Bullying as workgroup manipulation: a model for understanding patterns of victimization and contagion within the workgroup

Marie Hutchinson
Southern Cross University
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MARIE HUTCHINSON  RN,  P.h.D
Senior Lecturer, School of Health and Human Sciences, Southern Cross University, Lismore, New South Wales, Australia

Correspondence
Marie Hutchinson
School of Health and Human Sciences
Southern Cross University
P.O. Box 157 Lismore
New South Wales Australia 2480
E-mail: marie.hutchinson@scu.edu.au

Aim The aim of the present synthesis was to review the literature on bullying in the nursing workplace and develop an explanatory model for patterns of victimization and contagion within the workgroup.

Background Although research has demonstrated that bullying can cause significant harm there has been little investigation or theorizing into the place of the work-group as a vehicle for magnifying, transmitting or sustaining bullying.

Evaluation Narrative synthesis of the literature on bullying in the nursing workplace.

Key issues The putative model developed from a narrative synthesis of the available literature proposes four forms of bullying as workgroup manipulation.

Conclusions The model provides insight into mechanisms for the contagion of bullying and victimization within workgroups and an explanatory mechanism for the way bullying can escalate to implicate patient care.

Implications for Nurse Managers Recognizing workgroup manipulation processes and the patterns of victimization and contagion with the workgroup provides a deeper understanding of bullying and illustrates the place of intervention strategies which foster the emotional intelligence climate in nursing teams.

Keywords: bullying, horizontal violence, manipulation, nursing workplace

Introduction

The study of harmful behaviours in the nursing workplace has attracted a great deal of attention. Within this stream, researchers have studied bullying from managers, physicians and between nurses. Workplace bullying has been defined as a repeated and patterned form of psychological violence that involves power over another that is employed to victimize, undermine or intimidate and results in feelings of threat to personal wellbeing (Di Martino 2009). By definition, bullying incorporates the sub-set of behaviours that have been variously categorized in the nursing literature as horizontal or lateral violence, oppressed group behaviour, incivility, harassment, counterproductive behaviour and aggression.

For more than a decade a common explanation for the occurrence of hostile behaviours between nurses has been the theory of oppressed group behaviour and horizontal violence (Roberts 1983, Freshwater 2000, Vessey et al. 2010). These concepts have frequently been used to explain bullying between nurses who, as a result of their low personal self-esteem and poor group
identity, direct abusive behaviour towards each other (Roberts 2000, Corney 2008). Rather than being marginalized or oppressed, empirical findings have identified that nurses who engage in bullying may instead be popular, socially dominant and influential individuals who demonstrate high levels of social intelligence and opportunism (Lewis 2006, Hutchinson et al. 2009a). Employing sociograms to map workplace relationships in health care organizations, Hutchinson et al. (2009a) identified that actors implicated in bullying are often at the nucleus of organizational social relationships, in leadership positions or acknowledged as informal leaders or powerbrokers in workgroups. These findings are similar to studies of aggression among schoolchildren and adolescents where it has been reported that aggression is not a reaction typical of the socially marginal. Instead it is reflective of group status, with aggression escalating with increased peer status until one reaches the pinnacle of the group hierarchy (Farisa & Felmleea 2011).

Studies of adult aggression (Baumeister 1999, Björkqvist et al. 2000, Parkins et al. 2006, Dettinger & Hart 2007) and adolescent bullying (Birman et al. 2001, Kaukiainen et al. 2008) have drawn attention to the need to better understand the association between group status, social intelligence and aggression. Socially intelligent individuals are recognized as having well developed ‘theory of mind skills’ making them more attuned to the emotions and intentions of others, as well as enabling them to make accurate interpretations of situations, influence the emotions and behaviours of others and predict what others think or believe (Sutton et al. 1999, Kaukiainen et al. 2008). It is known those who are both socially intelligent and empathic are unlikely to engage in aggression, as empathy and care for others are at the core of pro-social forms of social intelligence (Björkqvist et al. 2000). Conversely, socially intelligent actors with low empathy are known to engage in covert and manipulative forms of behaviour that are counterproductive, harmful, self-interested and aggressive (Epley & Caruso 2004).

