COVID CONFESSIONS: healthcare professional stories from the frontline

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Abstract

Objectives: to gain an anonymous insight into the experiences and concerns of front-line health workers while caring for patients with covid-19

Design: A qualitative analysis of data collected through an anonymous repository of uncensored covid-19 experiences of frontline workers, accessed via a link advertised on the twitter feed of two high profile medical tweeters and their re-tweets. All NHS workers involved in the care of covid-19 patients, however remotely, were invited to take part.

Setting: community of NHS workers who accessed this social media.

Participants: 54 health care workers, including doctors, nurses and physiotherapists, accessed the website and left a 'story'.

Results: The length of stories ranged from one (expletive) word to 10 minutes of verbal storytelling. Thematic analysis identified a number of common themes across the stories, with a central underpinning aspect being the experience and psychological consequence of trauma. Specific themes were: (i) the shock of the virus, (ii) staff sacrifice and dedication, (iii) collateral damage ranging from personal health concerns to the long-term impact on, and care of, discharged patients, and (iv) a hierarchy of power and inequality within the health care system, and beyond.

Conclusions: Covidconfidential gave an outlet for unprompted and uncensored stories of health care workers in the context of covid-19. While stories of trauma may be expected, stories reflecting perceptions of poor management, inequalities of power between management and front- line workers, across professions, and across ethnicities identify remediable concerns that need addressing as a matter of urgency.

Article summary

Strengths and limitations of this study

- The covidconfidential website provided a safe context in which participants could offload stories of the care of covid-19 patients with no fear of personal consequences.
- The unprompted nature of the process that the stories they told were those that were most important to them.
- Recruitment via twitter resulted in a biased sample, largely comprising medical personnel and twitter users.

Funding statement

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors'

Competing interests

No author has any competing interests in relation to this research.

Key words

Covid-19 qualitative health care workers trauma

Word count

4112 words

Introduction

There are limited qualitative data describing health care professionals' experiences during the Covid-19 pandemic. One small Chinese study by Liu et al.[1] reported core experiences to include duty of care, exhaustion due to heavy workloads and protective gear, fear of becoming infected and infecting others, feeling powerless to handle patients' conditions, and managing relationships. Social support was vital to managing their emotions. In a larger study of Flemish primary care doctors, Verhoeven et al.[2] found high levels of concern over becoming infected, the emphasis on managing respiratory issues at the cost of non-Covid-19 problems, and the mental health consequences for vulnerable individuals. Sethi et al.[3]'s study of 290 Pakistani health professionals found unprecedented workload and overstretched health facilities to be the dominant issues.

Caring for patients with Covid-19 can be highly traumatic and may trigger significant future problems including post-traumatic stress, depression and health anxiety [4-5]. One way in which military and emergency sectors have responded to working in traumatic environments involves a process known as 'clinical debriefing'. This is intended to dissipate the immediate stress by talking, thinking, or writing about the experiences[6].

We have previously described a simple online method of facilitating such interactions (*covidconfidential*), which has proven of modest immediate psychological benefit[7]. This was advertised via the social media platform Twitter and encouraged health care workers of all types to engage with a simple procedure in which they recorded their experiences verbally or in written form. Participants were given no explicit instructions on issues to raise or identify; simply to recount their experiences, as a means of offloading any negative emotions they may have been experiencing at the time, in an uncensored form. The primary aim of this project was to offer a simple, accessible method of addressing the trauma of working during the Covid-19 pandemic. However, it also generated an anonymised repository of stories which identify the issues most pertinent to those using it. Through

this methodology, the data generated have a purity that data obtained in formal interviews lack, since much information in this context may be responses to prompts by the interviewer, and while relevant may not be of prime importance to the person being interviewed.

We therefore sought to better understand the self-declared experiences of healthcare workers from the frontline of the Covid-19 pandemic.

Methods

Ethical consent for the study was granted by the ethics committee of the Department of Psychology, Swansea University: approval number 4484. Patients and public were not involved in in the design, or conduct, or reporting, or dissemination plans of our research.

Participants

Fifty-four health care workers involved in the care of patients with covid-19 told their story on the study website: covidconfidential.co.uk. Of these, 27 were doctors, 13 nurses, two physiotherapists, one radiographer, one health care assistant, and 10 'other'. There were no exclusion criteria.

