding to out of work emergencies: A constructivist grounded theory study

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Abstract

Aim: To explore nurses' and midwives' experiences, views, perceptions and impact on their responses to out of work emergencies where first aid may be required.

Design: A constructivist grounded theory study was conducted between 2012 and 2019.

Methodology: In-depth, semi-structured interviews were undertaken with 16 nurses and midwives. Participants were recruited via a participant referral process with registered nurses and midwives being accessed from three NHS organizations. Data were analysed and coded using constant comparative analysis with the support of Nvivo 10 software leading to the construction of a substantive grounded theory.

Results: A core enduring in vivo theme, 'The Right Thing to Do', emerged as a central conceptual reality constructed via three key in vivo themes; 'Something I've Heard', 'Am I Covered?' and 'Just Who I Am', each with several sub-themes. A pervading anxiety about responding at off-duty situations requiring first aid was persistently evident across these themes.

Conclusion: The study showed a strong sense of moral agency among nurses and midwives, despite a powerful underlying feeling of anxiety surrounding broader issues of urban myth, protection and personal and professional identity. The substantive theory emerged as 'doing "The Right Thing" in a climate of anxiety'.

Impact: The study illuminates an area that has previously been the subject of anecdotal debate. The substantive theory, 'doing "The Right Thing" in a climate of anxiety' illustrates the issues and tensions that exist surrounding the off-duty response. Implications and recommendations for practice and education focus on the fostering of knowledge and understanding of professional identity, position in law and scope of practice, together with potential future research directions. This work provides the first in-depth qualitative study contributing a significant new perspective both nationally and globally.

KEYWORDS
constructivist grounded theory, first aid, midwives, nurses, off-duty emergencies

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1 | INTRODUCTION

At some time in their career, most health care professionals will encounter a situation when they are off-duty and witness a need for emergency first aid. Responding to these scenarios may cause significant anxiety with concerns about the process and outcome. It is likely that this anxiety and uncertainty will increase the reluctance of some health care professionals to intervene in these situations and that opportunities to improve health outcomes are missed.

Despite the universal importance of the off-duty emergency response, there is no research evidence to increase the understanding of the views of health professionals and to inform professional support that enables them to intervene in out of work emergencies. The aim of this study was to address this gap. For the purpose of this study 'first aid' pertained to emergency and/or urgent medical need and is defined as the actions of a first responder in a situation where there is a need for prompt emergency attention. 'Out of work' and 'off-duty' relates to not being in one's usual place and/or time of work, and not contractually bound by employer's policies or role descriptions.

2 | BACKGROUND

A variety of issues have been identified and discussed about healthcare professionals taking action when witnessing an out of workplace need for first aid or emergency care (Glover, 1999; Johnson, 2008; Sbaih, 2001). These discussions were largely prompted by concerns surrounding position in law. There are two distinct laws that inform the legal position of healthcare professionals when responding to emergencies and first aid situations when not at work or contractually obliged to do so: Good Samaritan and 'duty to rescue' laws are designed largely to allow healthcare professionals and other bystanders to feel able to help in an emergency without fear of litigation to increase the willingness of the public to help people in need. However, the application and interpretation of these laws vary internationally, the main difference being that Good Samaritan law emphasize the volunteerism of a responder, whilst 'duty to rescue' laws enshrine the mandate to assist in some way (Divers Alert Network Europe, nd; Gulam & Devereux, 2007).

Mooney (2008) discussed the results of a survey with 3500 respondents, asking whether they would get involved with treating someone in an emergency outside work. Seventy-five per cent stated that they had concerns about the legal risks and nearly 100% stated that they wanted clearer guidance on providing nursing and medical care when not at work. Almost 100% said they thought the public expected them to provide help outside work (Mooney, 2008). In 2010, the Nursing and Midwifery Council (NMC) re-introduced mandatory first aid and incident management into undergraduate nurse curricula, after an absence of 33 years (NMC, 2010 Standard 5, 6.1). The NMC provided more specific guidance about responding with first aid during off-duty time (NMC, 2017), however, ambiguities remain. The Social Action, Responsibility, and Heroism (SARAH) Act (2015) has also been enacted to address the concern about any member of the public-facing litigation when acting in good faith to provide assistance. More recently, nurses have provided assistance during terrorist attacks sadly including the death of an off-duty nurse (Eleftheriou-Smith, 2017; Longhurst, 2018; McKew, 2017). Both the Royal College of Nursing (RCN) (2017) and the NMC (2017) issued guidance on such situations advising nurses and midwives to prioritize personal safety and to alert the emergency services. This guidance also recognized that not all nurses and midwives are 'first aiders' and should do only what they feel safe and competent to do (NMC, 2017; RCN, 2017). The RCN state that 'there is no expectation that a nurse or midwife will put their own safety at risk' (RCN, 2017, p. 2).

The professional bodies for nurses and midwives, and doctors state a position about helping in an out of work scenario, where first aid may be required (General Medical Council, 2010; NMC, 2015). From March 2015 nurses and midwives were expected to 'always offer help if an emergency arises in your practice setting or anywhere else' (NMC, 2015, Standard 15, p. 12). This standard indicated that nurses and midwives should intervene as Good Samaritans. Currently, a Good Samaritan law does not exist in the UK. There is no legal obligation under UK law for healthcare professionals to provide care outside their normal work contract, and if they do, they may be liable in law if they cause harm (Bracken, 2014; Maudsley, 2015a, 2015b). In the United States, each state has Good Samaritan laws designed to allow healthcare professionals to feel able to help in an emergency without fear of litigation (Brown, 1999). Good Samaritan laws generally operate in countries where the underpinning legal principles are founded in English common law such as in Australia. 'Duty to rescue' law requires bystanders, and in some cases healthcare professionals, to offer assistance and holds those who do not liable in law (Eisenburg, 2002). At least two US States have a 'duty to rescue' statute aimed at healthcare professionals (Brown, 1999) which bears some similarities to the law in France, where the public has a Good Samaritan duty to at least summon help (Mooney, 2008). The Republic of Ireland has a form of Good Samaritan law with no duty to intervene unless a dependant or special relationship exists such as parent–child; transport carrier–passenger (Irish Parliament Act23, 2011). France operates a duty to rescue system with penalties ranging from compensation payments to imprisonment (Pardun, 1998). Israeli law also has a minimum requirement for bystanders to summon help and to claim compensation for damages caused to them whilst helping (Kirschenbaum, 1980). There is much variation in protection for the responder across the world and potential for confusion. Following some controversial cases in China, the first Good Samaritan law was passed in Shenzhen province in 2013 (Huifeng, 2013). One begins to see how healthcare professionals' understanding of legislation in the area may be confused, as each law has a similar ethos but different approaches, emphasis and interpretation.

There may also be confusion about the law in relation to international boundaries, for example whilst airborne. In practice,

this may be a relatively rare event but there is a precedent that highlights the issues surrounding off-duty medical help whilst airborne (Laur, 2013). Federal aviation law provides Good Samaritan protection in-flight over the USA, however internationally this is less clear (Buppert, 2015). There is currently no evidence of legal action against a healthcare professional who did not respond in-flight possibly because it would be difficult to identify them in many instances.

