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Selected Aspects of Nurses' Burnout Compared to Other Employees of Social Welfare Homes

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Abstracts

Introduction: The staff of social welfare home is exposed to the phenomenon of occupational burnout due to the specificity and characteristics of social welfare homes functioning. In social welfare homes there are people covered by 24-hour nursing and rehabilitation care, which required a significant amount of work on the part of the staff of such a centre. Nurses in their work constantly encounter situations which result in experiencing professional stress, which in turn results from the contact with another person waiting and requiring professional care and assistance. Due to specific conditions of the profession, nurses are particularly exposed to occupational burnout. As members of an interdisciplinary therapeutic team in social welfare homes, they spend most of the time with the residents, which promotes emotional exhaustion. The aim of the research was to present selected aspects of professional burnout of nurses compared to other welfare home employees.

Methods: The methods used in the research consisted of the diagnostic survey method and estimation method; research techniques: surveying and estimation scale technique, as well as PSS-10 (perceptible stress scale) and DS-14 (scale for D-type measurement) questionnaires were used.

Results: The study showed a statistically significant relationship between the intensity of stress between groups of social welfare homes staff, among whom there were nurses. The highest intensity of stress was observed in the occupational group of physiotherapists and nurses, followed by the medical caregivers/caregivers in the social welfare homes, social workers and occupational therapists/cultural and educational workers.

Conclusions: Nurses and medical caregivers/caregivers at SWH are the representatives of the therapeutic team most exposed to the occurrence of burnout syndrome. It is important to be aware of the threat existence and have a decisive attitude to counteract the phenomenon of occupational burnout.

Keywords: Occupational burnout; Nurses; Social welfare

Introduction

The image of modern nursing depends on global demographic and epidemiological trends, which include the aging of society and the increasing percentage of population affected by civilization diseases. Recipients of services from these groups require long-term care and commitment from nurses, also in the emotional dimension [1,2]. "Occupational burnout is a psychological emotional exhaustion, depersonalization and a reduced sense of personal achievement that can occur in people working with others in a certain particular way" [3]. Contemporarily, more and more researchers are paying attention to chronic stress, particularly among those employed in health care and in the social welfare sector [4]. Incorrect coping with stress in the work environment or lack of support in this area can lead to occupational burnout, which will result in reduced quality of work, and will prevent further professional development [5,6].

Social welfare homes are institutions to which there are directed those who cannot function independently in their daily life and require round-the-clock care due to their disability, illness or age [7-9]. Employees of such institutions are burdened with a large number of tasks related to the provision of professional services and are vulnerable to experiencing particularly stressful situations. Nurses providing professional services to chronically ill patients, in situations of increased and prolonged emotional tension, are exposed to stress generating situations.

Literature review shows that there is a lot of research in Poland regarding burnout among nurses. However, few of them take into account the aspects of professional burnout of nurses and other staff employed in social welfare homes [10].

The aim of our own research was to present aspects of occupational burnout among such employees of social welfare homes as nurses, medical caregivers, social workers, occupational therapists and physiotherapists. The awareness of the scale of this phenomenon will create the possibility of building the competence of the employees of the centres so that they can diagnose symptoms and respond quickly

enough, implementing appropriate strategies for coping with stress and preventing burnout [11-15].

A small amount of research conducted on this subject among Polish employees of SWH may be an important reference point for the management of institutions and contribute to a better knowing and understanding of the scale of the phenomenon among particular professional groups. In our own research, we analyzed the subjective feelings of SWH employees related to personal problems and events and assessed the intensity of stress associated with one's own life situation over a month. Another element subjected to the verification was the D-type personality-called "stress personality", which allowed to examine the tendency to experience negative emotions as well as the tendency to inhibit the expression of emotions in social contacts [16-20]. The aforementioned factors may cause an increased occurrence of the syndrome, which is burnout.

Methods and Participants

Research on the evaluation of selected aspects of occupational burnout was carried out in two SWH for somatically ill persons, one SWH was for mentally ill persons, and the second SWH for the elderly. The centres in which the research was carried out provided living, care, therapeutic, rehabilitation and educational services [21]. The group of people covered by research on selected aspects of occupational burnout consisted of employees of these institutions (n=100-men and women). It should be emphasized that despite the fact that the research group consisted only of 100 people, whom the research team obtained while conducting research in five institutions, all employees expressed their willingness to participate in the study [22,23]. The criteria for selecting respondents to the study group included: consent for participation in the study, no cognitive and functional impairment making it impossible to complete questionnaires, employment (employment contract) in social welfare homes [24,25].