To date there has been limited investigation or theorizing into the place of the workgroup as a vehicle for magnifying or transmitting bullying. Little has been written about how socially intelligent adults can influence group dynamics towards their own ends, or engage in manipulative behaviours that draw others into condoning or participating in hostile behaviours which transmit the contagion of bullying within workgroups. Presented in the following section is a putative model that outlines mechanisms for the contagion of bullying as workgroup manipulation.

Understanding bullying as workgroup manipulation

The model presented in the present study was derived from a synthesis of bullying behaviours reported in the literature interpreted through the lens of socially intelligent behaviour. The proposed model details four forms of bullying tactic and associated behaviours that are characterized as forms of workgroup manipulation (Table 1). The tactics of bullying as workgroup manipulation described in the model are: 'Influencing': where those engaged in bullying embed covert forms of social manipulation and influence day-to-day work group interactions to shape the perceptions of colleagues; 'Persuading': where actors involved in bullying persuade others to believe and accept what has been suggested or witnessed; 'Rationalizing': where those who engage in bullying justify their behaviour by making it appear rational or warranted; and, 'Complying': in which individual co-workers who have become accustomed to bullying begin to frame the behaviour as normal or acceptable, which ensures their ongoing conformity with bullying.

Influencing

Workgroup forms of bullying are common among nurses, with studies reporting more than 80% of those surveyed experienced this form of bullying (Royal College of Nursing 2002, Yildirim & Yildirim 2007). A common experience in nursing teams are masked forms of bullying such as invalidation, isolation from the remainder of the workgroup, exclusion from information or activities, gossiping, subtle undermining or unwarranted criticism of individuals and their work (Yildirim & Yildirim 2007, 2008, Shellie 2008, Vessey et al. 2009, Hutchinson et al. 2010a). These behaviors have been reported to be initiated by individuals recognized as informal powerbrokers within the group (Hutchinson 2009b, Hutchinson et al. 2009a, Vessey et al. 2009). In the proposed model of bullying as workgroup manipulation these less overtly hostile and often covert forms of bullying are conceptualized as forms of influence.

When considered in isolation, tactics such as gossiping, harming perceptions about reputation, undermining others, subtle innuendo and social exclusion, can be considered forms of reactive aggression. However, when framed as socially intelligent behaviour perpetrated by actors who understand the desire of individuals to belong to a group these forms of relational aggression can be seen as acts that seek to influence others while at the same time socially excluding or
harming the social status of a targeted individual. Although influencing others and framing the target of bullying as somehow deficient or unworthy, individuals targeted are increasingly isolated from the social support of the group, made to feel less worthy and excluded, while the intent of the perpetrator is not visibly hostile.

Influencing the thinking of a work group by spreading gossip in an effort to shape the perceptions and behaviours of colleagues towards a targeted individual (or individuals) requires a sound knowledge of group processes and high levels of social intelligence. Nurses’ professional self-esteem is reflective of the beliefs they form about themselves largely constructed through peer interactions and feedback (Corney 2008). Socially intelligent individuals understand that acceptance within a group provides a sense of security and social identity (Penhaligon et al. 2009). Bullying tactics that influence workgroup behaviours erode this self-esteem and result in targets feeling isolated and excluded with reduced opportunities for mutual support and cooperation (Lewis & Orford 2005). The resultant feelings of blame, guilt or fear (Corney 2008) lead targets of bullying to display disengagement, avoidance and withdrawal in the workplace (Hutchinson et al. 2010a).

**Persuading**

Perceiving the shifting mood of the team towards a targeted individual, and understanding the desire for individuals to belong to a group (Björkqvist et al. 2000), those engaged in socially manipulative work group bullying create further opportunities to undermine targeted individuals by persuading others in the work group to believe what they have heard or witnessed (Corney 2008). Through repeated exposure to the influence of a socially intelligent actor who is able to strategically influence and manipulate the beliefs and actions of others, team members can be persuaded into taking part in the hostility. Scapegoating can also reinforce the marginal position of individuals and reaffirm a sense of group identity, loyalty and conformity.