There has been much focus on the risk of litigation in the professional context, and there is a general consensus that confusion and concern exist. There remains a lack of primary research surrounding the views and perspectives of nurses, midwives and other healthcare professionals about responding whilst off-duty.

3 | THE STUDY

3.1 | Research question

What are the experiences, views and perspectives of nurses and midwives about responding to out of work emergencies where first aid may be required?

3.2 | Aim

The aim was developed to explore nurses' and midwives' experiences, views, perceptions and impact on their responses to out of work emergencies where first aid may be required.

3.3 | Design

A constructivist grounded theory methodology was used to explore participants' views with a focus on emergence directing the study and the flexibility to follow the data (Charmaz, 2014). The use of face-to-face individual in-depth interviews enabled a focus on discovery and the interpretation of the different facets of participants' perspectives and experiences (Rubin & Rubin, 2004). Four interviews were carried out in the pilot study. These were not included in the main study. Participants were registered nurses (RNs) from differing clinical backgrounds and grades. The main process issues that arose were the need to communicate that the purpose of the research was not to test knowledge of first aid and to avoid photographic imagery that included any paramedic presence. Photographic imagery was used as a starting point to elicit participant's views with a principle of open enquiry (Knowles & Cole, 2008). There were no set questions, rather the interview process was led by the contributions of participants using a laddering framework (Baker, 2002; Newell, 1994; Figures 1 and 2). Examples of questions include:

- 'Tell me your thoughts about this scene' (show the photograph)
- 'What did you do or consider doing?'
- 'That's interesting, what was it that you were worried about?'
- 'How did this make you feel?'

3.4 | Sample/participants

The pool of potential participants was drawn from three large NHS trust organizations encompassing an acute care hospital trust, a community focussed provision and a regional specialist centre, allowing for a sufficiently diverse range of nurses and midwives to be accessed. Inclusion criteria were that they must have up-to-date UK NMC registration and currently be practicing as a RN or midwife in the UK. Initial purposive sampling via letter accessed two nurses as a starting point (Charmaz, 2010). A 'snowballing' technique that involved building a sample through participant referrals was employed (O'Leary, 2005). A small number of these referrals did not meet the inclusion criteria, for example paramedics. Referrals included participants working in practice education, mental health, district/community nursing, emergency/critical care and acute care, palliative/cancer care, midwives, military nurses and higher education remits. Participants ranged from being very recently qualified (2 months) to having 31 years' experience. Fifteen were RNs with two participants holding dual RN/registered mental nurse qualifications. There were three midwives, of which one was a direct entry midwife, not holding an RN qualification. There were 14 female and two male participants. Demographic data was compiled for the purpose of tracing and auditing the research journey (Koch, 1994). To maintain confidentiality and anonymity participants chose pseudonyms (Table 1).

3.5 | Data collection

Data were collected using semi-structured interviews starting by showing a photograph of a first aid scenario as a trigger only. Data collection involved note taking and the verbatim transcription of audio recorded interview data, which was verified by participants. Interviewing took place over a 2-year period in a linear way enabling participant referrals to be followed up facilitating constant comparative data analysis. Sixteen interviews were carried out with no requests to change any of the content apart from one redacting of a place name mentioned during the interview. The following steps were employed to demonstrate the approach to data credibility.

- Interviews were recorded, and field notes were taken during and on completion of each interview.
- Mood, body language, facial expressions and other non-verbal interactions were noted.
- Transcripts were returned to participants for verification and/or correction.
- Research supervisors' scrutiny of raw data.

Audio recordings enabled the researcher to become immersed in the participants' narratives such that all the language and nuances

Interview completed (notes may be taken during interview)

Ensure work is dated / anonymity maintained

Create pseudonym folder

↓

Make initial notes following interview (within 30 mins of interview)

e.g. how it went – general comments, observations, non-verbal, tone.

Key points of note, concerns / issues

Listen to interview once – brief notes

↓

Interview transcribed

(usually within 7-10 days)

↓

Listen to interview and

read transcribed interview

↓

Line-by-line read and note / highlight phrases, topics, sections, points

↓

2nd line-by-line analysis to check for any missed data

↓

Make brief notes on the process for purpose of refining technique and reflection

↓

Group phrases, comments, into initial codes

↓

Generate tentative initial codes

↓

Begin memoing process

↓

Review and reflection

(loops back to "Listen to interview and read transcribed interview")

FIGURE 1 Interview data process flowchart

could be captured. Nvivo 10 data management software (Nvivo10, 2012) was invaluable when organizing and checking data.

3.6 | Ethical considerations

Ethics approval was gained from Buckinghamshire New University ethics committee. The study was also approved by respective hospital organizations' research and development processes. A confidential support mechanism for participants was built into the study given the potential sensitive nature of the topic. This was provided by the RCN and the three hospital organisations. It is not known if any participants accessed this.

3.7 | Data analysis

Manual line-by-line analysis of transcripts and field notes was used supported by Nvivo 10 (2012) software to aid theme construction. A constant comparative approach was used to examine statements, experiences and narratives in the same interview and then between interviews (Figure 1). Coding aimed to define and uncover the views and beliefs that participants held, and to look for how participants understood their situations. Birks and Mills (2015, p. 93) seven key questions were used to interrogate the data during the coding process (Figure 3). This iterative process progressively identified potential themes and developing concepts. This inductive and abductive activity enabled comparisons at each stage of analytic development

