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REVIEW

Autonomy in nursing: a narrative review of instruments and their measurement properties

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Abstract

Aim: Autonomy in nursing refers to nurses' ability to make independent decisions in providing nursing care without outside influence or control. Nurse autonomy is a key part of the provision of quality and safe care. *Design:* A narrative literature review was used for the study, performed according to the PRISMA ScR checklist. *Methods:* Relevant studies obtained from four databases were included in the narrative review. The data review was performed according to the PRISMA checklist. For data extraction and synthesis, the method of summative content analysis, in accordance with COSMIN criteria, was used. *Results:* The search identified four relevant studies published between 2003–2014. All instruments used in the studies were designed to measure nurse autonomy and were also used in combination with other instruments closely related to autonomy in nursing. The instruments demonstrated acceptable psychometric properties. *Conclusion:* Autonomy is an unexplored phenomenon in the context of the Slovak Republic and it deserves attention since nurse autonomy affects not only patients but also nurses themselves and their job satisfaction. It is important to enable nurses to participate in decision-making, planning and development of nursing as autonomous professionals.

Keywords: autonomy, professional autonomy, decision making, nurse, review, instrument.

Introduction

After examining published review studies, we identified autonomy as a relatively unexplored phenomenon within the Slovak socio-cultural context. Consequently, it deserves attention and further research. Nurses are a key component of any healthcare facility, providing exceptional patient care. Changes in the quality and quantity of health services are driven by a rapidly changing world and the needs of individuals. It is important for nursing as a profession to adapt to these changes (Miyashita et al., 2007). We view nurse autonomy as a dynamic element, not fixed or unchanging. It fluctuates depending on various factors or limitations, including religious, economic, political, social, and cultural elements, legal considerations, and personal or individual aspects (Baykara & Şahinoğlu, 2014). In the realm of nursing, a unanimous definition of nurse autonomy has yet to be established (Varjus et al., 2011). Autonomy is a broad concept that the authors understand from different perspectives. According to the American author Blegen, autonomy entails having the authority and responsibility for patient care and the functioning of a unit, including the right to make decisions and accountability for the outcomes (Blegen et al., 1993). Autonomy is seen as a major element in providing quality nursing care and has an important place in the professional identity of the nurse (Varjus et al., 2003). Autonomy is defined by Keenan (1999) as the practice of making independent judgments and having the liberty to make decisions within the boundaries of one's professional practice and discretion. Autonomy can have both a descriptive and a prescriptive aspect, and these two parts are interrelated. Autonomy from the descriptive point of view is understood as the capacity for self-government. From a prescriptive perspective, respecting autonomy means not interfering with people's control over their own lives and taking active steps to facilitate such control (MacDonald, 2002). Autonomy in nursing is under constant construction, but the process is complex and multidimensional. This complexity primarily stems from the distinctiveness of nurses' clinical responsibilities and the particular environment in which they operate (Gagnon et al., 2010). As an illustration, Kramer et al. delineated three dimensions of autonomy within clinical nursing practice environments. Clinical autonomy pertains to nurses making independent, collaborative,

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and responsible decisions for the well-being of patients. The second dimension is control over the autonomy of nursing practice, which refers to the creation and regulation of nursing policy by nurses. The third dimension, work / job autonomy, describes the process of making decisions at the unit group level to organize daily responsibilities and prioritize tasks (Kramer et al., 2006). The development of nurse autonomy is a very important issue in the evolution of the nursing profession (Melo et al., 2016). The nursing profession plays an important role within the healthcare system, and enhancements in this field are closely tied to improvements in the delivery of patient care. When levels of autonomy are elevated, the profession garners greater recognition and societal respect. Research findings indicate that nurses with a higher level of autonomy tend to experience greater job satisfaction (Mrayyan, 2004). Nurse job satisfaction leads to more effective care of patients and improvement of the healthcare system (Mulisa et al., 2021). It is important to develop the nursing profession by increasing the autonomy of nurses in their work since nurses play an important role in the healthcare system (Mulisa et al., 2021). In her study, Marla J. Weston (2009) examined the psychometric properties of commonly used instruments to measure autonomy and control in nursing practice. The outcomes of her research reveal that instruments frequently lack precision or fail to precisely gauge the targeted concept. Nevertheless, there are reliable tools available for assessing concepts such as clinical autonomy, work autonomy, and control over nursing practice – the Maastrick Autonomy Scale (de Jonge, 1995), the Nursing Authority and Autonomy Scale (Blanchfield & Biordi, 1996), the Control Over Nursing Practice Scale (Gerber et al., 1990), the Nursing Activity Scale (Schutzenhofer, 1987), and others.