The research included only employees employed on full-time basis. Another criterion that allowed for the participation of employees in the research was belonging to a given professional group: nurses, occupational therapists/cultural and educational employees, medical caregivers/caregivers in SWH, physiotherapists and social workers [26]. The majority of respondents were women 94%, 6% were men. The largest number of respondents lived in the country (63%) and 37% in the city. The most numerous group among employees of SWH were people aged 40-50 (37%) and 30-40 (29%). The smallest group included respondents aged 50 (16%). Most respondents had higher education (master's degree, bachelor's degree-56%) and secondary education concerned 44% of them. The largest occupational group among all respondents were caregivers in social welfare homes (38%-38 respondents), nurses ranked second (31%-31 respondents), followed by physiotherapist (16%-16 respondents), social workers (9% - 9 respondents) and occupational therapists (6%-6 respondents). The most numerous group included respondents with work experience of 0-15 years (74%). Experience of over 15 years referred to 26% of respondents. The research carried out in social welfare homes among specific professional groups of employees was of target, voluntary, free of charge and anonymous nature. The research was carried out within the period from June 2017 to September 2017 [27-30]. The employees of the centers received information for the participant of the scientific research, which contained instructions on the purpose and manner of conducting the research. After obtaining permission to participate in the study, the respondents were instructed to download blank questionnaires (surveys) in the social room, and then throw the completed sheets into a sealed casket, which had been prepared in each social welfare home before the entrance to the social room. In order to conduct the study, the research team used their own questionnaire containing a data sheet, which included: gender, age of respondents, place of residence, work experience, occupation and 4 closed questions, to which the respondent gave answers on a 3-level scale. These questions concerned: mental exhaustion of the staff, the frequency of feeling the lack of commitment in the relationships with the patients, the feeling of inefficiency in solving problems and feeling disappointment as a result of inefficient solution of the problem of SWH residents [31]. Another tool used in the study was the Perceived Stress Scale-PSS 10 by Sheldon Cohen, Tom Kamarck, Robin Mermelstein in the Polish adaptation of Zygfryd Jurczynski and Nina Oginska-Bulik. This tool is used to self-assess the intensity of stress associated with the employee's own life situation over the last month. Stress intensity is not characterized by the number of events only by their assessment. This scale is mainly used for research purposes, but it can be used in screening, prophylactic research or in the assessment of the effectiveness of therapeutic interactions [32].

The Perceived Stress Scale PSS-10 consists of 10 questions that refer to different subjective feelings related to personal problems and events, behaviors and ways of dealing with them. The person who completes the questionnaire gives their answers by entering the appropriate number from 0 to 4 [33]. The overall result of the scale is the sum of all points, the distribution of which ranges from 0 to 40. The PSS-10 index is a measure of stress and assessment of the life situation as stressful, where the requirements are perceived by the individual as exceeding their abilities. Filling the scale takes the respondents approximately 5 minutes [34]. Reliability of the PSS-10 scale was assessed by estimating its internal compatibility and stability. Internal compliance was tested in a group of 120 adults, obtaining the Cronbach's alpha coefficient 0.86. In the original version, the reliability of the scale varies from 0.84 to 0.86 [35]. Another tool applied by the team of researchers was the DS-14 questionnaire, which is the scale for measuring D-type in the Polish version by Nina Oginska-Bulik and Zygfryd Jurczynski [36].

The D-type consists of two main dimensions: negative emotionality characterized by the individual's tendency to experience strong emotions such as anger, fear, irritation, hostility and social inhibition associated with the individual's tendency to refrain from expressing negative emotions and behaviors consistent with these emotions. People with the D-type personality tend to worry, feel tension and have a tendency to blame. Such a person is characterized by a pessimistic way of looking at the world, low self-esteem and low satisfaction with life.