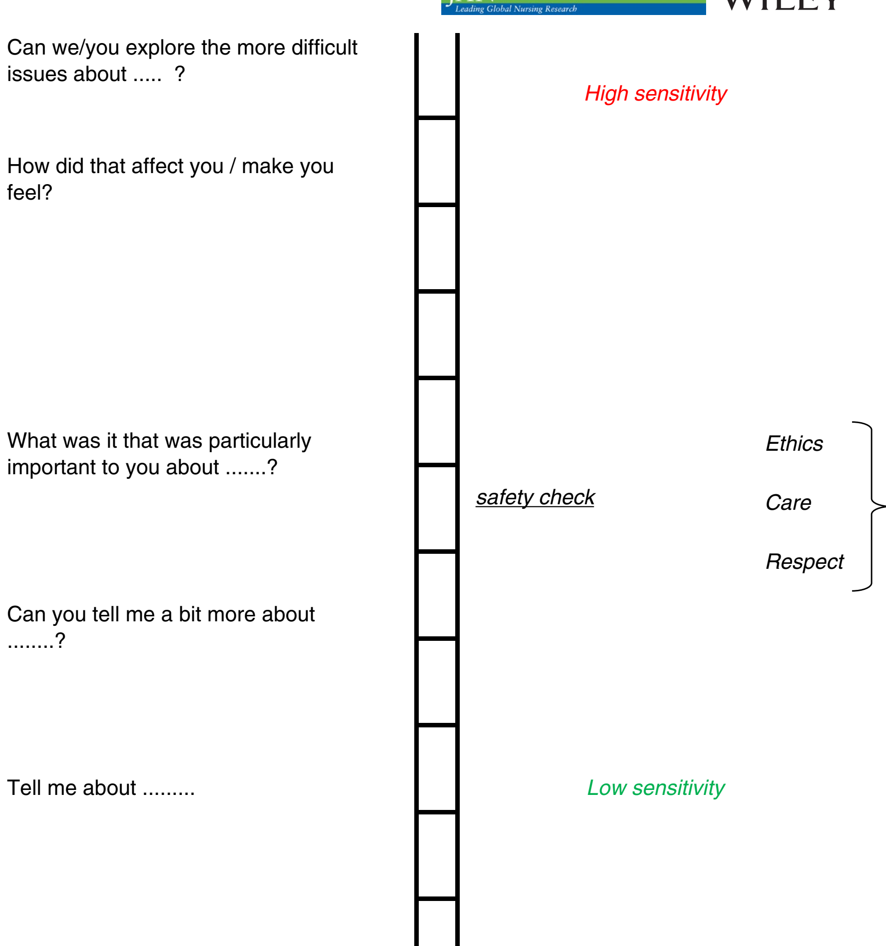

FIGURE 2 Laddering: Taxonomy of questioning

and the construction of theories grounded in data (Charmaz, 2014). Charmaz (2010) proposed that the construction is the result of an evolutionary research process that sees both data and analyses as created from a shared journey with participants.

3.8 | Methodological rigour

For grounded theory to be trustworthy, Glaser and Strauss (1967) emphasized the importance of clear criteria; 'good fit' with data; usefulness; conceptual density; durability over time; modifiability and explanatory power. Trustworthiness in grounded theory focuses on the building of theory that is faithful to, and illuminates the area under study, and has the potential to contribute to and influence existing knowledge and understanding (Strauss & Corbin, 1990). Rigour was promoted by providing sufficient data, as text narratives, quotes and examples of constant comparison in the form of line-by-line analysis. Authenticity was supported by participant verification of interview transcripts and opportunity for the participants to make changes to their transcript. It was important that no significant alterations were made as this may have changed the nature and meaning of data and whilst this was a risk of participant verification, the rigour and transparency that it conferred were invaluable. No participants asked for any changes to be made other than one who requested a place name redaction as she felt it might identify those that she spoke about. The lead author carried out the study and the analysis and interpretation was independently reviewed by two co-authors. The use of field notes and a reflexive journal to log observations and insights about data provided an audit trail of events (Koch, 1994).

The position and role of the researcher were made clear to participants together with the 'insider' knowledge and background being explicit (Rooney, 2005). The 'insider' persona and nature of the researcher's professional background meant that it was possible to appreciate the professional lives, language and potential dilemmas of participants, which helped to create credible core conditions for the interview (Holloway & Freshwater, 2007). The potential effects on the rigour of the study, both for the participants and researcher, using an interview process about a sensitive topic, were recognized and appropriate support was planned and accessible (Lee, 1993). COREQ guidance for reporting qualitative studies was followed (Tong et al., 2007).

4 | FINDINGS

Three key themes supported by several sub-themes were identified to generate the substantive theory. The three identified themes and sub-themes are discussed in this section: 'Something I've Heard'; 'Am I Covered' and 'Just Who I Am'. The themes and sub-themes illustrate significant blurring of boundaries, against a background of

TABLE 1 Demographic data

Pseudonym	Registered qualification	Gender	Years qualified	Current role	Other	Recommended referrals
John	RN, RMN	M	25	Executive Director Nursing		Midwife, mental health nurse, military nurse, palliative care nurse, newly qualified nurse
Tom	RN	M	5	Charge Nurse A/E		Community nurse
Chloe	RN	F	2 weeks	Community Nurse		Midwife
Linda	RN	F	18	Senior Nurse, Practice Development Acute Medicine		Non-UK nurse Non-acute care nurse
Sandra	RM	F	14	Specialist Midwife	Direct entry training	A/E nurse
Betty	RN	F	20	Community Nurse Practice Educator		Nurse without direct patient contact
Georgina	RM, RN	F	25	Midwife		Declined
Helen	RN	F	13	Student Nurse Placement Co-Coordinator	Trained in Australia	Mental health nurse, health visitor
Jennifer	RN	F	15	Emergency Nurse Practitioner Urgent Care	Ex-Army	Doctors Paramedics
Zayna	RMN, SEN	F	29	Senior Nurse, Community Mental Health Unit		General trained nurse RMNs—Non-UK
Claire	RN, RHV	F	34	Community Nurse Teacher		Psychiatric nurse
Charlotte	RN	F	25	Nurse Lecturer	Ex-Army, current reservist	Community nurse, non-nurse first aider
Viv	RN	F	7	Staff Nurse, Medical Ward		Cancer nurse Non-clinical nurse
Katy	RN	F	1 month	Staff Nurse, Acute Ward		Non-acute care nurse
Sophia	RM	F	32	Midwife		Aid worker, British Red Cross, MSF
Rose	RN	F	5	Clinical Nurse Specialist, Palliative Care		Lay person, non-healthcare professional

Abbreviations (specific terminology as stated by participants): A/E, accident and emergency; F, female; M, male; MSF, Medecins Sans Frontieres; RHV, registered health visitor; RM, registered midwife; RMN, registered mental health nurse; RN, registered nurse; SEN, state enrolled nurse (course discontinued before 2000); UK, United Kingdom.

FIGURE 3 Seven questions (after Birks & Mills, 2015, p.93)

1. Are there elements of process or action apparent in the early analysis?
2. What is left unsaid in the data analysis to date?
3. Are there more questions than answers? If so, what are they?
4. Who are the key stakeholders in the field?
5. Where else do I need to go to get more data? What should that data consist of?
6. Are there contextual influences at play?
7. Is the original research question / substantive area of enquiry / analysis remaining constant?

TABLE 2 Emergent themes

Sub-themes	In vivo themes	Core in vivo theme
'Some nurses' Media influences Unfamiliar/unpredictable environment	'Something I've Heard'	
Public expectation Safety	'Am I Covered?'	'The Right Thing to Do'
Environmental influences Training and education Human instinct	'Just Who I Am'	

anxiety (Table 2). All participants articulated some experience of an off-duty emergency situation. Discussion of relevant theme-specific literature is included in the findings.

4.1 | Theme 1: 'Something I've Heard'

'Something I've Heard' is supported by sub-themes media influences and 'some nurses', reflecting participants' narratives about the impact of myth and urban legend. Table 3 illustrates an overview of theme development.

