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Using storytelling in undergraduate dental education: Students' experiences of emotional competence training

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Abstract

Aim: The aim of the study was to explore the use of storytelling as a teaching method for emotional competence interventions within undergraduate dental curriculum (dental and dental hygiene students).

Materials and Methods: Students participated in five sessions related to emotional competence: one theoretical and four practical. During the latter, divided in small groups, students told individually two stories: a story about a clinical situation in which they had an emotional experience and a story concerning a patient's experience of the same emotion. Each session focused on a single emotion: happiness, fear, anger and shame. A questionnaire was used to collect perceptions about enjoyment, how stories were chosen, what was learned and if the sessions were stimulating in any way. A focus group was organised to collect reflections about the learning environment, process of learning and specific skill set developed during these sessions.

Results: The majority of the students enjoyed listening, telling and preparing the stories. They reported to experience social support and feeling a sense of community during the sessions. The students believed that stories helped them to reflect on their clinical work and to regulate their emotional experiences more efficiently in clinical situations. Regarding the learning environment, the dental students pointed out the distinctiveness and dissimilarities between the dental and dental hygiene students, but also expressed that they had a desire to learn more about the other student group.

Conclusion: Storytelling used as part of an emotional competence course appears to have benefits for students' reflection about their role as dental health professionals. This teaching method was well-perceived by the students included in this study.

KEYWORDS

emotional competence, emotional intelligence, narrative dentistry, narratives, story, storytelling

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1 | INTRODUCTION

1.1 | Background, aim of the study and previous related studies

Several studies argue for the inclusion of Emotional Intelligence (EI)/Emotional Competence (EC) interventions in higher education in general,[1] in health education[2–4] and in dental education specifically.[5,6] Notably, high EC/EI is negatively associated with perceived stress amongst dental students[7,8] and dental students with higher social skills perform better on clinical interviews.[5] In addition, patients' satisfaction with student treatment appears to hinge on the emotional skills of the dental student, with patients of dental students with high EC/EI being more satisfied with treatment than patients of dental students with low EC/EI.[9] There are several methods of teaching that can be used for achieving EI/EC-related intended learning outcomes that are connected to dental undergraduate education and training areas of competence in professionalism and in patient-centred care, with storytelling being one of these methods.[10] It has been suggested that storytelling should be used where it has the "greatest added value": For instance, in aiding clinical decision-making, highlighting the patient's experience in order to understand "otherness," and as a reflection on professional practice.[11] Thus, the main goals of storytelling as a teaching approach are to facilitate the process of critical reflection amongst students in professional practices and to acquire more balance between objectivity and subjectivity in dental curricula.[11,12]

In general, storytelling as part of "narrative medicine" is not a new concept;[13,14] however, there is no uniform definition of a story, as it may serve different purposes in different contexts.[15] The term "narrative dentistry" was coined recently,[16] and it refers to reinforcing humanities in the dental academic and educational environment through activities such as reading/creating and discussing patient narratives or film viewing and discussion. In medical practice, patients tell their stories in therapies and patients' stories of their illnesses are used by medical personnel to reflect over how it feels to be a patient (patient–doctor and doctor–self relation).[14,15,17–19] Health professionals share stories about their work, which helps them to reflect on their own professional practice (doctor–self and doctor–colleague relation).[11,18] In education, virtual patients' stories may have the potential to facilitate development of clinical reasoning skills.[20] In addition, storytelling seems to facilitate reflective learning and improve experience of illness, thus bringing more humanism into medicine.[21] For instance, narratives written by medical residents about any important life event that might have influenced their development as physicians appeared to have aided in facilitating reflection and self-awareness as health professionals.[12] However, in the dental field, limited studies provide evidence of the impact of humanities on dentists and their competence to treat patients holistically.[22] Focusing more specifically on storytelling, patients' stories in the form of virtual scenarios have been shown to be effective for the enhancement of ethical reasoning skills and professionalism in dentistry.[23] A recent study amongst senior dental students demonstrated that storytelling after external practice allowed students to improve reflection, deepen understanding and develop professional competence. Thus, this teaching method may have a relevant role in dental education.[24] A recent narrative review concluded that the most feasible programs for potential integration of narrative medicine into dental curricula are elective-based, small-group, graduate-level courses, with a level of evaluation such as residency competencies.[25] The aim of the current study was to explore the use of storytelling as a teaching method for EI/EC interventions within an undergraduate dental curriculum. The focus was on students' perceptions of the learning environment, the process of learning, specific skill set development and students' enjoyment in listening, telling and preparing the stories.