Data collection

Participants were recruited via Twitter, initially through the tweets of two doctors (intensive care and palliative care consultants) involved in the project with a cumulative following of 38,000 users. Targeted tweets regarding the project were also sent to medical Twitter "influencers", with requests for retweeting and further dissemination. The tweets invited NHS colleagues to take part in a study in which they could offload their experiences of care of patients with Covid-19 both as a potential means of dealing with stress and as a way of anonymously recording their experiences. Once at the site, potential participants completed a digital consent form after which they completed a minimal demographic questionnaire (work role, gender and age), before recording their story either verbally or in written form using the videoask.com website (accessed via confidconfidential.co.uk) which provided transcripts of verbal stories. There was a 5-minute time limit for recording. Most interactions were complete within this timeframe. One participant repeated this process to record 10 minutes of story. All audio recordings were deleted once transcribed.

Analysis

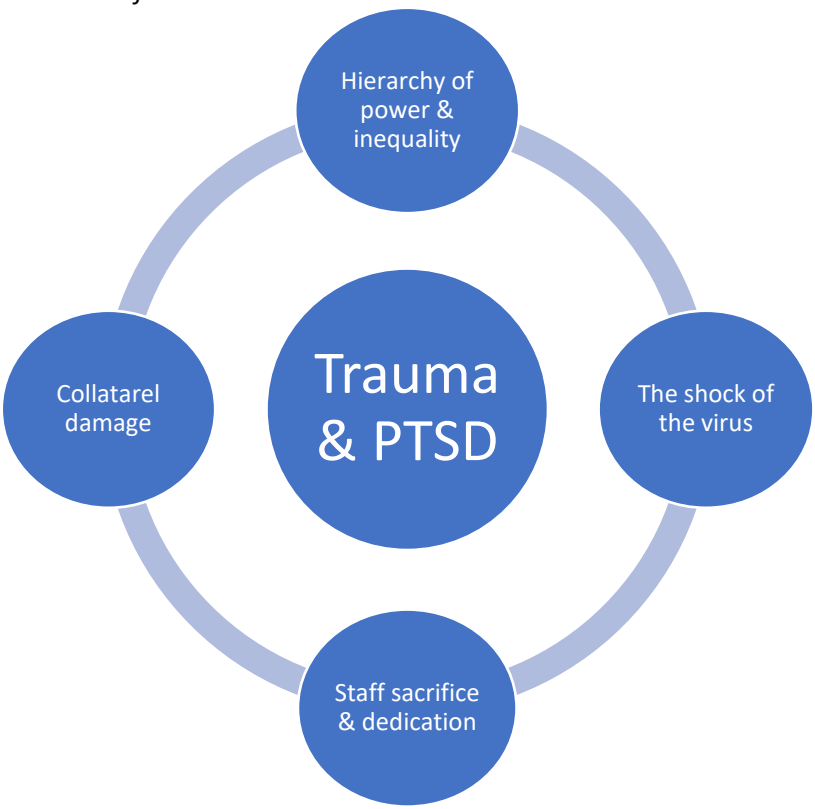
Transcripts of all audio and written data were analysed using the inductive thematic analysis of Braun and Clarke[8]. In this, transcripts were read repeatedly to ensure accuracy and enable the identification and generation of relevant initial codes and textual units for features and patterns in the data. Extracts and phrases were used to identify potential themes, with relevant data ('quotes') gathered within identified themes. Initial analysis was conducted by RH and the data were systematically reviewed by PB and others in the team to ensure that a name, definition, and exhaustive set of data were identified to support each category.

Results

Thematic analysis revealed five themes which appear central to understanding the experiences of these frontline health and social care staff during Covid-19: see Figure 1. Themes are supported by

verbatim quotes which also identify the role of the participant and the line/s at which the quote can be found in the raw data.