'Something I've Heard' is a phrase that encapsulates the stories, accounts and potential warning messages that participants spoke about. Stories, accounts, myths and legends are often passed down generations in professions and occupations and there is evidence of this in nursing and other healthcare professions (Barney, 2005; Clarke, 2008), often contributing to the identity and image of a group or profession. This was identified in participants' narratives, and comparisons amongst perspectives revealed a sense of warnings that should be heeded if they were to avoid risks to their professional lives (Table 3). However, participants with armed forces backgrounds and experience were the least concerned together with the midwives. The nurses expressed more anxiety, for example, Charlotte said:

> "You hear of people being taken to the NMC for doing the wrong thing".

Claire and Chloe also voiced anxiety about errors of competence, judgement and poor outcomes.

Claire: *I think about stories from my past where I've been told about people who've helped, and they've done the wrong thing. When I was younger someone came off a motorbike, the person helping took the helmet off and caused damage to the neck and the person was left paralysed from the neck down, so that kind of put me off—always stayed with me. It was horrific.*

Chloe: *In my training I heard someone say about a nurse helping someone—the person wasn't happy and sued the nurse.*

Chloe went on to recount an unsubstantiated story about a motorway incident involving a chemical spillage where a nurse attempted to help resulting in her 'dissolving' in the substance.

4.1.1 | Sub-theme—Media influences

Participants spoke with emotion about how a variety of media influenced public perception and expectation of nurses and midwives and the alleged pre-disposition for adverse litigation. There was discussion of how healthcare is reported in the popular media, proposing that it was generally negative, sensationalist, inaccurate and unhelpful, and may contribute to a reluctance to offer assistance. In particular, it was noted how video recording of incidents including the use of social media-induced anxiety about scrutiny and misuse.

TABLE 3 Theme 1 development '*Something I've Heard*'

	Sub-theme 'Some nurses'	Sub-theme Media influences	In vivo Theme 'Something I've Heard'
Properties	Quality of nurses or midwives Identifying who '*some nurses*' were Less probably to help or respond Value-based differences	Beliefs and perceptions Influence and impact Power Value laden Healthcare workforce reporting	Stories heard and shared Fear and anxiety Myth and contemporary legend
Dimensions	Perceptions of competence Moral positions and value bases which are difficult to pinpoint Sense of letting the side down, being unprofessional	Unfair scrutiny and blame Use and misuse of social media Inaccurate information predominates Sensationalist reporting Printed word and headlines	Warnings and risk to professional future if unheeded Impact on practice Feeling wary, fearful and anxious Handed down from the previous generation of nurses/midwives

Viv made links with threats to her personal safety, along with Georgina, whilst continuing the theme around influence and scrutiny of and by the popular media.

> Media plants ideas in the public's minds—I would worry about my own safety really, because of the stories that you hear in the papers and in the media—There's a lot of negative publicity, very few positive stories come out for us. The way we are judged is quite high and I think sometimes it's a bit harsh.

4.1.2 | Sub-theme—'Some nurses'

The in vivo sub-theme 'some nurses' arose from an area of concern that was articulated as a feeling or belief that there was a group of nurses and midwives who would be unlikely to offer help or respond when off-duty in the event of a need for first aid. Participants often talked about 'some nurses' or 'certain nurses'.

John alluded to issues surrounding the work culture in the UK NHS suggesting that some nurses may be wary of committing to help during off-duty time:

> Bad experiences in the past—Some people are paralysed by the fear of doing something wrong, perhaps they are managed by people who are blaming or who are critical.

Sandra considered the research area through a lens of vulnerability making links with societal changes and the impact on workload and work culture:

> I think sometimes whether you're a nurse, a doctor, you don't want to get involved. Some people want to cut themselves off from seeing it. They may feel afraid to get involved, because they don't know how to deal with the situation. I think that's kind of evolved over the years—people were a little bit more wanting to be involved. What you have to deal with—it is so stressful. We all work long days; you sure enough need your days off because you're normally out for the count.

Key findings Theme 1

- The in vivo theme 'Something I've Heard' involves ideas and accounts of stories that exist as warnings.
- Sub themes: media influences and 'some nurses' include issues and concerns surrounding public expectation, visibility, accuracy of reporting and professional behaviour. Most of these accounts are largely unsubstantiated or without evidence.
- These accounts may be part of the urban myth and legend often seen in professions.
- They serve to act as warnings and increase fear and anxiety around professional activity.

4.2 | Theme 2: 'Am I Covered'

This theme focussed on the protection of professional registration and was underpinned by three sub-themes, public expectations, unfamiliar and unpredictable environment, and safety. Tables 4 and 5 provided examples of theme development.

'Am I Covered?' crystallized participants' feelings, beliefs, views and perceptions about their sense of risk from, and potential for, adverse litigation in relation to the research area (Tables 4 and 5).

John was the only nurse who felt unequivocally clear about how being 'covered' applied to him and was also one of two who discussed the significance of omitting to help at an off-duty situation.

John: *I think you've got a duty of care to anybody that you come across in a public place. Got no time for people that say, I might be professionally compromised or I might do the wrong thing, or I might get sued. You're more likely to be criticized for not doing something than you are for doing something.*

TABLE 4 Example of theme development

Raw data	Initial code	Sub-theme	In vivo theme
Tom 'you panic a little bit, your colleagues aren't there to support you, completely on your own'	Feeling anxious in an alien environment	Unfamiliar/ Unpredictable environment	'Am I Covered?'
Chloe. 'You've got to be so careful, always cover your back'	Protecting myself	Safety	'Am I Covered?'
Viv. 'People expect you to do miracles'	Concern about expectation	Public expectation	'Am I Covered?'

TABLE 5 Theme 2: 'Am I Covered?' theme development

	Sub-themes			Key concept being protected
	Public expectation	Unfamiliar and unpredictable environment	Safety	In vivo theme 'Am I Covered?'
Properties	Anxiety Wider societal expectations Being under pressure	Anxiety Environment of chaos The unexpected Different to usual work role	Anxiety Safety principles Awareness of risk	Anxiety and Fear Views/perceptions about litigation Knowledge and understanding of the law 'Duty of care'
Dimensions	Realistic vs. unrealistic Sense of scrutiny Unforgiving and punitive expectation of others	Training needs Doubts over competence Being isolated Potential for conflict Being unprepared Away from peers and unsupported	Professional safety Physical safety Personal safety Risk of criminal activity	Levels of confusion Lack of clarity and understanding Relationship between sub-themes as a source of anxiety Beliefs about practice competence Potential for and risk of adverse litigation

TABLE 6 Example of coding—Viv

Narrative data	Focussed coding
Viv	
people expect you to do miracles, I would worry about expectations. People's expectations of what I'm supposed to do. It's just the public pressure of being watched,	Pressure of unreasonable expectation and scrutiny. Perceptions of expectations
especially if you are now identified as a healthcare professional. As a nurse, I think that's a worry, very keen still to help, but I would worry about expectations, people's expectations of what I'm supposed to do,	Being visible as part of a group with an expected behaviour and knowledge Wanting to help despite being judged
there could be other complicated issues.	Awareness of complexities
I think it's just the public pressure of being watched, especially if you are identified as a healthcare professional, as a nurse, that's a worry.	Feeling overwhelmed and anxious about expectation and scrutiny by others Repeating concerns
I'd worry about what kind of support I would get from people around me. Would they be helpful or would they be putting pressure on me because everybody would come up with their suggestions?	Worry/fear about potential isolation, lack of support and ongoing scrutiny
–you're no longer thinking clearly because you've got an audience and people are putting pressure on you. People panic,	Being under pressure, under scrutiny Anxiety about making decisions in unpredictable and chaotic situations
they expect you to do something quite quickly and get the situation under control really'.	Expectation to deliver a result