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### Table 1

<table>
<thead>
<tr>
<th>Tactic</th>
<th>Description</th>
<th>Behaviours</th>
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<tbody>
<tr>
<td><strong>Influencing</strong></td>
<td>Use of subtle and barely discernible forms of aggression</td>
<td>Non-verbal intimidation displayed in front of other team members:</td>
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<td></td>
<td>Attempts to influence attitudes and perceptions of bystanders</td>
<td>Ignoring target’s presence</td>
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<td></td>
<td>Creating a perception that there is something ‘wrong’ with the target</td>
<td>excluding from conversation or activity</td>
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<tr>
<td></td>
<td>No one individual readily identified as the ‘face’ of bullying</td>
<td>Derisive tone of voice</td>
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<td></td>
<td></td>
<td>Eye rolling, sighing</td>
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<tr>
<td><strong>Persuading</strong></td>
<td>Individual leading bullying shapes the group agenda</td>
<td>Spreading rumours that damage reputation</td>
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<tr>
<td></td>
<td>Use of subtle but discernable forms of aggression</td>
<td>Innuendo and exclusion</td>
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<tr>
<td></td>
<td>Hostile intentions remain masked as being reasonable or justified</td>
<td>Creating perceptions of incompetence</td>
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<tr>
<td></td>
<td>Others are persuaded to believe what they hear and to accept what they are</td>
<td>Public commentary on alleged shortcomings</td>
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<td></td>
<td>told</td>
<td>Providing inappropriate feedback</td>
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<td></td>
<td>Coworkers begin to tolerate bullying as if it were normal</td>
<td></td>
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<tr>
<td><strong>Rationalizing</strong></td>
<td>Rational reasons are proffered for the bullying behaviours</td>
<td>Gossip backed up by an appearance of rational evidence</td>
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<tr>
<td></td>
<td>Bullying is framed as normal and permissible within the work group</td>
<td>Public statements that rationalize bullying behaviours</td>
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<tr>
<td></td>
<td>Coworkers begin to rationalize bullying (others and their own)</td>
<td>Legitimate organizational processes used to attack the target</td>
</tr>
<tr>
<td></td>
<td>Group begins to take a more active role in bullying behaviour</td>
<td>Work allocation reflects alleged incompetence or sets up individual to fail or force error</td>
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<td></td>
<td>Targets are viewed as deserving of blame</td>
<td>Targets branded and labelled as incompetent or ‘bad’</td>
</tr>
<tr>
<td><strong>Complying</strong></td>
<td>Others in the team become the ‘face’ of the bullying</td>
<td>Workgroup turns a blind eye to overt aggression</td>
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<td></td>
<td>Team members can be relied on to downplay the significance of bullying behaviours and support lead individuals</td>
<td>Favourable treatment for bystanders who are compliant or participate</td>
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<tr>
<td></td>
<td>Perpetrator is able to act with impunity, confident of their protected position</td>
<td>Perpetrator seen to fulfil a legitimate role</td>
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<td></td>
<td>Increasingly overt aggression tolerated by workgroup</td>
<td>Rule breaking and more high risk behaviors tolerated within the team:</td>
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<tr>
<td></td>
<td>It is advantageous within the group to support bullying</td>
<td>compromised patient care</td>
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<tr>
<td></td>
<td>(i.e. receipt of favourable treatment)</td>
<td>withholding clinical information to force error</td>
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<td></td>
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<td>overt misuse of legitimate processes</td>
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within the group by uniting individuals against those whom they blame or incriminate (Corney 2008). The process of influencing the perceptions of others and manipulating them to engage in acts of hostility requires not only the ability to understand how the perceptions of others are formed or shaped, but also the ability to shape and influence group values and behaviours (Kaukiainen et al. 2008).

By embedding bullying within a range of day-to-day interactions in the work team it is difficult for both targets and co-workers to discern the intent of the manipulation occurring. Denigrating another’s competence through influencing and persuading the work group without apparent anger or aggression, harms the targeted individual without bringing attention to the intent of the perpetrator. Persuaded that the targeted individual is somehow less worthy, bystanders begin to engage in behaviours indicative of disdain or intolerance such as repeatedly ignoring the targets presence, loud sighing, eye rolling and other facial gestures (Lewis 2006, van Heugten 2010). As a result of the subtle, repeated and incremental nature of this exposure workgroup members may be unaware that they are being influenced or persuaded in this way.