Figure 1: The five themes identified



Trauma and PTSD

Participant accounts clearly identified a paradox for many working on the frontline during Covid-19. Their work was both immensely rewarding and profoundly traumatic. However, the costs frequently outweighed the emotional benefits. Many talked about *feeling "broken" (Doctor, 197)* by what was described as *"the horror that is Covid-19" (Nurse, 491).* This language of annihilation was used to depict how "*we ended up smashing ourselves and our trainees to pieces to get a vaguely safe rota" (Doctor, 322)*. The working environment was brutal, and staff reported regularly feeling inadequate and overwhelmed: "*I felt so inadequate and tried my very best to make sure these poor patients had anticipatory medication. Staff were in tears and I watched a group of cardiology nurses cry as they tried to cope with patients with severe Covid". (Nurse, 737-737).* The impact of working on the frontline in this pandemic was described as "*affecting staff mentally, emotionally, psychologically and physically*" (*Nurse, 303-304).* Symptoms of post-traumatic stress were common, with descriptions of intrusive, vivid and traumatic thoughts or memories, as well as emotional numbing:

> *"I think what I really feel is quite numb" (Nurse, 802)*

"I think about it all the time. I think about all those people that died in the beginning alone. And I also really think about the patients that we discharged who are with us for 50 odd days who will never ever get back to what they were like before." (Physiotherapist, 38-40)

"Nothing will ever prepare a person for having to tell a family their loved ones have died over the phone or standing there holding an ipad as they watch their dad pass away via a video link." (Nurse 492-493)

Participants also reported a wider impact on their life and relationships whether in the short-term "*I'm actually hiding from my family a little bit." (Nurse, 803); "My partner is now, uh, moved out. So, uh, it's had a huge impact on my life."* (Doctor, 615-616*))* or thoughts of the future: *"I think I will be revaluating my career path after this." (Nurse, 223).*

Patient trauma was also highlighted, with devastating descriptions of psychological trauma among surviving ITU patients:

"They don't sleep. They have nightmares. They think that you know, one man doesn't sleep because he's worried that if he goes to sleep he'll never wake up again. Another man still thinks sometimes that his family are dead or that he, you know, his family sold him to some sort of slave trader, you know, those delirium kind of nightmares just haven't gone away." (Physiotherapist, 57-61)

The 'shock' of the virus

Frontline medical staff described how they had "*never seen so many…so many people who were so sick." (Physiotherapist, 4-5); "some of the sickest I've ever seen." (Nurse, 467-468).* Staff were shocked by the physical and psychological brutality of the virus; separating families in their most desperate hour.

"They were the most sick people I've ever seen and there are so many people dying and we weren't allowing any visitors. The thought of people saying 'bye to relatives via Skype just absolutely broke me every single day, and I cried and cried and cried about it when I got home." (Physio, 8-11).

Staff were often shocked by who was vulnerable to the virus. One participant described how *"we are getting our eyes opened because this disease does not discriminate." (Other, 777).* Indeed, some were shocked just how many young or middle-aged people were affected: "*And young people! Not as the media would portray these elderly vulnerable with underlying medical conditions." (Doctor, 171-172).*

Covid-19 does, however, disproportionately affect older people and this rendered many senior clinicians as highly vulnerable and consequently impacted on workforce availability:

> *"We were told of course that it should be the most senior person intubating, but also that they were the people probably at highest risk! And so I can see the look almost a fear in the eyes of some of my consulting colleagues." (Doctor, 182-184)*

There was broad agreement that services were "unprepared" for Covid-19, personally and organisationally:

> *"I certainly wasn't prepared for the horror that is Covid-19, anyone that says they were is a liar." (Nurse, 490-491)*

> *"Before the government announced anything we pulled together a team as we realised we could quickly be getting cases but were not prepared for it." (Nurse, 904-907)*

Living and working through this pandemic was described as "*a world disaster. Hopefully once in a lifetime experience." (Doctor, 429),* but also a shared experience that patients and frontline staff had faced together:

> *"I found myself on a night shift on ITU with a gentleman on everything. 'Kid, you shouldn't be here, and I shouldn't be here'. And how weird and strange it was that we were both here!" (Nurse, 807-809)*

Staff sacrifice and dedication

The dedication of staff and commitment to fulfil their duty of care was described as "*Herculean…the extra work and hours that have been put in to support the NHS." (Nurse, 930-931).* This is in spite of the practical and emotional challenges faced:

> *"My clinical colleagues have been unbelievable. Adaptable, honest, efficient, true to patient need. Facing fear head on. Maintaining polite lines of conversation despite internally screaming at management types that it's too little, too late." (Doctor, 449-451)*

"We have bent over backwards to flex towards patient need. At less than 6hr notice not infrequently. Many of us now have Covid but there hasn't been a shift unfilled. We want to step up to demand, for our patients and organisation. Yet.... HR are demoralising us." (Doctor, 193-196)

Fears of infection were influenced by experiences of caring for the most unwell patients. People felt that while the risk of infection "*was something that was inevitable." (Doctor, 886)*. Many were terrified and traumatised:

"If I'm not crying because I'm scared of getting ill or infecting my loved ones, then I'm awake at 3am after hearing families sob their hearts out because they cannot hold their loved ones in their last moments." (Nurse, 493-496).

Importantly, the unprecedented and unique challenges of Covid-19 meant that new ways of working have to be adopted and standards may be compromised:

"You have to change the way they are nursed, they don't respond to things in the usual way or within usual time limits. This is hard when you've spent years learning now best to do something, it's like you're new to ITU again." (Nurse, 467-470)

"They can't work within their values. They can't do the care they want to provide. And I've been talking to them [staff] a lot about seeing that feeling as 'moral injury' because that's what they're experiencing." (Doctor, 895-897)

At the heart of testimonies, however, were descriptions of patient focussed care with many describing being *"proud of myself" (Nurse, 594)* and how *"my patients are hugely important to me, at these times more than ever. I have a personal responsibility to them" (Doctor, 427-428).* This dedication was also seen in the descriptions of *"a kind of survivor guilt" (Doctor,645)* when forced into redeployment due to health risks. Herein staff were left feeling "*worthless and guilty about not doing my bit for the NHS." (Doctor, 708).*

Collateral damage

Participant accounts were punctuated by regular descriptions of the repercussions, or 'collateral damage' of Covid-19. This ranged from the "*inevitable" (Doctor, 886)* nature of contracting the virus, to inappropriate levels of risk forced upon staff:

> *"We wanted to make changes but were not heard. We've had staff die on our wards. I was reprimanded for wearing gloves and a pathetic 'pinnie [apron] on the ward before one member of staff member died, because it wasn't approved policy yet and we would worry patients." (Doctor, 451-454)*

There were frequent concerns relating to marginalised and vulnerable groups, with reports of inadequate risk assessments as well as a description of inappropriate 'do not resuscitate' instruction both highlighted:

> *"The response of my organisation to the employees of BAME origin has left me feeling bitter. In fact; appalled. My colleagues deserve so much more than a prefilled risk assessment, sent awaiting a signature. Surely inviting a person to discuss is the first point of any risk conversation. WHY WOULD THIS EVER BE OVERLOOKED?! We have lost three staff... How many more!" (Doctor, 208-212)*

> *"My work is with people with learning disabilities and I have seen how they have been marginalised even more than they have been prior to the advent of the pandemic. I have been asked on more than one occasion to clarify DNAR status when I believe that this is inappropriate." (other, 580-583)*

Significantly the health repercussions of continued lockdown, as cases of Covid-19 declined, were indicated as being serious and far reaching for people with mental health issues:

> *"Only two patients on ITU have Covid. The rest are people at deaths door from suicide attempts. All have a history of mental illness, all known to mental health services. All having had a sequential deterioration over the lockdown period with reduction in mental health support services, community projects, peer support, drop ins etc. What I am seeing is the tip of the iceberg: those whose suicide attempts are not successful but bad enough to need ITU. What of all the others who are managed on non-critical care beds? What of those who are*

turned around quickly in A and E in order to minimise admissions. We are beginning to get a picture of the knock-on effects of this pandemic." (Doctor, 134-141)

Some participants felt that responses to Covid-19 and the subsequent reorganisation of services had led to some poor decision-making which was affecting patient care broadly, with *"people coming in with very serious problems which were being missed" (Doctor, 500-503)*. Relatedly, inadequate assessment of risk for patients and their places of discharge was also described, highlighting the context of services already struggling to cope before the pandemic:

Something that usually takes years in the NHS happened over night with not enough realisation at the top of organisations quite what was happening. The government encouraged discharges to care homes with no testing system in place, saying it was low risk (Nurse, 913-918) #