John, along with Georgina, Sandra and Jennifer were less worried about potential adverse litigation. Even though the midwives were relatively comfortable with their legal position, they all expressed and acknowledged concern with wider societal issues and the existence of other nursing and midwife colleagues' anxiety about being 'covered' in off-duty situations. It was noted that bystanders may also be a source of anxiety. Most countries' laws, including the UK's, do not expect anyone to put themselves at risk but do only what is reasonable (Bolam v Friern Hospital Management Committee, 1957) which equates with the 'minimally decent' Samaritan identified by Hursthouse (1987, p. 191).

Viv's palpable anxiety related to public expectation and her views about society and the risk of adverse litigation (Table 6).

Helen spoke about a situation where she had responded asserting herself to override a member of the public, and being concerned with her legal knowledge:

> I know what I'm doing. I didn't quite know my legal responsibilities.

Tom felt comfortable with his emergency first aid knowledge and skills but remained concerned about a potential risk for adverse litigation:

> If you do something wrong, are you going to end up getting sued, struck off? I think that I do the best to my abilities to look after people within the best of my boundaries and knowledge, that will never get me struck off.

Similarly, Chloe was confident about her skills, however, was aware that she was 'Not sure about duty of care' and had many questions about what this meant and how it applied to her which were shared by several other participants. Participants drew parallels with a perceived lack of strength and support from professional bodies. The NMC were often spoken of with a sense of fear about punitive scrutiny. Rose challenged this anxiety:

> The fear is that if you don't stop and someone finds out that you're a nurse, there could be a reprisal. Not stopping wouldn't even be a thought to me—If we're all scared of getting whacked up in front of the NMC I think it's a bit of a sad place that we live.

Townsend (2013) suggests that there is some persuasive evidence of a general increase in litigious activity in the UK bringing it more in line with that in the USA. However, this is not reflected in litigious actions associated with off-duty responses by healthcare professionals. Maudsley (2015a; 2015b) knew of no cases in UK law where nurses or midwives faced prosecution for Good Samaritan acts. The RCN legal department expressed a similar understanding (Hooper, 2014).

Katy made her point:

> They drum it into you about your PIN (professional identity number) if anything happens, you can lose your PIN. Got to protect my PIN, got to protect my PIN all the nurses say that all time. I hear that probably at least 3 or 4 times a day.

Participants articulated an underlying understanding about competence and scope of practice but experienced a very palpable sense of fear and anxiety about protecting their registration. Knowledge of 'duty of care' was often confused. Whilst the majority of participants mentioned duty of care, when asked about it, they were unclear or hesitant to discuss their understanding of it.

Sandra shared some of Zanya's perspectives on coming from different clinical backgrounds:

> I'm a midwife, unless it's a midwifery case and the woman is pushing in front of me, I then have a duty of care, but do I have a duty of care to go to a roadside accident? We do hear a lot about litigation, it's quite a strain.

Claire's narrative was heavily influenced by views and perceptions around a 'rights' aware society and the impact of this:

> I would be worried that I would be subject to litigation, more so than years ago. I think we follow the pattern in the U.S., the general public will sue if they think that harm's been caused, even if it's inadvertently—you see adverts on the television for solicitors touting for business, that kind of attitude puts people off helping others—fear of doing something wrong.

Many nurses from the military work in emergency departments (EDs) and acute care settings as that are likely to have been their focus whilst in the armed forces. Jennifer had come across accounts of nurses facing litigation but was less anxious and felt that her military ethos had informed her competence and confidence, saying 'being a medic in the military was good grounding'.

4.2.1 | Sub-theme—Public expectation

This sub-theme explores participants' perspectives about public expectation whilst off duty. John articulated his thoughts:

> The way nurses portray themselves in public has an influence on the way that the public perceives them. There's a lot of public criticism of nurses, a lot of nurse bashing. I think the public would rightly expect, if a qualified nurse was walking past, whatever type of nurse, would intervene and do their best. Image, conduct, credibility, and integrity are terribly important.

John, along with other participants, articulated an underlying feeling of concern, fragility and anxiety surrounding the public's expectation of nurses when off-duty. This anxiety may be fuelled by confusion about role clarity and the impacts on professional confidence that this may foster (Daly & Carnwell, 2003; Takase et al., 2006).

Viv talked about the public being 'unreasonable' and also noted the relationship with 'negative publicity' from the media:

> The public expectation is unreasonable, yes I am a nurse but they've got to understand that I'm in an

> unfamiliar environment and I'm under pressure. Ideas are planted in their (the public's) minds by the media; public are unforgiving of errors. That is what robs people, the good nature from people.

Table 6 provides an example of focussed coding.

The wearing of uniform was noted by some participants with regard to public expectation and the attention it drew. Nurses with armed forces backgrounds articulated a different stance in relation to the wearing of uniform and the promotion of wearing a (non-clinical) uniform in public and being proud to do so (Spragley & Francis, 2006), with links made with never being off duty. All other data that mentioned uniform surrounded attracting attention, potentially raising the expectation of what the uninformed individual could do to help. This is always related to statements that indicated a level of anxiety about performance, potential errors, unrealistic expectation and being judged.

4.2.2 | Sub-theme—Unfamiliar and unpredictable environment

The nature of these situations is implicitly unpredictable, unfamiliar and unexpected. All participants alluded to standard assessment guidelines initially such as ABCDE (airway, breathing, circulation, disability and environment) when viewing the trigger image. Some participants noted discomfort with this out of normal work situation where the decision-making process is likely to be rapid and chaotic. This was often articulated as an internal conversation. Participants noted how first aid decision making whilst off-duty in unfamiliar environments with incomplete information was a source of much anxiety. Pugh (2002) recognised the limited primary research relating to decision making in off-duty situations. This could be considered an easier transition for nurses with acute or emergency care backgrounds compared with those from other clinical or non-clinical backgrounds. However, this cannot be assumed as Tom indicated:

> Outside of hospital is a completely alien environment—you have to think on your own, without all this equipment that you usually have, you panic a little bit, your colleagues aren't there to support you—completely on your own.

Being without peer support was a sentiment that persisted throughout the data, as illustrated by Charlotte:

> You need to be careful when you have got your skills base and you're trying to adapt it for a different scenario—I'm very happy in an intensive care scenario, ILS (intermediate life support) trained, a defib on hand and an E.T. tube and an anaesthetist. Take that out into the community—you don't feel nearly as confident.