The functioning of people with D-type personality has a specific character in the processes of cognitive appraisal and ways of coping with the stress noticeable in three components: cognitive, emotional and behavioral. An individual with a D-type personality copes with negative emotions by refraining from expressing emotions [37] and behaviors, which causes an increase in the sense of stress leading to vegetative and emotional changes and to a disease. The DS-14 scale consists of 14 statements. Seven of them measure one's tendency to experience negative emotions, whereas the seven remaining determine the tendency of the individual to refrain from expressing emotions and related behaviors [38]. The reliability of the Polish version was assessed on a group of 1154 respondents.

Cronbach's alpha coefficient is: for the Negative Emotionality scale 0.86, and for Social Inhibition 0.84. Similar indicators characterize the original version [39-42]. The study verified the issues related to the

intensity of perceptible stress PSS-10, personality type DS-14. The research team also observed whether the results obtained are differentiated by such selected variables as: age (age groups), place of residence, education, profession and the period of service of employees in social welfare homes. The significance level of $p \leq 0.05$ was assumed to be statistically significant and the hypothesis zero (H0) that there is no difference among the studied groups [43-46].

Statistical 10.0 and Microsoft Excel spreadsheet were used to analyze data (calculations) and make drawings using the standard program functions. The study was approved by the Bioethical Commission at the Nicolaus Copernicus University in Toruń, Collegium Medicum in Bydgoszcz (No. KB434/2017). Participation in the study was anonymous, voluntary, free, and respondents could stop participating at any time of the study, without giving a reason. The confidentiality of the respondents was ensured by not including the name in the survey questionnaires, returning the completed questionnaires to a sealed ballot, prepared in a public place in front of the entrance to the social room in each of the SWH.

Results

The analysis of the questionnaire results - the perceived stress scale PSS-10 (table 1) shows that the highest average number of points respondents received in response to the following questions, which indicated the experience of stressful situations: How often do you feel nervous and stressed? How often did you feel angry with matters that have slipped out of your control? and How often were you upset when something happened unexpectedly? The smallest average number of points were scored by the respondents in answers to the following questions: How often were you able to control irritability? How often did you feel that you were able to cope with your personal problems? and How often did you feel that things were going the way you wanted?

Question from the PSS-10 questionnaire	N	Arithmetical mean	SD	Trust -95.0%	Trust +95.0%	Mini.	Median	Max.
How often were you upset when something happened unexpectedly?	100	2.32	0.815	2.16	2.48	0	2	4
How often did you feel that you could not control important matters in your life?	100	2.11	1.024	1.91	2.31	0	2	4
How often do you feel nervous and stressed?	100	2.42	0.819	2.26	2.58	0	2.5	4
How often do you feel that you were able to cope with your personal problems?	100	1.4	0.953	1.21	1.59	0	1	4
How often did you feel that things were going the way you want?	100	1.38	0.801	1.22	1.54	0	1	4
How often did you state that you could not manage with the matters that you should deal with?	100	2.29	0.967	2.1	2.48	0	2	4
How often were you able to control irritability?	100	1.43	0.807	1.27	1.59	0	1	3
How often did you feel that you were controlling the situation?	100	1.54	0.758	1.39	1.69	0	2	4
How often did you get angry at things that were slipping out of your control?	100	2.42	0.987	2.22	2.62	0	2	4
How often did you feel that the difficulties were piling up so that it was difficult to overcome them?	100	2.32	1.205	2.08	2.56	0	2	4
N-number of persons participating in the study, SD-standard deviation in a given group, Max - maximum (maximum value), Mini (minimum value).								

Table 1: Average the PSS-10 questionnaire items.

The obtained results confirm that the respondents are people with a high level of stress perception at the borderline of the average. The most numerous group consisted of respondents with high intensity of stress (59.0% of respondents) and 19% of respondents obtained results indicating a low level of perceived stress. The persons presenting a high level of perceived stress may be exposed in the future to the development of burnout syndrome.

The age of the respondents did not remain in a statistically significant correlation with the intensity of stress ($p>0.05$). The highest average number of points indicating the feeling of stress was recorded among the respondents aged 30-40. The lowest average number of

points concerned people aged 20-30 -17.11 points. Respondents aged 20-30 most often obtained average results (7 persons -38.9%) and 5 people low results (27.8%). Perception of stress most often concerned respondents aged 30-40. The lowest level of stress was observed among employees aged 20-30. However, in the group of respondents aged over 50, the results regarding the stress perceived were high on the border of average.