Aim

The aim of the narrative review was to offer a comprehensive summary of studies that focus on assessing nurse autonomy in clinical practice.

Methods

Design

A narrative literature review.

Eligibility criteria

The formulation of the research question and the approach for conducting the search adhered to the PCC (Participants: nurses; Concept: autonomy; Context: tools for measuring autonomy in decision-making in clinical practice) framework. Following this, an examination of the chosen studies was conducted, involving critical assessment of their psychometric properties. The precise research questions were as follows:

- What tools in the existing literature assess nurse autonomy and what fundamental attributes do they possess?
- What do the psychometric properties reveal about the instruments used to measure nurse autonomy?

Search strategy

A narrative literature review was conducted, guided by the PRISMA ScR checklist (Page et al., 2021). We proceeded by the following steps: determination of the question, search strategy, eligibility criteria, information sources, search, selection of sources of evidence, critical evaluation of individual sources of evidence, selection of studies, data extraction, and analysis. We systematically searched for relevant scientific literature across four different databases: PubMed, Scopus, ProQuest, and Web of Science. The selection of these databases was influenced by their availability. Across all the databases, the following combinations of relevant terms were used, created using Boolean operators: (“nurse” OR “nursing staff”) AND (“professional autonomy” OR “clinical autonomy”) AND (“making decisions”) AND (“assessment tools”) AND (“psychometric properties”).

Study selection inc. PRISMA flow diagram

Throughout the identification of studies, we adhered to the PRISMA diagram (Figure 1). In the initial phase, a total of 1,414 studies were identified (PubMed 562, Scopus 549, ProQuest 39, Web of Science 264). After removing duplicates (n = 13) and studies with no access (n = 65), 1,336 studies were analyzed based on their abstracts. In the subsequent phase, 400 studies were assessed according to the eligibility criteria. Afterwards, we assessed the quality of full-text articles (n = 40). Following individual analyses, four studies were selected based on qualitative synthesis.

Evaluation of quality of articles

The data extraction and synthesis abided by the summative content analysis method, in accordance with the COSMIN criteria (Mokkink et al., 2010). The COSMIN taxonomy, established through international consensus, encompasses three fundamental measurement properties: reliability, validity, and responsiveness. This framework serves as a standardized guide for evaluating the quality and appropriateness of measurement instruments.

Data extraction

The purposeful selection of studies from 1993 was due to the fact that the first available study matching our criteria was in this year. The inclusion criteria related to individual components of the PCC question. We included studies published between 1993 and 2022 that met the following criteria: 1) empirical articles; 2) available abstract; 3) written in English; 4) quantitative, qualitative and mixed research methods; and 5) published in peer-reviewed journals. The exclusion criteria included: 1) all types of reviews; 2) no available abstract; and 3) paid access to studies. The researchers extracted the following information from the final four studies: author, year, country, aim, design, sample size, informants, data collection methods, analysis, main results, and psychometric properties. The data was synthesized in both a narrative and tabular format.