The ability of individuals to manipulate work group interactions and eventually persuade the group against those targeted relies upon the successful concealment of any hostile intent. Randle (2003) characterized nurses who bully as manipulative with good social skills that enable them to build supportive cliques. They often choose their targets from the most vulnerable in the group or those who lack established relationships. Among newly licensed nurses the experience of bullying includes being isolated, lack of support and being set up to fail through allocation of demeaning or more intense work by cliques of colleagues (Simons & Mawn 2010). Reports of nurses devaluing other nurses and publicly commenting on alleged shortcomings are also commonplace (Vessey et al. 2010). Character assassination, put-down, ridicule or contempt (Felblinger 2008) can be embedded into day-to-day workgroup interactions and if repeated often enough they become taken for granted or normalized behaviours.

The manipulation of the workgroup in this way serves to pull together a core group, while outcasting others who are framed as unwanted or less worthy. The power of these more subtle forms of behaviour comes from them being witnessed, with many nurses having witnessed a colleague being bullied (Royal College of Nursing 2002, Hoel et al. 2007, Yildirim & Yildirim 2007, Vessey et al. 2010). The calculated ability of the perpetrator to influence others may be so skilful that these actions go unchallenged or fail to be recognized as hostility or bullying.

**Rationalizing**

Influenced or persuaded to condone bullying, individuals can be further socialized within the workgroup towards a more active role in hostility through rationalizing, such as framing others as somehow deserving of mistreatment. By labelling or blaming in this way, co-opted individuals can avoid connecting their own actions with the moral categories of right or wrong (Adams & Balfour 1988). Employing balanced arguments as to the deficiencies of the target, while concealing any hostile intent, rationalization can convince others of the merits of the information put forward against the target. By offering convincing arguments to others, further exclusion or hostility towards those targeted can be made to appear justified and tactics such as allocating demeaning or less responsible work to a targeted individual can appear rational or reasonable. Through rationalizing individuals effectively separate themselves from any wrongdoing they may have participated in.

It is known that influential workgroup actors can engineer relationships, attitudes and rationalizing belief systems that encourage others to also adopt and condone antisocial behaviour (Robinson & O’Leary-Kelly 1998). Among nurses it is recognized that clique formation is a pervasive means of marginalizing those perceived as different (Farrell 2001, Lewis 2006). Those who do not conform to accepted team norms can be targeted through payback and sabotage, placing them under further pressure and making their work life more difficult (Jackson et al. 2010). Rationalization strategies can be employed by both actors engaged in bullying (to convince others that what they were doing was normal and acceptable) and co-workers (to enable them to reduce any feelings of guilt and dissonance that may have been experienced about the hostile behaviours that they were witnessing taking place). With targets isolated from the social support of their colleagues, demeaned and their competence questioned, unsubstantiated attacks can be escalated to involve legitimate workload, complaint or performance management processes, with this appearing warranted (Yildirim & Yildirim 2007, Simons & Mawn 2010).

**Complying**

The concept of compliance within the workgroup provides insight into the often reported phenomena that nurses who witness bullying do little to intervene in
support of a targeted colleague (Woelfle & McCaffrey 2007). Although individuals may initially abhor bullying, or have been targets of bullying themselves, they may become compliant once they learn from others and eventually gain power or status within the workgroup (Lewis 2006). Over time, exposure to increasing levels of hostility can have a normative effect, shaping socialization processes (Robinson & O’Leary-Kelly 1998, Hutchinson et al. 2006) and dulling the awareness of team members that bullying is not acceptable (McKenna et al. 2003, Curtis et al. 2007, Corney 2008, MacKusick & Minick 2010, Simons & Mawn 2010). Those recruited into tolerance and complying through repeated exposure and low-level participation must first acknowledge their involvement in passive acceptance or more active participation if they are to speak out or act against further hostility, which may precipitate feelings of guilt, shame or remorse. In such situations of dissonance individuals are known to adopt rationalization strategies to justify their inaction and reduce their own remorse and psychological discomfort (Anand et al. 2003).