1.2 | Emotional competence

Contemporary views of higher education mostly agree that acquisition of scholarly theoretical or practical/technical knowledge are no longer sufficient in order to function well as a health professional. Being successful and effective in any given profession requires a wider skill set or competencies that encompass values and attitudes towards both oneself and others; in the field of dentistry this notion would appear to align with the patient-centred approach.[26,27] EI has been identified as one such potential set of skills, sometimes defined as the ability to perceive and manage emotions, as well as the ability to understand emotions and use emotions to promote or enhance thinking.[28,29] Whilst some have criticised the concept of EI as being too broadly defined,[30] it will be used here inter-changeably with the more skill oriented or practical concept of EC. As noted by others,[31] the distinction between EI and EC is perhaps less important than the predictive value of the measurable concept, that is that individual differences in EI/EC can be measured and that these differences are helpful in predicting behavioural outcomes. EC/EI are natural concepts of interest in patient centred health education since the emotional relationships between stakeholders could be important in determining the outcome of treatment or interventions.[32] There is mounting evidence that EC/EI can be improved by training,[33] and a meta-analysis supports the effectiveness of training programs aiming at increasing emotional intelligence (the overall training effect on emotional intelligence was found to be significantly different from zero [$p < .001$]).[34] This also appears to be the case for brief interventions, with results being measurable after three months after an intervention including a single workshop, a one-on-one session and an SMS reminder.[3] Typically, EC/EI interventions are designed to improve specific capacities related to the EC/EI concept, for instance, identifying, understanding, expressing and managing emotions.[35,36] Such interventions will often involve sharing emotional experiences with other participants through storytelling, group discussions, role playing or similar means.[37,38]

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1.3 | Conceptual aspects of storytelling

Learning through storytelling refers to "a process in which learning is structured around a narrative or story as a means of sense-making."[39] Though the terms "story" and "narrative" are often used interchangeably, a story is considered to be "a real or imagined account of events that describes experience," whereas "narrative is a structured interpretation of story," which includes additions and omissions.[40] Sharing stories can help with creating meaning, understanding what has happened and preparing for what may happen in the future.[41,42] As such, stories and storytelling are likely the oldest form of teaching that humanity has used.[43,44]

There are different types of stories and storytelling. Categorising them by the medium of storytelling, there can be analogue stories (oral, written, graphic or embodied[45]) or digital stories; by the number of story tellers, there can be individual storytelling or collective/group storytelling; by the story teller (in the context of medical practice), there can be patient stories, practitioner stories, teacher stories or student stories; by the focus of the story, there can be personal stories or somebody else's stories; by the degree of authenticity, there can be true stories, fiction stories or a mix.[46] Moreover, there are different activities associated with a story[15]: constructing a story; selecting an appropriate story to tell in a given context; telling of a story; listening to a story; perceiving, memorising and reconstructing a story for retelling; adapting a story from one medium to another; researching a story or stories in qualitative research.