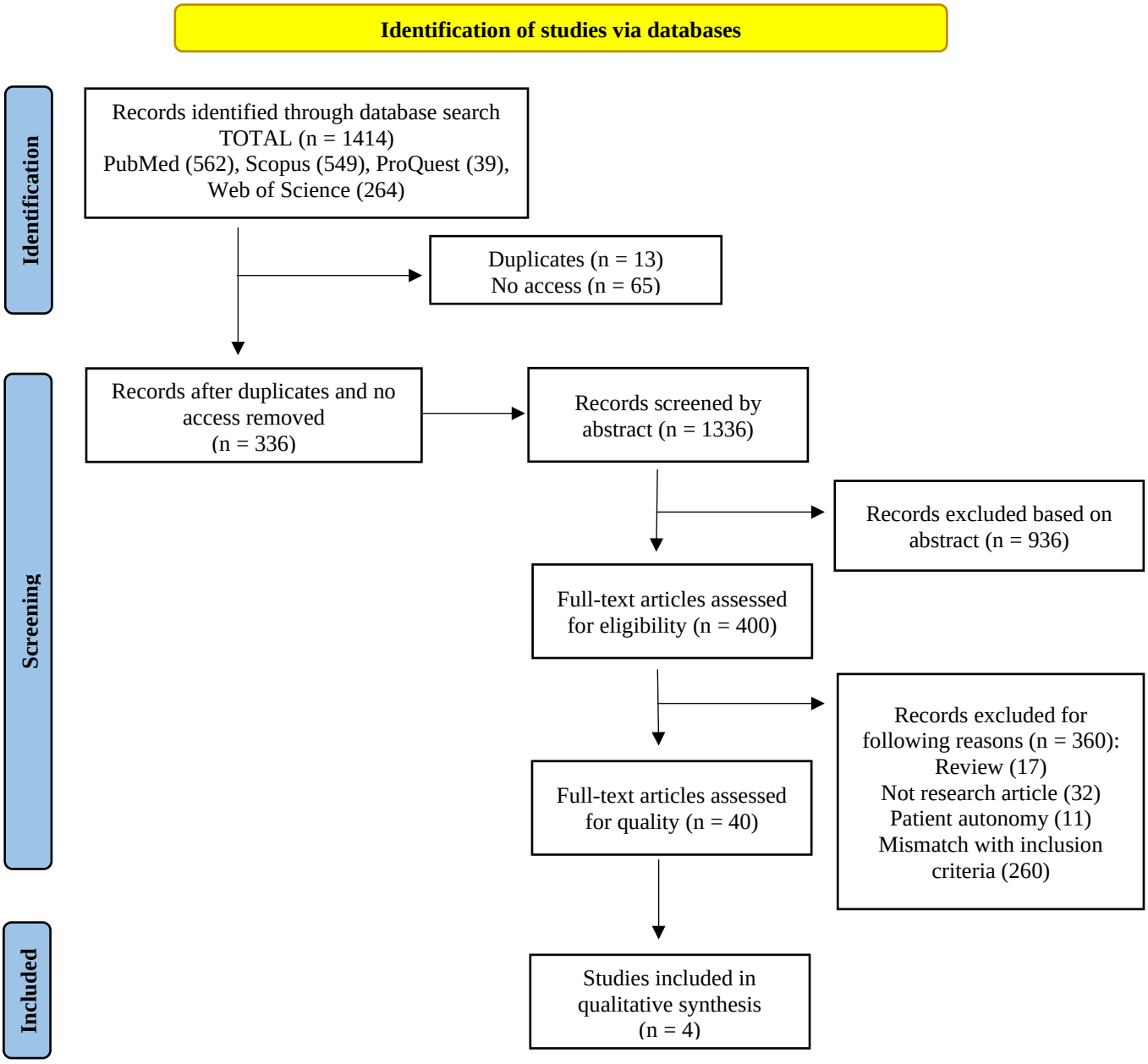

Figure 1 PRISMA flow diagram

Results

Research question 1: What tools in the existing literature assess nurse autonomy and what fundamental attributes do they possess?

The literature review consisted of four studies in which the authors examined nurse autonomy using multiple instruments. The studies under analysis were sourced from Cyprus (n = 2), Finland (n = 1), and Jordan (n = 1). The sample number ranged in size from 172 to 566 nurses. Table 1 provides an overview of the characteristics of the included studies and the utilized tools, namely: Varjus's Autonomy Scale, Blegen Autonomy Scale, the Nurse Manager Action Scale, the Corley Moral Distress Scale, and the Collaboration and Satisfaction About Care Decisions Scale. A more detailed description of the instruments is provided in the response to research question 1.

The Finnish authors Sirkka-Liisa Varjus et al. (2003) used an instrument of their own construction in their study "Varjus' Autonomy Scale". A pilot test for the questionnaire was conducted in hospital intensive care units. The instrument is divided into two parts: demographic data (11 items) and autonomy issues (18 items). A six-point Likert scale was used to rate each item, with the "don't know" item omitted, forcing respondents to adopt a position. The autonomy domain is composed of six knowledge items, six activities, and six values items. The autonomy knowledge base explores decision-making as a cognitive process. The items measured nurses' right to participate in patient care decisions, accountability for decisions nurses made in providing nursing care, and nurses' beliefs about their autonomy in the decision-making process. The action base of autonomy measured nurses' views of their independence in nursing activities and in activities related to organizing the operation of the nursing unit. The last component of the autonomy value base evaluated whether nurses could adhere to their personal values while delivering nursing care and establish a foundational set of values for their work.