Where's the support going to come from for these people? There are no Community Services! You know, we're discharging people to their homes and there's no physio. There's no OT. There's no carers. There's no psychological support. […]. You know that there was never any of their stuff for people that have had lengthy ITU days before; this is not a new thing but there's just so many of them now (Physiotherapist, 68-73)

It seemed impossible for these concerns to be raised without it being regarded as critical and unhelpful for morale:

"I also think is a problem that people are able to accept that we are providing substandard care to everyone other than those with Covid. It, um I don't know what the solution is. It's very hard knowing how to raise this. Not so much a whistleblowing as it was, just a public safety issue. But people <u>are</u> working hard. People are getting tired now and the last thing they need is for people to turn around and say, 'Oh, by the way, you're all crap'." (Doctor, 513-517).

Hierarchy of power and inequality

There was a widely reported disconnect between senior management and frontline staff, with clinicians' views and requests frequently reported as being disregarded:

"We weren't prepared. We were not ready. Immediately before the first wave hit our Hospital, we'd been begging Hospital management staff to cancel elective surgery because we started to see cases and we knew what was coming. They ignored our requests." (Doctor, 158-160)

"I'd like to be able to say, 'in hindsight, we would have done differently'. The fact is, us clinicians knew all along at the time. And our voices were quashed in a sea of management meetings, who frankly were rearranging deckchairs rather than encouraging us to make the changes we needed to make. Exec. teams must be led by clinicians and supported by managers. Not vice versa. I'm angry because I believe we were not heard." (Doctor, 455-460)

Participants felt that risk was disproportionately assigned to the frontline and that those who were most vulnerable were not adequately protected:

"I work with others that have a lot to lose. Either from ethnicity, age, comorbidity. And yet they show up day after day. Certain senior colleagues have vanished under one guise or another. What gets my goat is their instructions, advice and criticisms from afar. They are largely white. Sadly, more men than women too." (Doctor, 412-415)

"Covid-19 has exposed innumerable inequalities. I thought I was aware. I am not. I'm learning that organisations are powerful. How do the BAME frontline workers get heard?!" (Doctor, 212-213)

"If anything, please can we take from this, that a white middle class manager, working from HOME has absolutely NO PLACE in assigning risk to any front-line staff seeing febrile and sick unscreened patients daily. That has happened to BAME employees in my organisation." (Doctor, 417-420)

Many participants felt abandoned by their organisation and "*poorly supported trainees felt like being left as sacrificial fodder" (Doctor, 722-724).* Frequently frustrations and conflict emerged between staff groups, notably where GPs "*won't see anyone but us nurse practitioners are expected to" (Nurse, 126-127).*

While some participants did report cohesive and supportive team working and management, the majority described a sense of abandonment by management and described anger that *"the government failed us all" (Nurse, 929).* This lack of support, combined with high levels of trauma

created a sense of feeling hopeless and left many staff feeling disillusioned about their career and organisation:

> *"I've never felt more detached from senior management. After this is over, I'm going to seriously reflect on whether I feel this is an organisation I want to work for and with. I'm seeing it in a different light. I no longer think this is for me." (Doctor, 291-294).*

> *"The "talk" of management has been great, especially as staff died. Their actions however have been pitiful. In fact, insulting to those that have died as both patients and staff. Yet I have very limited faith anyone will personally realise, what they could have done which would have helped (Doctor, 421-424)*

There was a sense of staff waiting for government guidance which was *"non-existent but then came thick and fast - as soon as you implemented something everything changed again" (Nurse, 913-914)* and this fuelled anxieties about best practice. More broadly, staff felt a personal mistrust of government. One particular "flash-point" for these views emerged around publicity regarding a senior government advisor, Dominic Cummings, who apparently broke lockdown rules:

> *"We want proper credible leadership which listens to experts, values its staff and its population. I don't think I have ever been so angry with a government as this one over their behaviour over Covid-19" and Cummings in particular (Doctor, 144-146)*