According to the level of significance ($p>0.05$), there was no statistically significant difference observed between urban and rural residents in terms of perceived intensity of stress. In the urban population group, most respondents received high results-23 people (62.2%), the lowest results were obtained by five people (13.5%). Among the residents of rural areas, most respondents obtained high results-36 people (57.1%), the fewest obtained average scores-13 people (20.6%).

Greater stress was perceived by city residents than by those living in the countryside. The results of the stress perceived were at the high level on the border of average.

Respondents' level of education did not remain in a statistically significant correlation with the results of stress intensity perception.

As regards the level of significance ($p<0.05$), there was a statistically significant difference between the groups of the profession performed and the perception of stress intensity, which is presented in Table 2.

Profession	Mean	SD
Nurse	21.19	7.06
Medical caregiver/Caregiver in SWH	18.58	5.3
Therapist /Cultural and educational employee	14.5	6.44
Rehabilitant /Physiotherapist	22	3.67
Social worker	17.89	3.82
SD - standard deviation in a given research group.		

Table 2: Average scores of stress intensity perception by SWH employees.

The highest point average indicating the intensity of stress was observed in the group of rehabilitants/physiotherapists and nurses. The lowest average number of points was noted in the group of therapists/cultural and educational workers. In the group of nurses, the results of stress intensity at the high level were obtained by 20 nurses (64.52%), and the average results concerned only five nurses (16.1%).

By verifying the scale of intensity of stress in the group of medical caregivers, most employees obtained high scores-20 respondents (52.6%), the lowest results-seven respondents (18.4%). In the professional group of therapists/cultural and educational workers, most of them obtained low scores (four people-66.70%), only two people achieved a result of a high level of stress intensity (33.3%).

The seniority of the members of the therapeutic team in social care homes did not remain in a statistically significant correlation with the intensity of stress ($p>0.05$). Nevertheless, the highest level of stress experienced concerned respondents with seniority of 10-15 years, and the lowest in turn people with seniority of 0-5 years.

Based on the DS-14 questionnaire, there is carried out an analysis of the tendency to experience negative emotions and of tendencies to inhibit the expression of emotions in social contacts by the respondents participating in the study. In the surveys conducted, those who obtained high scores on both subscales (≥ 7 points) were classified as respondents with a D-type personality.

Out of all the negative aspects analysed, which concerned the respondents, the highest rates (severity) were reported in the following items: I often care about trifles and I often realise that I am worried about something. The lowest rates in turn the respondents achieved in the following aspects: I am often in a bad mood and I see everything in dark colours. However, from all analysed aspects of social inhibition, it was found that the highest rates (intensification) were observed: in contacts with other people I often feel inhibited and I prefer to keep distance to people. The lowest rates in turn, were achieved by the respondents in the following responses: I am a closed person and I easily establish contact with people.

Over half of the SWH employees (59%) present a D-type personality, that is, a stress personality, which may be a significant predictor of the occurrence of burnout syndrome in the future. The age of the respondents did not remain in a statistically significant correlation with the results of the D-type personality measurement scale ($p>0.05$). The highest D-type personality index was recorded in the 30-40 age group (20 people-69.0%) and in those aged over 50 (10 respondents-62.5%). The lowest result was observed in the age group of 20-30 years (seven respondents-38.9%).

There were no statistically significant differences ($p>0.05$) observed between urban and rural residents on the DS-14 scale. A slightly higher D-type personality index was recorded among people living in the city (22 people-59.5%).

The respondents' education also did not remain in a statistically significant correlation with the results of the D-type personality scale. The highest D-type personality index was recorded in the group of people with a bachelor's degree (21 respondents-63.6%), the lowest in the group with a master's degree (11 respondents-47.8%).

There was a statistically significant difference ($p<0.05$) between SWH employees in terms of negative emotionality. In turn, the results of social inhibition and D-type personality in the studied group were on the verge of statistical significance, as shown in Table 3.

Profession	Nurses		Medical caregiver/Caregiver in SCH		Therapist /Cultural and educational employee		Rehabilitant / Physiotherapist		Social worker	
Personality	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
D-type	22	71	21	55.3	1	16.7	11	68.8	4	44.4
Non-D-type	9	29	17	44.7	5	83.3	5	31.3	5	55.6
Overall	31	100	38	100	6	100	16	100	9	100
% -. typographic sign denoting percentage, D-type - stress personality, Non-D-type - non-stress personality.										