Those new to the workgroup can be socialized into norms tolerant of bullying either through becoming targets of bullying or through recurrent exposure to others bullied. In nursing teams newcomers are reported as experiencing hostility, and those who challenge the status quo are neutralized through hostility (Daiski 2004). Bullying has been reported to be normalized to the extent it is normalized and considered a part of how work is done. This is reflected in a previous study by Hoel et al. (2007) that reported the changing attitudes towards bullying held by student nurses. Behaviours such as intimidation, ignoring colleagues requests for assistance and isolating or refusing help have been reported in nursing teams (McKenna et al. 2003, Corney 2008, Curtis et al. 2007, Simons & Mawn 2010).

In work groups characterized by low emotional intelligence, it has been reported that individuals can be persuaded to participate in less ethical behaviours (Ayoko et al. 2008). Previous studies have identified sabotage and payback within nursing workgroups that involve acts that impede the delivery of care (Hutchinson et al. 2010a, Jackson et al. 2010) or are directed towards nurses who speak out about actions that compromise patient care (Farrell 1997, Jackson et al. 2010). The likelihood of nurses engaging in unethical behaviour is reflective of the influence of peers and perceptions of the team ethical climate (Deshpande & Joseph 2009). Studying student nurses, Randle (2003) described eventual conformity to ‘accepted’ behaviours initially considered shocking including humiliating, isolating or belittling patients.

Randle (2003) and Dietsch et al. (2010) reported nurses’ displays of confidence in group compliance with power used openly to publicly humiliate, belittle and isolate patients. Other behaviours that reflect group compliance in the contagion of bullying include deliberately withholding or refusing to pass on relevant clinical information with the aim of making work difficult for targets, placing someone under pressure by allocating them work for which they are not skilled or attempting to force an error (Corney 2008, Hutchinson et al. 2008, Jackson et al. 2010, MacKusick & Minick 2010). Within the workgroup, complying is further assured through favourable treatment of those who engage in or condone bullying. Reported in the nursing literature are ‘rewards’ for clique members such as committee membership, attendance at training, preferable roster allocations, preferable meal break allocations or a lighter workload (Lewis 2006, Hutchinson et al. 2009a). In light of the proposed model, such favourable treatment can be seen as a means of securing team members ongoing compliance, with individuals likely to act to preserve self-interest rather than addressing the unfavourable treatment of colleagues.

Intervening and responding to bullying as workgroup manipulation

Halting the process of workgroup manipulation requires a different response to prohibitive or zero tolerance policies or mediation between two parties. At the workgroup level, a first step in breaking the cycle of manipulative bullying is for individuals to understand the place of bystander non-intervention in escalating unacceptable and hostile behaviours. While one or more individuals may take a lead role in perpetrating bullying, the majority of behaviours that constitute bullying require others to witness or participate in some way.

As highlighted in the proposed model, the power of much bullying comes from the passive or active involvement of others. Individuals within workgroups need to understand that remaining passive is not simply a neutral or harmless act. The destructive force of bullying behaviours is magnified by avoidance, which enables the perpetuation of influencing and persuading tactics within the workgroup. Nurse managers might usefully explore strategies to foster the emotional intelligence climate of a team including factors such as team empathic concern, team emotions management and team conflict management norms (Ayoko et al. 2008). It has been demonstrated that the emotional
intelligence and ethical behaviour of peers has a significant impact on the ethical behaviour within nursing work teams (Deshpande & Joseph 2009). In work teams, higher emotional intelligence has been linked to improved team collaboration, higher job satisfaction and lower turnover (O’Boyle et al. 2011). Fostering the emotional intelligence climate as a moderator of workplace bullying and focusing upon emotionally intelligent leadership strategies to influence the emotional climate of workgroups is likely to create a climate less conducive to manipulative behaviour.