The Jordanian author Majd T. Mrayyan (2004) used an electronic questionnaire in his study, which consisted of four parts. The first part included a questionnaire focusing on nurses' autonomy by the American author Mary A. Blegen. The "Blegen Autonomy Scale" instrument contains 42 items. The first 21 items focus on patient care decisions, and the panel members grouped them into four sections: defining patient care provision, improving staff collaboration, handling patient and physician complaints, and resolving diagnosis and discharge-related issues. The other 21 items focus on decisions related to the nursing unit and the panel members grouped them into four sections: organizing their own work, planning to deliver high-quality care, developing and revising patient care procedures, and managing unit resources. The authors of the instrument used a Likert scale from 1 to 5 to measure the statements, whereby 1 means nurses have no authority and accountability and 5 means nurses have full independent authority and accountability. The second part includes a questionnaire that was specifically designed for the study based on the literature review by Majd T. Mrayyan. The "Nurse manager action scale" instrument asked staff nurses to assess whether nurse managers performed certain actions e.g., "supports nurses to resolve conflicts with physicians, patients, and colleagues", and "supports staff nurses' autonomous decision-making." The third section was reserved for collecting demographic data, and the fourth part comprised open-ended questions, in which nurses were asked to suggest three factors that contributed to increasing their autonomy and three factors that restricted their autonomy.

Cypriot author Elizabeth D. E. Papathanassoglou and his team (2012) used three tools in their research. The first instrument focused on nurse autonomy. Autonomy was assessed using an instrument by the Finnish author Sirkka-Liisa Varjus called the "Varus' Autonomy Scale". A more detailed description of the instrument is given in the aforementioned study (Varjus et al., 2003). Another instrument used was the modified "Corley Moral Distress Scale" by the American author Mary C. Corley. The instrument consists of 21 items that describe situations that could trigger moral distress. Respondents rate both the frequency and the level of distress that the situation causes on a scale of 0 (never occurred / not disturbing) to 4 (occurred very frequently / very disturbing). To measure the level of moral distress, the frequency and intensity scores obtained are multiplied for each item. The product of each item ranges from 0 to 16 and is then totaled to obtain a composite score. With this scoring approach, any elements that receive ratings of "never occurred" or "not disturbing" may be disregarded. The last instrument used in this study was the "Collaboration and Satisfaction About Care Decisions Scale" by American author Judith G. Baggs. The instrument contains ten items that nurses rate using a Likert scale from 1 to 7. The tool is used to measure nurses' perceptions of the level of collaboration and satisfaction with care decisions. In addition to the aforementioned instrument, respondents also completed a short questionnaire regarding demographic data. This questionnaire

included items such as educational background, frequency of participation in continuing education programs, clinician to patient ratios, degree of job satisfaction, importance of job independence for the participant, and to what degree participants thought people in their country appreciated the work of critical care nurses.

In the last study, Cypriot author Maria N. K. Karanikola et al. (2014) used three different tools: Corley's Moral Distress Scale, Varjus' Autonomy Scale, and Bagg's Collaboration and Satisfaction About Care Decisions Scale. More detailed characteristics of the mentioned instruments may be found in the afore-mentioned texts (Mrayyan, 2004; Papathanassoglou et al., 2012; Varjus et al., 2003).