According to McDrury and Alterio,[41] who explored extensively the theory and practice of story and storytelling in higher education in general and in practice settings in particular, there are three key storytelling characteristics. The first characteristic is the setting: informal, which accommodates casual encounters or formal, which requires planning but promotes dialogue and provides opportunities to explore alternative approaches to practice dilemmas. The second characteristic is the listeners: one or many, who can engage in response discourse, thus helping the teller explore experience in depth, or in response story, shifting the focus to a new experience being shared. The third characteristic is the story, which can be spontaneous, closely linked in time to practice settings, or predetermined, where the teller has considered the event in a pre-story reflective phase and wants to explore it further. Combining these three characteristics, the storyteller has available eight storytelling pathways, each with its own consequences on the learning process. This has to be taken into consideration by the educator who uses storytelling as a learning method.

2 | MATERIALS AND METHODS

This study focused on educational activities at the Department of Clinical Dentistry, Faculty of Health Sciences, UiT The Arctic University of Norway (UiT), in the Autumn semester in 2019. Professional Competence (PROFCOM) is a mandatory longitudinal subject that is taught during semesters 5–10 for master-level students in dentistry and semesters 1–6 for bachelor-level students in dental hygiene. Note that dental students participate in a professional competence course together with medical students in the first two years of study and that similar topics can be found at other health studies at the Faculty of Health Sciences at UiT. During the eighth semester of the dental studies and the fourth semester of the dental hygiene studies, the topic of EC is covered as part of PROFCOM, which includes theoretical teaching (one session) and training exercises (four sessions). The theoretical part consists of a two-hour lecture (non-mandatory attendance), whilst the training part consists of four successive storytelling sessions (mandatory attendance) that individually address the emotions of happiness, anger, fear and shame related to a clinical situation that the students have experienced.

In this study, in the theoretical part, students received a lecture providing theoretical materials concerning emotions and the relevance of emotions in dental education and practice, alongside instructions for the storytelling sessions. In the training part, the dental and dental hygiene students were divided into four groups of nine students, each group with its own separate seminar room. The students had been informed beforehand about the structure of the storytelling sessions. Specifically, they were told to be prepared to share with the group a story about a clinical situation in which they had an emotional experience. Moreover, they were told to prepare a story concerning a patient's experience of the same emotion. Each storytelling session was meant to focus on a single emotion, and the sessions were arranged so that "happiness" was the focus of the first session followed by "fear," "anger" and, finally, "shame." This specific order was chosen as "happiness" was thought to be a safe introduction to the sessions, since it is a primary and common emotion. "Shame," which is regarded as a more complex emotion than the others and possibly more difficult to address in class, was scheduled last, hoping that students would be familiar with the session structure and would feel safer discussing this aversive emotion. Each group had a member of the clinical staff as a group moderator, whose task it was to ensure that the storytelling activity adhered to the specific emotional theme and to the pre-established structure of the sessions, as well as to encourage student participation. Whilst equal student participation would be considered the ideal, and was encouraged by the group moderator, active participation was not mandatory. Stories were told individually, with reflections and discussions following each story, however, some variation in structure would be expected, for example, if students had very similar experiences they would perhaps share and reflect about their stories together. Each session planned to start with the stories concerning one's own emotional experience and finish with the stories regarding patients' emotional experiences, which provided two distinct parts of the sessions: self-related stories versus other-related stories. The details of the storytelling sessions are listed in Table 1.

The stories that were told as part of this study were thus individual oral analogue stories, told by students. They were both personal stories (a story about a clinical situation in which students had an emotional experience) and stories from somebody else's

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TABLE 1 Description of the storytelling teaching context