In responding to incidents of bullying as workgroup manipulation strategies are required that foster a workplace climate that is socially just. Restorative approaches have been widely used in schools and the juvenile justice context to address bullying, with suggestions the approach could be employed within the nursing context (Braithwaite & Ahmed 2005). The restorative approach requires all of those who have a stake in the wrongdoing or who have been harmed to come together and collectively identify strategies to address the harm caused; and re-integrative shaming, which requires those who have engaged in wrongdoing to openly acknowledge to those affected by their wrongdoing while also demonstrating acceptance of their responsibility to make amends into the future (Braithwaite & Ahmed 2005). Employed to address manipulative workgroup bullying, restorative circles or restorative conferencing are a strategy that seeks to foster a supportive context for individuals within the workgroup to be made accountable for their actions and the harm caused by their behaviour (Braithwaite & Ahmed 2005). While the process shames perpetrators, the supportive group context provides avenues for collegial support and collective action with the aim of establishing respectful workplace behaviours (Hutchinson 2009b, p. 151). Rather than mediation between two individuals, which does little to address the workgroup processes that enable or condone bullying, the broader workgroup involvement employed in restorative processes creates opportunities for the workgroup to develop consensus on key values and create a safe space to reflect upon unacceptable behaviour in a non-punitive environment.

Discussion
In spite of the pervasive nature of bullying, little attention has been given to understanding workgroup processes that perpetuate the behaviour. The proposed model illustrates how workgroup manipulation can be a mechanism for bullying that is characterized by coercion and disregard for the harm caused to others. Engaging in this form of bullying, individuals may manipulate others for self-interest or as part of a competitive strategy (Katrinli et al. 2010). On the other hand, the desire for individuals to belong to a group is strong, even when it involves tolerance or participation in wrongdoing. Similar to the group processes that operate in situations of organizational rule-breaking (MacLean 2001), white collar crime (Coleman 1987) and corruption (Ashforth & Anand 2003, Hutchinson et al. 2009a), those exposed to bullying may be motivated to avoid workgroup rejection leading them to tolerate or engage in unacceptable behaviour.

The process of influencing, persuading and rationalizing detailed in the model presented in the present study provides a possible mechanism for how individuals exposed to manipulative workgroup bullying may be less likely to initiate remedial actions. Working in a group under the influence of an actor who is socially intelligent and engaged in bullying, the moral compass of group members can be subverted by normalized, destructive work group dynamics, especially as they operate and escalate over time (Schein 1999). Alternatively, individuals may be persuaded to take part in bullying through fear of rejection or workgroup mistreatment (Penhaligon et al. 2009). In this way, bullying can be a form of a strategic emotional game played out to assert power over others and influence attitudes and opinions. Once enmeshed in this process, co-workers can be influenced to engage in more destructive and overt bullying acts.

The proposed model raises an important ethical issue, those who engage in manipulative bullying may not only degrade or humiliate their colleagues, the ethical climate of the work team may be eroded to such an extent that it paves the way for patient care to be implicated in the hostility. Repeated exposure to negative emotions and conflict can lead to contagion of victimization across the workgroup (Contractor & Monge 2002). By eroding trust and support within the workteam, manipulative bullying may reduce the likelihood of positive citizenship behaviour within workgroups. It is recognized that organizational citizenship behaviours are important in professions such as nursing, which is characterized by high levels of reciprocal interdependence, work complexity, uncertainty and rapid change (Zellars et al. 2002, Spence Laschinger et al. 2009).

While the proposed model explores socially intelligent workgroup manipulation as an explanatory framework for bullying it is important to recognize that certain organizational characteristics may increase the
likelihood of this type of behaviour. Health care organizations are characterized by rapid change, frequent restructure, workforce downsizing, rapid throughput and resource scarcity which sustain a climate that is stressful and competitive. There is a dynamic relationship between exposure to violence, aggression and bullying and organizational chaos, with exposure more likely in the context of the latter (Roche et al. 2010). The backdrop of resource scarcity or turmoil creates a situation ripe for socially intelligent individuals to engage in manipulative forms of bullying.

Conclusion
The proposed model draws attention to the ways in which individuals who engage in manipulative forms of workplace bullying can shape workgroup dynamics. Self-interested individuals may deliberately engage in and incite aggression which erodes the social fabric of work teams, undermining teamwork, social support and communication and creating a toxic environment. The eventual compliance of team members to the regime of bullying sets the scene for an escalation of behaviours towards a tolerance of more high-risk activities such as sabotaging work in ways that potentially impacts on patient care or the abuse and mistreatment of patients. Once set in motion, this form of behaviour may create a self-perpetuating cycle of hostility that has the potential to undermine the moral fabric of work teams.

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