Table 1 Instruments measuring nurse autonomy and their basic characteristics (Part 1)

Author (year), country	Aim	Design	Sample size, informants	Data collection methods	Analysis	Main results
Varjus et al. (2003), Finland	The purpose of this study was to describe Finnish ICU nurses' experience of autonomy in their work.	Not reported.	172 ICU nurses (random selection)	Questionnaire Varjus' Autonomy Scale (VAS) (Varjus et al., 2003)	The data were analyzed by using frequencies, percentage distributions, cross tabulation and statistical nonparametric tests.	Autonomy was defined as being composed of three bases: knowledge based (independence, right and responsibility in decision-making), action based (independence, right and responsibility in actions), and value based (independence, right and responsibility in values). A larger proportion of respondents felt that they had more autonomy in decision-making and actions concerning patient care than in decision-making and actions concerning the intensive care unit as a whole.
Mrayyan (2004), Jordan	The aim of this study was to examine the role that nurse managers had in enhancing hospital staff nurses' autonomy.	A comparative descriptive survey design.	317 hospital nurses (A convenience sample of nurses)	Questionnaires The Autonomy Scale (Blegen et al., 1993) Nurse managers' actions scale (Mrayyan, 2004)	The research questions were addressed by using data analysis procedures and statistics such as mean, standard deviations, frequencies, Pearson product–moment correlations, regression analyses, and content analysis for the two open-ended questions.	Nurses were more autonomous in decision making and patient care than unit operational decisions. They perceived their autonomy to be at a moderate level. Nurse managers' actions had a strong relationship with nurse autonomy in deciding on patient care and unit operation decisions, and with total autonomy. The three variables that increased nurse autonomy were: supportive management, education, and experience. The three variables that decreased nurse autonomy were: autocratic management, doctors, and workload.

ICU – intensive care unit; VAS – Varjus' Autonomy Scale

Table 1 Instruments measuring nurse autonomy and their basic characteristics (Part 2)

Author (year), country	Aim	Design	Sample size, informants	Data collection methods	Analysis	Main results
Papathanassoglou et al. (2012), Cyprus	To explore levels of autonomy among European critical care nurses and potential associations of autonomy with nurse-physician collaboration, moral distress, and nurses' characteristics.	Descriptive correlational study.	Convenience sample of 255 delegates attending a major European critical care conference	Questionnaires Corley's Moral Distress Scale (CMDS) (Corley et al., 2001) Varjus's Autonomy Scale (VAS) (Varjus et al., 2003) Bagg's Collaboration and Satisfaction About Care Decisions scale (CSACD) (Baggs, 1994)	Data were analyzed by using SPSS software. Descriptive and inferential statistics were used.	The mean autonomy score and the mean composite (frequency and intensity) moral distress score were both moderate. The mean collaboration score was 47.85 (SD 11.63; range, 7–70). Italian and Greek nurses reported significantly lower nurse-physician collaboration than did other nurses ($p < 0.001$). Greek and German nurses reported significantly higher moral distress ($p < 0.001$). Associations were noted between autonomy and work satisfaction. Frequency of moral distress was associated inversely with collaboration and autonomy and positively with intention to quit.
Karanikola et al. (2014), Cyprus	To explore the level of moral distress and potential associations between moral distress indices and nurse–physician collaboration, autonomy, professional satisfaction, intention to resign, and workload among Italian intensive care unit nurses.	A cross-sectional correlational design.	566 Italian intensive care unit nurses (Target selection)	Questionnaires Corley's Moral Distress Scale (CMDS) (Corley et al., 2001) Varjus'Autonomy Scale (VAS) (Varjus et al., 2003) Bagg's Collaboration and Satisfaction About Care Decisions scale (CSACD) (Baggs, 1994)	Data analysis was performed using the SPSS. Descriptive statistics of all variables were explored and mean values and standard deviations were reported.	The intensity of moral distress was 57.9 ± 15.6 (mean, standard deviation) and the frequency of occurrence was 28.4 ± 2.3. The mean score of the severity of moral distress was 88.0 ± 44. The severity of moral distress was associated with nurse–physician collaboration, dissatisfaction with care decisions, and intention to resign. The frequency of occurrence of moral distress was associated with the intention of nurses to resign.

CMDS – Corley's Moral Distress Scale; VAS – Varjus' Autonomy Scale; CSACD – Bagg's Collaboration and Satisfaction About Care Decisions scale; SD – standard deviation; SPSS – Statistical Package for Social Sciences

Research question 2: What do the psychometric properties reveal about the instruments used to measure nurse autonomy?