> *"Families were giving up so much! And in fact, this one [paediatric oncology patient] may have limited time left …. Was giving up so much! And this man [Dominic Cummings] is allowed to break rules with impunity and treat the public with such disregard and such contempt that they feel like they can get away with it. Really?! …um I think the experiences I've had the last few weeks have been very, very different to any I've had before. And it feels quite personal when Dominic Cummings is being defended on TV by the Prime Minister." (Doctor, 382-387)*

Discussion

To a large extent, the results speak for themselves, and require no embellishment. While the health care workers who told their stories did experience intense positive emotions, caring for Covid-19 patients brought a significant emotional toll and strained relationships between immediate front-line staff, their families, management, and even government. There is a sense that in the beginning of the epidemic staff were driven by adrenalin and optimism, but over time this dissipated to be replaced by

exhaustion, numbness, and dread expectation of a 'second wave'. The stories reflect not only the personal horror of caring for profoundly ill patients who were not responding to treatment, they also reflect wider societal concerns. In particular, the failure to test older people being discharged to care homes, and the now unfolding evidence of the need to provide long-term care for many people discharged from hospital: a key future challenge for the NHS, particularly at a time when there needs to be 'catch up' in the care of other patient groups whose treatment has been delayed as a consequence of Covid-19. Finally, the Dominic Cummings 'affair' has been seen as a key turning point in the population response to the epidemic. It resulted a loss of trust in government and reductions in levels of protective behaviour[9]. The anger towards his behaviour and the Government's response to it was palpable.

The responses to these stories are complex and multi-factorial, not always easy to implement in a rapidly changing context at a local level. But some can be addressed. Clearly, there is a need for staff having proper and effective protection and working rotas that permit time off and rest. However, at a more systemic level, the voices of workers at the front-line need to be heard. There are clear rifts between 'workers' and 'management', senior and junior colleagues, and those with more or less power within the system. This means that essential clinical expertise in how the organisation should respond to the crises has been lost. While these may not be novel findings in the NHS, they are amplified at a time of crisis, and cannot be ignored. Pathways of communication between each group, and sub-groups within them such as people from BAME backgrounds or those with legitimate personal health concerns, need to be established or re-established and respected.

As with all studies, the data needs to be viewed within the limitations of the study. Firstly, the National Health Service comprises over 1 million staff, including over 112,000 doctors and 310,000 nurses and the data reported purport to represent all views. Secondly, sampling strategy whilst disseminated widely, was initiated through two doctors' accounts and this may have led to the sample being doctor "top-heavy". Furthermore, there is likely to be a degree of sampling bias since Twitter use and, in particular, active engagement with Twitter is likely to be restricted to a particular cohort of the healthcare profession. Finally, whilst every effort was made to simplify the "Covidconfidential" website, engagement still required a degree of effort and it is possible that the views expressed represented the more extreme experiences leading to the most motivated participating.

Despite these limitations, there was strong concordance between experiences suggesting these concerns, whilst extreme, are likely to be true and we ignore these reported data at our peril. Behind many well publicised healthcare scandals, opportunities to address serious concerns have been missed by those who have dismissed concerns on the grounds they have been raised by a small number of vocal individuals. It is also important to consider that loyalty and fears of

legal/organisational repercussions may result in understandable silences among many NHS workers. This suppression denies access to honest descriptions form staff from which many important lessons can be learned. This confidential and anonymous method of data collection enable us to bypass that censorship and as such, the data collected here holds valuable information which cannot be ignored.

What is also evident is that workers have been highly traumatised and there a significant proportion of testimonies which included plans or potential plans for leaving the organisation and professions after the pandemic. This reflects not only the extent of trauma but also points to significant concerns for the retention of staff within organisations. Accordingly, health care providers need to consider how to mitigate this impact. Such mitigation needs to start at the workplace. Staff should be confident that their needs are being respected and feel safe within the working environment. In addition, the toll of continuous engagement with Covid-19 may be mitigated by rotating staff in and out of caring for Covid-19 patients where possible, and holidays becoming mandatory. Psychological care should be easily accessible in a timely manner should this be required.

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Author statement

Bennett: lead author of submitted paper, study design.

Hunter: led analysis, contributed to study design and final submission.

Johnson: website design, set-up, and contributed to final submission

Noble: contributed to study design, analysis and final submission.

Jones: contributed to study design, analysis and final submission.