Table 3: D-type personality results among SWH employees.

The highest daily D-type index was observed in the group of nurses (22 people-71.00%), then rehabilitants/physiotherapists (11 people-68.8%) and medical caregivers/caregivers in SWH (21 people-55.3%). The lowest result was recorded in the professional group of therapists/cultural and educational employees (one person-16.7%). In the analysis of the highest point means of negative emotionality they were recorded in the group of rehabilitants/physiotherapists, nurses and medical caregivers/caregivers in SCH - 13.08 points. In turn, the lowest point mean concerned workers. The highest point means regarding social inhibition were recorded in the group of nurses, rehabilitants/physiotherapists and therapists/cultural and educational workers. The lowest results were obtained by the group of social workers.

There was a statistically significant difference ($p<0.05$), noted between the D-type and non-D-type personality in the group of respondents in the range of results obtained by them on the PSS-10 scale of perceived stress, as presented in Table 4.

Type of Personality	D-Type		Non-D-Type	
PSS-10 result	**Number**	**%**	**Number**	**%**
Low	1	1.7	18	43.9
Average	8	13.6	14	34.1
High	50	84.7	9	22
Overall	59	100	41	100
PSS-10 - scale of the perceived stress, % - typographic mark denoting the percentage, D-type – stress personality, non-D-type - non-stress personality.				

Table 4: PSS-10 results in personality type groups.

Among the respondents with the D-type personality, the largest group consisted of employees with scores showing high intensity of stress (50 people-84.7%). Only 1 person (1.7%) obtained a low score on this scale. Among the respondents with non-D-type personality, the largest group consisted of those with low stress scores (18 people - 43.9%). On the other hand, the high stress intensity results concerned only nine respondents (22.0%). Those with a stress personality display a higher level of stress intensity, compared to people with a non-stress personality, who present a tendency of lower intensity of stress.

Discussion

Social welfare home (SWH) employees are exposed to the phenomenon of occupational burnout occurrence due to the specifics and characteristics of the centre functioning, in which there are people who require 24-hour nursing, care and rehabilitation. Social welfare homes in Poland provide living, supportive, and educational services at the level of the applicable standard, in the scope and forms resulting from the individual needs of those in it. The organization of the institution, the scope and level of services provided take into account, in particular, freedom, intimacy, dignity and a sense of security of the residents as well as their physical and mental fitness [47].

The centres can also provide care and specialist services for non-residents. The staff provides residents with support in everyday activities, the organization of free time, care in illness and assistance in the use of health services. Within 6 months from the date of admission to the institution, an individual support plan prepared by a therapeutic and care team is created, comprising: a manager, psychologist, nurse, occupational therapy instructor, physiotherapist, medical caregiver or caregiver in a social welfare home. Depending on the type of dysfunction of residents and the scope of services provided, the SWH is divided into the following types - homes for: chronically sick people, the elderly, chronically mentally ill, adults with intellectual disabilities, people with physical disabilities and children and youth with intellectual disabilities. A large scope of duties resulting from statutory provisions may lead to physical and mental exhaustion in nurses [48].

The international research next program (Nurses' Early Exit Study, QLK6-CT-2001-00475), carried out in 10 European countries (Belgium, Finland, France, the Netherlands, Germany, Great Britain, Italy, Poland, Slovakia and Norway a non-EU member) aimed to diagnose the reasons for premature resignation of the profession by nurses [49]. The study also included nurses working in social welfare homes. One of the main reasons for the premature departure from the

profession was low job satisfaction and professional burnout, understood as a sense of emotional exhaustion [50].

Own research showed differences occurring in the level of perceived stress related to professional activities in the group of SWH employees. Nurses compared with other respondents present a high level of stress intensity. Stress increases the risk of deficits in the mental and physical health of employees. Nurses who are under stress are not able to work effectively and efficiently; they are exposed to making mistakes and faults during their work. The results concerning the high level of stress experienced by nurses compared to other employees may also result from the characteristics of the work and the scope of duties performed at individual positions.