In the context of the second research question, it is important to note that different names and definitions for measurement properties are constantly used in the literature, and different terminology can lead to confusion. To assess psychometric properties, we therefore decided to use the COSMIN taxonomy of measurement properties, which is based on international consensus. It distinguishes three domains: reliability, validity, and responsiveness, with each domain containing one or more measurement property (Mokkink et al., 2010). Varjus et al. (2003) analyzed the data by using frequencies, percentage distributions, cross tabulation, and statistical nonparametric tests. In the study, the content validity was assessed based on a detailed review of the literature and peer discussion among nursing experts. The construct validity was primarily obtained through a literature review from the 1990s. The questionnaire's reliability was determined by analyzing its internal consistency. Cronbach's alpha reliability coefficients were calculated for the three subscales: 0.56 for knowledge base, 0.62 for action base and 0.76 for value base. Mrayyan (2004) formed an expert panel consisting of ten nurse managers. Their task was to assess the content validity of the developed instrument. The nurse manager's action scale, which was found to be satisfactory. The internal consistency of the instrument's items was assessed by correlating each item with the total score of the item. Due to the small number of items, the concept of negative correlation was used, in which one item showed a negative correlation and was subsequently excluded. The overall correlation among the remaining eight items fell within the range of 0.12 to 0.84, and the reliability coefficient was 0.66. Nurse managers were invited to provide feedback on the content of the second draft of the scale. Among the ten respondents, four believed that nurse managers should promote autonomous decision-making, self-scheduling, and involvement in capital expenditure planning. Following the pilot test, the revised scale included 11 items. The reliability coefficient for the 11 items was 0.88, which is considered acceptable for a newly-created scale. The psychometric properties of the Blegen Autonomy Scale instrument were not mentioned in the study. Papathanassoglou et al. (2012) reported that during a pilot study with 160 randomized intensive care unit nurses, the following parameters were examined: face validity, feasibility, comprehensibility, test-retest reliability and the internal consistency of the Greek version of the Collaboration and Satisfaction About Care Decisions Scale. The Cronbach α coefficients for all scales were greater than 0.8. The reliability of the test-retest was measured in a convenience sample of 20 ICU nurses. The reliability of internal consistency of all scales was examined in a sample collected from a conference, during which all attendees were directed to independently complete the questionnaire. In the study, the authors reported that internal consistency was sufficient for the following subscales: autonomy scale ($\alpha = 0.878$); knowledge base ($\alpha = 0.698$), action base ($\alpha = 0.75$), and value base ($\alpha = 0.818$) subscales; the moral distress frequency ($\alpha = 0.87$) and intensity ($\alpha = 0.87$) subscales; the composite moral distress subscale ($\alpha = 0.86$); and the collaboration scale ($\alpha = 0.91$). As mentioned above, the author Karanikola et al. (2014) used three instruments in their study. The validity and reliability of the Moral Distress Scale instrument was reported as adequate in the study. Cronbach's $\alpha > 0.95$ was also reported. Another instrument used was Varjus' Autonomy Scale for which, as with the previous instrument, the validity and reliability were reported to be adequate (Cronbach's $\alpha > 0.80$). In the last instrument, the Collaboration and Satisfaction About Care Decisions Scale, the reliability was given as Cronbach's $\alpha > 0.80$. The authors mentioned that the reliability and validity of the scale had been examined and found adequate elsewhere. See Table 2.

Table 2 Psychometric properties of the instruments

Author (year), country	Face validity	Content validity	Concurrent validity	Construct validity	Internal consistency	Reliability
Varjus et al. (2003), Finland	-	✓	-	✓	✓	-
Mrayyan (2004), Jordan	-	✓	-	-	✓	-
Papathanassoglou et al. (2012), Cyprus	✓	-	-	-	✓	✓
Karanikola et al. (2014), Cyprus	-	-	-	-	✓	✓