Reflecting the need for skills in incident management, Claire noted:

> You could misread a situation—you're on your own, you're having to make decisions alone.

Zayna cited her experiences and involvement at out of workplace scenarios:

> When it's out on the street, it's very different—you're on your own and you have to make a snap decision. As mental health nurses, it's not the kind of problems we come across very often. It's quite scary.

Kolyva, in Sprinks (2015), considers how nurses make rapid judgements under pressure at work, and the difference outside that setting, adding that environmental factors and personal circumstances may impact on responses to scenarios during off-duty time. The complexities of an unfamiliar and unpredictable environment necessitate the importance of clear guidance, and consideration of human factors literature (Dekker, 2011). The NMC (2015) requires registrants to respond in some capacity, that is to say, to not ignore the need for assistance. This sub-theme indicates that the NMC's (2010) inclusion of first aid and incident management in undergraduate nurse education curricula was a timely and appropriate development.

4.2.3 | Sub-theme safety

This sub-theme highlights participants' concerns about personal and professional safety. There is a significant body of evidence alluding to personal safety in adverse circumstances (Atkins, 2013; Clarke & Ward, 2006). This literature is closely linked to the growing body of knowledge around the place of human factors in healthcare where clinical practice is becoming informed by evidence about human behaviour under pressure regardless of knowledge or ability (NHS England, 2013; The Health Foundation, 2017).

Viv explained how she worried about 'Some kind of scam' where the responder is a target for criminal activity. Georgina mirrored Viv's and Claire's concerns as she explained:

> You have to be cautious; in case it's a trap—You make sure you're safe. I certainly wouldn't be rushing in to help somebody down a darkened alley at night.

Several participants considered their personal safety. Sandra noted 'Fear of getting hurt yourself'. Several participants talked briefly about concerns relating to infection control and personal risk. Linda said, 'did mouth to mouth—what about Hep. C. risk?'.

This reflected anxiety surrounding risk to their own health which, whilst small (Resuscitation Council (UK), 2017), was still a risk that some participants worried about, especially as off-duty situations are likely to mean that there is little or no access to safety equipment or the medical history of the victim:

Helen: I got into a situation where I did have blood on my hands. I used to have gloves and a mask in my bag. It's an automatic thing to get some gloves on.

Professional safety concerns broadened out to the key theme 'Am I Covered?'.

Key findings Theme 2

- Protecting professional status is a source of anxiety for nurses and midwives
- The inherent unexpected nature of the off-duty scenario magnifies this anxiety
- Beliefs about, and experiences of, public expectation have a significant impact on the level and degree of anxiety
- There is anxiety and fear surrounding the perceived risk of adverse litigation relative to responding at off-duty situations where first aid may be required
- Narratives were characterised by the following quote:

Sophia—"We do not want to be moulded by this culture of litigation".

4.3 | Theme 3: 'Just Who I Am'

This theme reflected participants' narratives surrounding personal and professional identity continuing the rich narrative resulting in the in vivo theme 'Just Who I Am':

Linda was clear that she would always help saying: *Just get on with it, can't walk by.*

Sophia: *I would actually choose to be a helper rather than the observer, my default mode.*

Betty: *Wouldn't walk by—normal human behaviour is to help in some way but that fear and anxiety may affect how nurses behave in out of work situations.*

Chloe: *A sense of decency. I have compassion for people, not only being a nurse, but just being a human. If I wasn't a nurse I'd still go over. Just who I am.*

Katy: *I would never walk away from anyone that was in trouble—who I am.*

Rose: *It's just that mind set. I'd want to do something—being a nurse and also the kind of person I am.*

The data suggest some evidence of deep-seated influences in relation to family experiences, parental behaviours and what it means to be part of a community. Those participants with a military background appeared to have the clearest sense of their identity relating this to their military ethos which they felt strengthened their clarity of position, support, belonging and confidence. McLeod (2008) suggested that a history of positive affiliation influences pro-social behaviour. The midwives also had a clear sense of where they sat in relation to who they were both personally and professionally, and articulated this in terms of role clarity, peer group identity and understanding of their position in law.

Ohlen and Segesten (1998) concluded that professional identity and self-image is developed via interaction with other nurses and wider society and has a significant impact on self-esteem. Hoeve et al. (2014) concluded that nurses needed to more visibly communicate their work and roles to the public to clarify their self-concept and professional identity.

'Just Who I Am' appeared as a constant and consistent point of reference which threaded through data. This *in vivo* term occurred frequently and with slightly differing terminology including 'It's who I am', 'personally', 'just do it', 'autopilot' and 'automatic' as applied to their behaviour, characteristics and perceived instinct.

4.3.1 | Sub-theme—Human instinct

Participants identified the idea of an instinctive response early on in the interview process together with, and sometimes interchangeably with doing 'the right thing'.

Georgina related her 'innate ability to respond' to the notion of instinct, suggesting instinct was a fundamental and healthy human response. Chloe also considered the idea of innateness 'healthy moral behaviour is to help in some way. You just do it'. This was emphasized by Helen, 'you just go into nurse mode', frequently calling it her 'auto pilot' alluding to it as an instinctive response saying, 'I never actually switch off as a nurse'.

Viv raised issues around instinct and conflicting feelings of anxiety:

> My first instinct would be to help. I don't think I could walk away from a situation where somebody clearly is in trouble ... I would probably end up doing it, but I would be a bit uncomfortable. It's not just professionally because I'm a nurse but just it's a human kind of thing to do.

Beliefs about instinct led participants to consider morally right behaviour as virtue suggesting a relationship widely reflected in the data and articulated as an obvious and automatic trait. Linda felt very clear saying 'just do it', as did Tom 'comes natural to me'. Armstrong's discourse on the nature of virtue suggests that the difference between instinct and virtue is the moral nature of virtue as a choice, as different to the notion of instinct and survival which are considered innate drives (Armstrong, 2010).

4.3.2 | Sub-theme—Environmental influences

This sub-theme illustrates data identified as potential environmental influences on participants' views and experience about the research topic.

Narrative and comparative analysis suggest that the influence of family and early life is significant. Several examples indicated that such influences played a key part in moral development:

Tom: *The way I was brought up and what my parents taught me—and how that's passed on to you. My Mum's a nurse—a big influence on me—it was a tight knit community. I was brought up to do what you can to help other people and,—you will get your reward—definitely a spiritual upbringing.*

Jennifer considered the military ethos and how she had a respected place in her community in common with Tom. Jennifer felt this had developed her sense of belonging: 'Military training and ethos—get on and do it. You can spot a nurse with a military background'. Griffiths and Jasper (2008) described the binding nature of the military nursing ethos embodied in a core category identified as 'It's who we are!' demonstrating a parallel with participants in this study.

4.3.3 | Sub-theme—Training and education influences

Training, education and preparation issues were reflected in terms of individual personal and professional development, and knowledge and understanding of legal, moral and ethical issues. There was some narrative around mentorship and selection processes. Selection concerns alluded to the ability to select those with the appropriate characteristics to be a nurse or midwife.