Characteristics	Description
Subject	Professional competence in dental health professions (PROFCOM).
Topic covered	Emotional Competence.
Learning outcomes	Reflecting about emotions. Recognising and managing emotions.
Students (all undergraduate) and their clinical experience	• Dentistry 8th semester. 24 students (culturally homogenous group). From the 6th semester, students start working with patients at the university clinic; the entire 7th semester is used in external clinics. Students perform dental clinical examinations and mainly restorative treatments. Some students might perform endodontic treatment or extractions. During the 8th semester, students resume their work at the university clinic. • Dental hygiene 4th semester. 12 students (culturally homogenous group). Dental hygienist students start their clinical training in the 2nd semester. During the 4th semester, these students have practice at the university clinic. They mainly work with dental examinations, professional oral hygiene, preventive measures, instructions for home oral care for adults and children.
Instructions	Identify and describe emotions that occur in a clinical context. Confidentiality. An emotional experience a student had in the clinic (clinical situation): • How did it feel? • What did you do? • How did you show this? A clinical situation when you experienced that a patient had an emotional experience: • How did you notice that? • How did it affect you? • How did you experience the collaboration in this situation?
Evaluation	Questionnaire (dental and dental hygiene students). Focus group (dental students).
Assessment	No assessment.

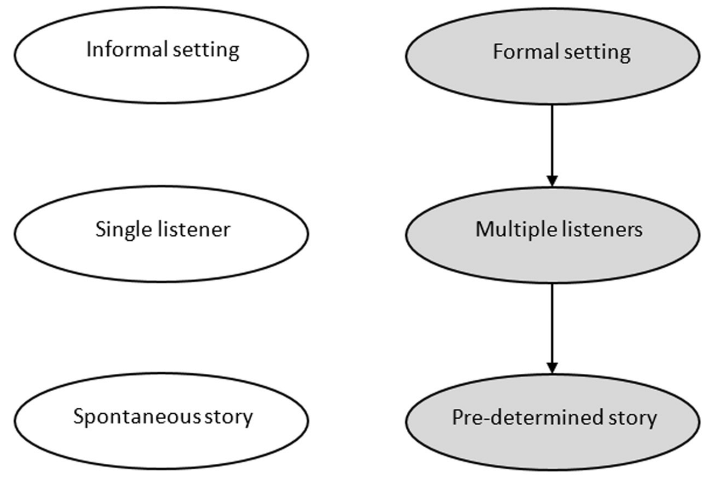

FIGURE 1 Storytelling pathway taken in this study

perspective (a story concerning a patient's experience of the same emotion). All stories were expected to be true. The storytelling pathway (see[41]) used in this study was Pathway 8: Formal setting -> Multiple listeners -> Pre-determined story (Figure 1), thus involving a reflective group process, in which a story was shared, and a practice situation examined. The storyteller has considered the event prior to the storytelling process, which is likely to result in significant learning.

Approximately one week after the last storytelling session, an evaluation was arranged during which all the 36 students who participated in the storytelling sessions were invited to fill in an anonymous paper-based evaluation form (i.e. a questionnaire). The

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students were asked if they enjoyed different parts of the storytelling sessions ("1" yes, I did, very much to "4" not at all) and open-ended questions about how they chose which story to tell, what they learned, if the sessions stimulated them in any way and suggestions for improvements. The questionnaire did not ask the respondents to indicate whether they are dental students or dental hygiene students. Descriptive statistics were obtained using Statistical Package for the Social Sciences (SPSS) version 26 (IBM SPSS).

Dental students were invited to participate in an in-person focus group that was conducted approximately two months after the final storytelling session (dental hygiene students were occupied with their final examinations and thus it was not possible to invite them in this phase of the study). Ten students registered to participate and eight participated. The focus group was conducted by one of the authors and the conversation amongst the participants was structured around a focus group interview guide that had been used at the University of Sheffield, UK, in investigating storytelling activities in their curriculum.[24] This interview guide had three main predetermined categories related to the educational activities and asked the participants to reflect amongst themselves about specific aspects related to the storytelling sessions and the learning environment, the process of learning and specific skill set that they developed during these sessions (Table 2). The focus group was audio recorded and the audio record was transcribed by a native Norwegian speaking research assistant, ensuring students' anonymity. The transcriptions, as well as the qualitative data from the open-ended questions of the questionnaire described above, were then used in a thematic qualitative analysis.[47]

The study was approved by the Norwegian Centre for Research Data (NSD; reference number 232225).