Nurses in social welfare homes are responsible for medical, nursing and therapeutic services provided to patients. A smaller scope of duties is imposed on other occupational groups, which may result in a lower level of stress and therefore a lower risk of burnout syndrome. Occupational therapists/rehabilitants/physiotherapists are responsible to a large extent for rehabilitation activities, improving physical fitness. Medical supervisors to a large extent deal with all activities related to patient care, nursing, and therefore are the next professional group most at risk of burnout syndrome. Employees burdened with the effects of stress generate unfavorable socio-economic costs. Research conducted by C. Jurkiewicz among employees of social welfare homes and studies by M. Sekułowicz in Poland confirmed the risk of burnout syndrome among SWH employees.

The research conducted showed that in the group of SWH employees, nurses, physiotherapists/physiotherapists and medical caregivers/caregivers in SWH are most exposed to stressful situations. The vast majority of members of the SWH therapeutic team presented D-type personality. This means that people with stress personality are characterized by unsatisfactory relationships with other people, they are depressed and fearful. The highest D-type personality index was recorded in the group of nurses, compared to other professional groups employed in SWH. The highest tendency to present negative emotionality was registered among physiotherapists and nurses.

The World Health Organization recognises the workplace as one of the main sources of stress. The contact of nurses with chronically ill patients who need support is a big burden for this professional group, which may increase the risk of professional burnout development.

The conducted studies indicate that in the group of SWH employees, nurses are exposed to the greatest extent to the development of burnout syndrome. This process can develop for months, even years. The initial stage is characterized by fatigue, discouragement or disappointment. Nurses are working more and more, but their activities are becoming unfortunately less and less effective.

There is a limitation of interpersonal contacts and a lack of personal commitment to taking care of the patient. The previously quoted next international research has shown that in Poland there is a high risk of nurses' intention to leave the profession, which may be a significant social challenge. The reasons for the premature departure of nurses from their profession include psychosocial and physical features of work as well as psychological and physical well-being. One of the determinants of leaving the profession by nurses is their occupational burnout understood as emotional exhaustion. The nurses who experienced severe occupational burnout more often considered leaving their profession.

In the foreign literature, one can find a number of studies on the professional burnout of nurses, occupational therapists and social workers in medical centres. The research conducted by Painter Jane, Duane Akroyd, Sharon Elliot and Robert D. Adams on occupational burnout among occupational therapists showed that occupational therapists working in long-term care facilities showed higher levels of burnout than those working in other healthcare centres. The research carried out in Sweden by Henna Hasson and Judith E Arnetz aimed at determining the competence of nursing staff, workload and stress showed that in both care institutions where the research was conducted, work-related exhaustion was the strongest (opposite) work satisfaction indicator. The results of research carried out in SWH showed a higher risk of emotional exhaustion in nurses and medical caregivers than in occupational therapists and social workers. The study of aspects of occupational burnout among nurses in Poland will allow to determine the scale of the phenomenon compared to other professional groups and take steps to implement preventive measures.

Strong Points and Limitations

The conducted research has made it possible to assess the scale of the phenomenon of occupational burnout among nurses working in social care homes in comparison with other professional groups. The significance of the presented study can be perceived as limited due to the small size of the studied group –100 respondents. However, it should be emphasized that in the survey all persons working in five social welfare homes in which research was conducted by the research team expressed their willingness to participate. The small size of the group of respondents is related to the characteristics of the employment of staff in social welfare homes in Poland.

Conclusions

The highest intensity of stress was recorded in the occupational group of physiotherapists/nurses, medical caregivers/caregivers at the SWH. Nurses and physiotherapists obtained high rates of stress personality. Employees with the type of D-type personality perceive their work as more stressful and feel stronger effects of functioning under stress. Nurses and medical caregivers/caregivers at SWH are the representatives of the SWH therapeutic team most exposed to the occurrence of burnout syndrome. The burnout syndrome is an increasingly common problem in the 21st century that all employees are exposed to. In social welfare homes nurses as members of care and therapeutic teams support residents, serve their knowledge, experience and skills. Permanent contact with chronically ill people who need support can be a psychological burden that leads to burnout. In the face of the problem increase, the management team at SWH should pay attention to activities aimed at maintaining job satisfaction and making it easier for employees to maintain a balance between work and private life. The foundation of an effective preventive strategy should consist in educating management personnel of the recognition of the first symptoms of burnout and developing a support plan for staff who loses satisfaction and motivation for further work.

Conflict of Interest

It does not occur.

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