Tom, in common with John, articulated strong views about being professionally current and how all nurses should have the ability and competence to respond in some way regardless of specialism or role:

Jennifer: *Military training involved a lot of simulated scenario learning—Quite confident and comfortable with my role.*

The findings surrounding training and education often led to concerns with competence relative to risk of adverse litigation:

Sandra: *Knowing your limitations—It's kind of drummed into you from training.*

Zayna: *We're trained in emergency life support; I've only ever used it twice. I'm not first aid trained. Mental health nurses don't always feel very skilled in those areas because it's something we don't have to do a lot of.*

Rose: *Knowing my limitations, you do your basic CPR training, but I don't think anything really prepares you ever to find somebody in that situation—you have that moment of shall I, shan't I? With the nursing training you get, you're taught to help—Nursing has given me a lot of confidence to be able to stand up for myself and say No, I don't want to do that, I don't feel I can do that.*

First aid training and preparation appeared in the data in relation to participants practice competence to carry out initial assessment, and as a fundamental recognition of its value in responding to off-duty situations.

Key findings Theme 3

- Nurses and midwives have a strong sense of personal identity.
- It is notable that midwives and those with an armed forces background had a stronger sense of professional and personal identity.
- Whilst professional identity was evident, anxiety appeared as a potential modifier or barrier to action.
- The sub-themes relating to instinct, environment and learning provide clues to factors influencing response at 'off-duty' situations.
- There was a sense of a moral intention and character that operated despite the feelings of anxiety about 'off-duty' situations.

4.4 | Core theme 'The Right Thing to Do'

Thinking and acting with moral agency voiced by participants as doing 'the right thing' was a belief that they all articulated early on in, and consistently during the interview process and is constructed from the analysis of the three in vivo themes and their sub-themes. Being wrong was associated with being judged, doing harm and the fear and anxiety that this would bring:

John: *I might be professionally compromised or I might do the wrong thing—I feel quite clear about my moral position.*

Participants considered their position as if stepping into a role with moral and practical tenets that appeared to override fear or anxiety. These narratives provided examples of an apparent mismatch between anxiety about their response and a sense of stepping into a new persona. Participants' ideas about 'The Right Thing to Do' were driven by their beliefs surrounding moral intent and action. This discussion is contextualized against a backdrop of pervasive anxiety in the data about responding at off-duty situations. There is significant overlap and blurring of boundaries between themes and sub-themes serving to interpret the multiple perspectives and dimensions by providing a rich construction of the data (Braun & Clarke, 2006).

Helen's statement crystallized the key message about sound moral action despite her lack of clarity and reservations. Helen encompassed the concepts embodied in two of the three key themes about protection in law and how she would still feel a sense of moral agency:

Helen: *Even now when I've done, a level seven in law and ethics course, going back to where I stand on the street—I don't think I'm exactly still clear about that. I would still help, the right thing to do.*

The construction of the core theme 'The Right Thing to Do' illustrates moral intention and action as expressed in the participants' narratives. Morality is defined as beliefs about right and wrong, and good and bad persons or character (Vaughn, 2013), and this was reflected throughout the narratives. There are a variety of definitions of moral agency and all allude to being capable of or acting for what is considered good and right.

4.4.1 | Substantive grounded theory

In line with constructivist grounded theory methodology, data emerged via a process of induction with concepts grouped under increasingly higher-order sub-themes and themes and relationships noted. This approach provided the basis for the construction of the substantive theory that is represented in Figure 4. The final construction has the concept of moral agency as its central and enduring tenet voiced as 'The Right Thing to Do', constructed via the themes of identity: 'Just Who I Am', Urban myth and legend, 'Something I've Heard' and concern surrounding position in law, 'Am I Covered?' and their sub-themes. The pervading and ever-present anxiety identified in this study seeped through the narratives in varying degrees from mild concern to significant fear on occasions.

4.5 | 'Doing "The Right Thing" in a climate of anxiety'

The overarching core theme overlapped all the themes and sub-themes. The red fog in the diagram represents the confusion surrounding the area. Anxiety exists as a backdrop to the concept of a moral compass that is ever-present (Figure 4).

5 | DISCUSSION

The three key emergent themes had a persisting ethos that conveyed the presence of a sense of moral agency articulated as the central and core theme 'The Right Thing to Do'. This concept informed all participants' narratives in some respect both implicitly and explicitly. The underpinning theories central to these narratives were Good Samaritan principles defined by a moral drive to offer help often reflecting religious and spiritual beliefs (Gulam & Deveraux, 2007) and to some extent bystander behaviour theory found in psychology literature (Darley & Latané, 1970; Finkelstein & Penner, 2004; Garcia et al., 2002).

The in vivo theme 'Something I've Heard' articulated myth and contemporary legend as warnings (Brunvard, 2004; La Motte, 2014;

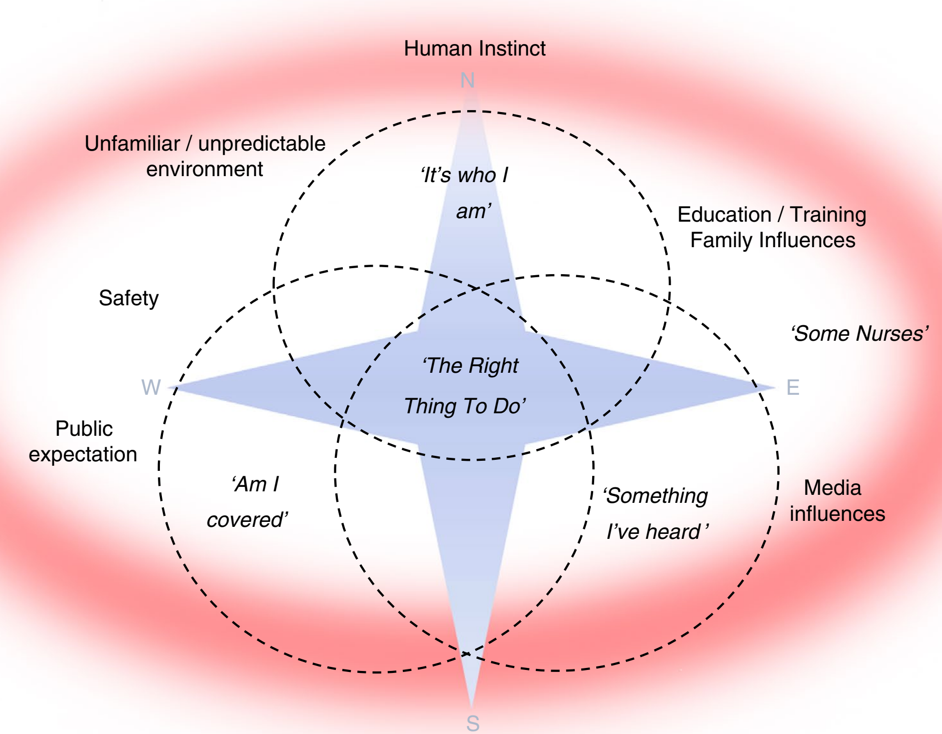

FIGURE 4 Substantive grounded theory. Doing 'the right thing in a climate of anxiety'

Mortimer, 2013) impacting on motivation to act morally suggesting that some nurses and midwives may not do so, although this connected with concerns around professional cohesion. The notion of urban myth and legend is defined as anecdotal stories passed down and between generations and professions, often based on some facts but with additions to create interest, shock or amuse. 'Something I've Heard' alluded to accounts that often informed participants' professional lives (Clarke, 2008; Thompson, 2013). Morally good intention, expressed as doing 'the right thing', was a position that participants consistently returned to despite their concerns about risk and warnings (Vaughn, 2013).