3 | RESULTS

3.1 | Quantitative

In total, 28 (78%) students filled-in the evaluation forms distributed after the last storytelling session (i.e. the questionnaire; though the practical sessions are mandatory, we do not know if all the students attended these, as we did not collect data on attendance of each individual session). The majority of the students enjoyed listening, telling and preparing the stories for storytelling sessions (Table 3). The students thought that stories helped to reflect on the clinical work and would like to be part of storytelling sessions again.

3.2 | Qualitative

3.2.1 | Questionnaire

The questionnaire contained two open-ended questions, in which students could write free-text responses about perceived learning outcomes ("what did you learn from the stories?") and potential changes made due to the storytelling sessions ("did the activity stimulate you to change in some way?"). Of the 28 received questionnaires, 23 contained free-text responses related to learning outcomes, and 24 had free-text responses related to potential personal changes made as a result of participating in the emotional competence course.

With regard to learning outcomes, the most common theme to emerge from the analysis of the free-text responses described having experienced sessions as providing them with social support, as well as feeling a sense of community and similarity to fellow students participating in the storytelling sessions (10 responses; 43%). Six responses (6; 26%) referred to learning about the importance of self-awareness and a belief that they were able to regulate emotional experiences more efficiently as a result of the course, whilst five responses (5; 22%) included mentioning of practical strategies for handling (negative) emotional experiences. Two responses (2; 9%) contained unique themes, specifically: accepting diversity (in emotional experience) and expressing doubts about the learning outcome.

With regard to any personal changes as a result of participating in the storytelling sessions, the most common theme was that students had become more self-aware and attentive to emotional responses occurring in clinical situations (9; 38%). Five responses (5; 21%) were about development of practical strategies and handling emotional experiences in a clinical setting, whilst four responses (4; 17%) indicated

TABLE 2 Thematic categories and key questions included in the focus group guide

Thematic category	Key questions
Learning environment (LE)	Was the LE appropriate? What did the students think about the LE? What did they think could be improved with respect to the LE?
Process of learning (PoL)	Was the storytelling helpful in improving the students' learning experience? How did the storytelling help them learn? Did the process improve any specific aspects of learning? What did they think could be improved with respect to the PoL?
Specific skill set (SSS)	What aspects of their development, if any, did they think they acquired from the storytelling sessions? What aspects of their development, if any, did they think they improved from the storytelling sessions? What did they think could be improved to help them develop SSS?

TABLE 3 Number of students (%) that filled in the questionnaire distributed after the fourth and last storytelling session. The total number of answers is different for each statement due to missing data

Statement/Degree of agreement	1-Yes, very much	2-Yes	3-No	4-Not at all
Did you enjoy listening to the stories?	15 (54)	13 (46)	-	-
Did you enjoy telling the stories?	5 (18)	23 (82)	-	-
Did you enjoy preparing the stories?	1 (4)	22 (79)	5 (18)	-
Did the stories help your reflection on your clinical work?	16 (57)	11 (39)	1 (4)	-
Would you like to do this again?	7 (25)	19 (68)	2 (7)	-

that no personal change had taken place as a result of the storytelling sessions. The remaining responses (5; 21%) were either non-specific about the nature of change ("yes"; 2; 8%), indecisive ("not sure"; 2; 8%) or contained unique themes (1; 4%; about the respondent being now more perceptive about how students are similar).

3.2.2 | Focus group

The learning environment: key topics

In total, 10 dental students signed up to participate in a focus group and eight participated. The participants commented frequently about having EC groups comprised of both dental students and dental hygienist students. Note that none of the dental hygienist students participated in the focus group. Oftentimes the dental students' comments were related to the group dynamic between the two student groups, e.g.:

- "[…] the [dental hygiene students] who were with us in the groups did not really contribute a lot with their own experiences. […] I would have wished that we could have heard more from them also."
- "[…] the dental hygiene students, they contributed very little, and a few of them did not attend the groups on several occasions."