Discussion

The literature review primarily concentrated on examining instruments for assessing autonomy in nursing and evaluating their psychometric properties. For both the first and second research questions, we identified four studies. An instrument that focused specifically on autonomy in nursing was found in one study (Varjus et al., 2003). The other three identified studies included related concepts of how nurse managers can enhance nurse autonomy, and the potential associations of autonomy with nurse-physician collaboration, moral distress, and nurse characteristics (e.g., Karanikola et al., 2014; Mrayyan, 2004; Papathanassoglou et al., 2012). One frequently used tool was Varjus' Autonomy Scale. As reported in our literature review, it was often used in combination with instruments that measure moral distress or nurses' and physicians' cooperation and satisfaction with their decisions. However, we also found it used alone in many studies, for example in the work of the Jordanian author Mahmoud Maharmeh (2017), in which the results of the study showed that most nurses working in intensive care units had high levels of autonomy. Nurses were more autonomous in basic activities and knowledge than in independent decision-making. In addition, education and experience emerged as important variables in improving nurse autonomy. Oshodi et al. (2019) found that clinical autonomy is a component of professional autonomy and is closely linked to the decision-making process in patient care. Nevertheless, within the context of clinical practice, nurses follow physicians' instructions, meaning comprehensive autonomy is not possible. Berti et al. (2008) state in their results that disrespect for nurse autonomy is more deeply recorded by physicians. The relationship between nurses and physicians can even be confrontational, especially in situations in which physicians do not read nursing records, do not accept physical examinations performed by nurses, or require them to perform procedures that are exclusively medical. Similarly, the Blegen Autonomy Scale, included in our research, was also used independently, (e.g., Mrayyan, 2004; Mrayyan, 2005; Shohani et al., 2018). The results of the study (Shohani et al., 2018) showed that nurses had more autonomy in making decisions related to patient care compared to decisions concerning ward issues. Nurse managers should assume responsibility for improving the status of nurse autonomy and try to eliminate barriers. Similarly, Papathanassoglou et al. (2012) describe how nurses had more autonomy when making decisions about nursing care than about the management and operation of the unit. Another descriptive study (Georgiou et al., 2017) looked at nurse-physician collaboration and nurse autonomy. The results of this thesis are particularly important in highlighting the positive relationship between nurse-physician collaboration and their autonomy. The main results include low scores for nurse-physician collaboration and satisfaction with care decisions, moderate overall early perceived autonomy, with higher scores attributed to the value base of autonomy and lower scores attributed to issues related to control over the organization of the unit, and an association between autonomy indices and scores on nurse-physician collaboration. Pursio et al. (2021) state in their studies that it is important to enable nurses to engage in decision-making, contribute to planning, and actively participate in the development of nursing through shared leadership. However, healthcare facilities are still dominated by a strong hierarchy and shared leadership is slow to spread. It further states that nurses should be considered equal members of the team that provides health care. Even if there are legal restrictions on the professional autonomy of nurses, nursing should be evaluated in the same way as medicine in practice. Similarly, AllahBakhshian et al. (2017) reported that both interprofessional and intraprofessional support for nurses' independent decision-making and critical thinking can improve nurse job satisfaction and motivation. Also important are strong, unified nursing communities and professional organizations that strive to promote progress toward autonomous nursing care. The psychometric properties least frequently reported were face validity and construct validity. Concurrent validity was not mentioned in any of the studies. Instead, the measurement properties most frequently reported were content validity and reliability. The internal consistency of the instrument was the only psychometric property reported in all four studies. Authors from different countries considered the psychometric properties of the instruments in our study to be acceptable (Karanikola et al., 2014; Mrayyan, 2004; Papathanassoglou et al., 2012; Varjus et al., 2003). In summarizing the analysis of psychometric instruments, Varjus et al. (2003) focus on content and construct validity, as well as internal consistency. Mrayyan (2004) examines content validity and internal consistency. Papathanassoglou et al. (2012) describes only face validity, in addition to internal consistency and reliability. Similarly, Karanikola et al. (2014) examine internal consistency and reliability in their study. In conclusion, we can state that regarding psychometric properties, the studies analyzed in the literature review were relatively weak in reporting measurement properties.

Limitation of study

The study had several limitations. The search for relevant studies for the literature review was limited by the English language and the institutional availability of scientific databases

Conclusion

Understanding the concept of autonomy is essential to the provision of competent, safe, and ethically appropriate nursing care. Nurses' professional autonomy affects not only the satisfaction of health service recipients and their positive health outcomes but also the nurses themselves and their job satisfaction. Enabling nurses to be actively involved in the decision-making, planning and development of nursing as an autonomous profession is essential.

Ethical aspects and conflict of interest

The authors have no conflict of interests to declare.

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Author contributions

Manuscript proposal (LCH, KŽ), data collection (LCH), data extraction and analysis (LCH), manuscript draft (LCH), critical and constructive suggestions for enhancing the manuscript (KŽ), final approval of the manuscript (LCH, KŽ).

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