The focus of theme two 'Am I Covered?' was mostly, but not entirely, one of fear and anxiety surrounding protection, and drew attention to potential barriers and modifiers to good or right moral action both professionally and personally. The *in vivo* theme 'Am I Covered?' surrounded concerns about protection particularly in relation to participants' fears of scrutiny and adverse litigation and the impact on their ability to maintain their professional registration. Participants continued to return to their sense of moral agency despite these anxieties. Given that more individuals now possess first aid skills for both personal and work-related reasons, a nurse or midwife may not necessarily be required; however, it is likely that a level of public expectation remains. The COVID 19 pandemic has increased the visibility of nurses and midwives serving as a reminder of the need for clarity and preparedness. Surveillance technology and information sharing activity including social media may be raising awareness and concern about scrutiny and subsequent judgement.

The third theme 'Just Who I Am' considered personal and professional philosophies arriving at a position that acknowledged the countering influences and risks that they associated with responding to situations during off-duty time where first aid may be required. This recognition of their anxieties and concerns appeared to be overridden by a sense of moral agency frequently articulated as 'Just Who I Am', asserting participants personal and professional stance despite the context of anxiety and perceptions of societal change. There were indications in the narratives, however, that a professional culture that lacked cohesion generated fear, threat and anxiety which may inhibit helping behaviour at off-duty scenarios.

Participants' ideas about doing 'the right thing' reflect morally good character and this appears grounded in ideas of religion, spirituality and value laden human nature. This understanding then influences beliefs about the nurse/midwife role. The research question removes notions of employment contract from the discussion allowing for focus both on moral action and morality in general (Carbonell, 2013). Such intrinsic reasons and the associated motivation are plausibly part of what it is to understand vocation and may go some way to understanding why people choose careers in nursing and midwifery (Lundmark, 2007). The overarching and intrinsic golden thread of moral agency articulated as 'The Right Thing to do' suggested levels of moral development informed and impacted by the themes and their sub-themes. Nagel (1987, p. 63) asserts 'there is no substitute for a direct concern for other people as the basis of morality'.

What is strongly implicit in this data is a vocational outlook on life. For some, this seemed to have a spiritual foundation (Bradshaw, 1999) and others a more secular humanistic one (White, 2002). All participants felt they would stop to help because it was a clear instance of good and right action, motivated by personal and professional perspectives (Carbonell, 2013) reflecting findings from a questionnaire study of UK doctors about providing first aid when off-duty (Williams, 2003).

The result is a value-based or morally infused outlook on life that is pre-existing or developed as properties and dimensions of 'The Right Thing To Do' identified in the themes and sub-themes in the data. However, anxiety remains a constant feature in and of the process. Arguably this anxiety could inhibit or even override feelings of moral agency in some situations. The themes 'Am I Covered' and 'Something I've Heard' demonstrate significant anxiety and concern in this respect.

5.1 | Strengths and limitations

This study provides a detailed in-depth analysis of a very challenging area of professional practice providing much-needed theoretical insights. As a RN, being an 'insider' researcher facilitated the gaining of participants' trust, with a credible understanding of the nature of their professional lives (Simmons, 2007).

Limitations relate to participant self-selection, possible 'halo effect' and the potential for researcher bias. Despite the lack of mandatory inclusion of first aid education in pre-registration programmes for 33 years, most nursing and midwifery education providers continued to provide some first aid training. All participants stated that they had undertaken some form of first aid training during their pre-registration course. The lack of standardisation of this training may be a limitation for this study. The inclusion criteria did not require participants to have actual experience of an 'off-duty' emergency although all did as the study was exploring perceptions and views as well as experience. This presented the potential risk of insufficient data. Furthermore, although the substantive theory offers a unique insight into the experience and views of nurses and midwives about responding to out of work emergencies, questions remain about whether all sources of anxiety that contribute to the substantive theory have been captured.

5.2 | Recommendations for policy, education and practice

It is essential for the NMC, RCN and employers to consider how they support and prepare staff for off-duty situations. The visibility of nurses and midwives both on and off-duty is likely to increase, therefore it is crucial that clarity is achieved if anxiety surrounding cultures of blame, scrutiny and expectation is to be addressed. Guidance issued to other healthcare professions including doctors (General Medical Council, 2010), social workers (British Association of Social Workers, 2014) and paramedics

(Bird, 2020; Health & Care Professionals Council, 2018) could be valuable in collaborating to strengthen the understanding of all health professionals, including nurses and midwives, about their position in 'off-duty' scenarios.

The substantive theory, with its backdrop of anxiety about scrutiny and its consequences, may usefully inform research, debate and learning about first aid and incident management in nursing and midwifery education and practice (NMC, 2010), given the level of confusion about the legal position, especially 'duty of care'. A review of available support mechanisms, for nurses and midwives who experience off-duty events where they have provided first aid or other help, is appropriate. The findings from this study can assist the NMC and RCN with a view to informing future policy in the area.

5.3 | Recommendations for future research

Research with health care employers and professional bodies exploring how they could better inform and support nurses, midwives and other staff about off-duty response situations is indicated. The core theme of moral agency identified as 'The Right Thing to Do' had a common central theme in the findings that suggest a need to gain a better understanding of what it means to act morally as a healthcare professional both on and off-duty. There needs to be further investigation of nurses, midwives and other healthcare professionals and their preparedness for responding to off-duty emergencies with a particular focus on anxiety reduction and understanding the law. A key consideration for future research is to explore the views of the lay public surrounding their understanding and expectations of health care professionals in off-duty situations, given the prominence of the narratives in the sub-theme public expectation.

6 | CONCLUSION

The findings from this study provide a unique account of the position about the beliefs, perceptions and experiences of nurses and midwives when faced with a non-workplace scenario where first aid may be required. The findings impact on all nurses and midwives and have implications for other healthcare professionals. The tremendous tension and anxiety in the area suggest that tolerance of risk (perceived or otherwise) is a significant concern.

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CONFLICT OF INTEREST

None.

AUTHOR CONTRIBUTIONS

Carolyn Crouchman, Lauren Griffiths, Ruth Harris, and Keiran Henderson made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data; involved in drafting the manuscript or revising it critically for important intellectual content; given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

PEER REVIEW

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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