The comments clearly indicate that the dental students feel both that they are two distinct groups, with perceived differences in contribution to the storytelling sessions, but also that they have a desire to learn more about the dental hygiene students. They also appeared to attempt to envision the other groups' perspective and potential reasons for non-participation:

- "A comment [on what X said]. They might have felt outnumbered, and perhaps not as confident to contribute."

In addition, the focus group participants commented on the role of the clinical supervisors in the EC groups, both in terms of how the supervisors worked as group leaders, but also about their relationship with these clinical supervisors in the university clinic:

- "I felt that I had a group supervisor that was not fit to be supervising in a course about Emotional Competence."
- "[…] I somehow felt that my supervisor [as group leader] did not provide me with anything, maybe because I know how that supervisor [usually] relates to me and others, and I do not always appreciate that."

The process of learning: key topics

Several comments were made about the process of learning about EC separately from the outcomes/usefulness (although they are naturally related). Some comments were related to timing and the relation to, for instance, clinical practice during the studies:

- "[…] it is in some ways like a double-edged sword, because [on the one hand] I would have liked to learn this earlier. [Perhaps] before we went out into [clinical] practice. […] On the other hand, it was nice to be introduced to this after we came back, because we felt a bit down trodden and incompetent then."

Other comments addressed the complex and longitudinal nature of learning clinical dentistry in relation to the topic of EC:

- "The processes of learning in this line of study include many ups and downs, […] you have to relate to adversity and it is not like it is always moving forwards and forwards […] and then you're a dentist and it is all good."
- "I think this is [part of] a continuous process, since we are beginning to be evaluated from the third year and onwards."

In addition, some hints were made in terms of how learning about EC could impact learning more generally (in the dental studies):

- "[…] one is able to be more rational with regards to that feeling of hopelessness in that […] [I am more] capable in handling the tougher sides of the studies and the process of learning and those types of things."

Specific skills set development: key topics

The focus group participants made several comments related to the development of specific skills and the usefulness or perceived outcomes of storytelling sessions about EC. Some were related specifically to the intrapersonal, internal processing of emotional states related to the clinical situation:

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- "I think it has also helped to become more self-aware, in certain situations, that one is able to calm down and take a step back to think before one acts out."
- "[…] if I have a bad day at the clinic, or do something wrong, I am able to handle it better […]."

Other comments about usefulness and outcomes dealt with social aspects, namely feeling more connected with others (social support):

- "[…] if you are for instance a large class, or it is people there that you do not know too well, then [it is good] to be able to talk about stuff, and hear that they have had the same experience […] it is not only you, I have also been angry, or upset, or frustrated, or felt that I could not cope with this. And to show to others that, 'ok – it is no big deal, it will be ok'."
- "[…] you feel safe, both emotionally and in the clinical setting, because you know that you are not alone in this."

The social usefulness aspects were also generalised into the overall study environment (relative to the clinic):

- "So, I feel it contributes to [feelings of] openness and safety, […] and that is it very positive for the social climate in our class […]."

4 | DISCUSSION

Students who participated in this study expressed that they found the EC training to be useful in that it encouraged *development of skills* related to self-awareness and self-reflection in emotional situations. Based on the way it was expressed through the comments from the focus group, this self-awareness appears to be in line with ideas concerning "professionalism" within healthcare professions.[48] Also, it is tempting to view the emotional processing of emotions as a form of self-control, akin to the notion of wilful "suppression" of dysfunctional emotional expressions vs. automatic and perhaps less functional control mechanisms such as "repression."[49,50] Also, usefulness appeared tightly connected to social concepts, for instance, social community[15] and the sense of belonging, or "belongingness," to other students in that everyone to some degree have comparable emotional experiences. This has been shown to be important in education of health professionals with regard to student motivation, acquiring a sense of professional identity, as well as students' well-being and mental health.[51]

Regarding the *learning environment*, the dental students' reflections appeared to centre around the differences between the two prospective dental professions involved (i.e. dental hygienist and dentists), as well as their relationship with, or view of, their clinical supervisors that functioned as group leaders. As for the former, whilst some reflections might have merely noted differences between the two student groups (e.g. activity level), some reflections incorporated a real desire to understand the other group and dealt with concepts such as being in minority (in the group settings) and the value of heterogeneous perspectives in the learning environment. Thus, the inclusion of both student groups in these activities appears to be both a challenge, in terms of overcoming the limitations of group dynamics, but also a unique opportunity in eliciting reflections about the other students and their experiences. In addition, dental students were left to reflect about their clinical supervisors' emotional competence and their roles as group supervisors. Whilst this might be interpreted as mere individual criticism, it is tempting to view these comments in the light of literature that highlights the importance of challenging the hierarchical structure of healthcare settings for the benefit of patient care.[52] This might be operationalised in many ways, including acts of "speaking up" about perceived errors,[52,53] challenging authority and critical appraisal of information[54] within the framework of "evidence-based dentistry."

Finally, the dental students had several reflections about the *process of learning*. The majority of the dental students agreed that storytelling facilitated their reflection on their own clinical work. Interestingly, the storytelling sessions, although time-limited, appeared to highlight the longitudinal and formative dimension of training to become a dental professional. This included ideas about this process (of learning) stretching beyond the duration of their study programmes, and into life as a dental professional. As such, the EC training could be argued to have secondary outcomes that relate more to the importance of continuously developing skills and competencies, that is "lifelong learning,"[55] than to the overt learning outcomes in the here and now.

The majority of the participants in our study enjoyed listening, telling and preparing their stories, suggesting that this teaching technique is well perceived by students within dental education. This finding is in line with what has been previously described about the experience of storytelling in dental education.[56] Stories and experiences, when shared in a communal setting amongst those with similar backgrounds, tend to keep the attention and improve engagement. Whilst listening to a story is a tool to learn from other people's experience, telling a story may help making sense of own experience.[57]

As final considerations in this section, several limitations of the study will be addressed. The current study explored students' views on storytelling as a teaching method. Eight students volunteered to participate in the focus group, and there was only one focus group arranged. Therefore, self-selection bias may not be ruled out. Moreover, since only dental students were invited to participate in the focus group due to practical reasons, the views of dental hygiene students remain unknown. Furthermore, according to the results of the questionnaire, there was one student who reported that storytelling did not help to reflect over own clinical practice, and two students reported that they would not like to do storytelling sessions again. It would be interesting to explore the reasoning behind these answers, however, it is not known if these students participated in the focus group.

Only dental and dental hygienist students' views were explored in the current study. It would be interesting to investigate the dental staff's perceptions about storytelling as a teaching method for EI/EC, not at least since the dental staff role as supervisors was a topic that the students reflected about in the focus group.

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In addition, it remains unknown if intended learning outcomes were reached using this teaching method as no objective assessment was performed and there was no long-term follow-up. This would have been interesting to explore, especially because there were some students that expressed doubts about the learning outcomes. However, there is no consensus on the best tool to conduct such assessments.[58]

5 | CONCLUSION

Storytelling used as part of an EC course appears to have benefits for students' reflection about their role as dental health professionals. This teaching method was well-perceived by the students included in our study. This study contributes to the narrative dentistry field by bringing empirical evidence related to the contribution of storytelling as teaching method in dental education. We encourage the community to publish their experiences with using this method (for EC or other areas), in order to expand the knowledge database from which dental educators can draw on.

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CONFLICT OF INTEREST

The a uthors have no conflicting interest to disclose.

DATA AVAILABILITY STATEMENT

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

DISCLOSURE

Authors 1,2 and 3 has nothing to disclose.

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