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Enhancing effective healthcare communication in Australia and Aotearoa New Zealand: Considerations for research, teaching, policy, and practice☆

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ABSTRACT

Objective: In this article we present a conceptual framework for enhancing effective healthcare communication in Australia and Aotearoa New Zealand.
Methods: Through an iterative, deliberative dialogue approach, we, as experts from a variety of health professions and academic disciplines, worked together to identify core values and considerations for healthcare communication across numerous health professions and disciplines and within research, teaching, policy, and practice contexts.
Results: The framework developed includes five core values at its centre: equitable, inclusive, evidence-based, collaborative, reflective. Around this are concentric circles showing key elements of collaborators, modality, context, and purpose. Each of these is explored.
Conclusion: This work may support benchmarking for healthcare providers, researchers, policymakers, and educators across a breadth of professions to help improve communication in clinical practice. The framework will also help to identify areas across disciplines that are shared and potentially idiosyncratic for various professions to promote interprofessional recognition, education, and collaboration.
Innovation: This framework is designed to start conversations, to form the foundation of a dialogue about the priorities and key considerations for developing teaching curricula, professional development, and research programs related to healthcare communication, providing a set of values specifically for the unique contexts of Australia and Aotearoa New Zealand. It can also be used to guide interdisciplinary healthcare professionals in advancing research, teaching, policy, and practice related to healthcare communication.

☆ SJ White and C Gilligan led the development of this article and are listed as first author and last (senior) author. This article was contributed to through conceptualisation, drafting, and editing by all the authors, who are listed alphabetically between first and last author.

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1. Introduction

Communication forms the basis of healthcare provision through interactions between consumers[1] and healthcare providers,[2] between providers, between other members of health teams, and through the provision of information to the public. Given its centrality to the work of healthcare, many national and international agencies have developed position papers, frameworks, and curricula for supporting education, research, and policy development relating to healthcare communication [1-8]. Such approaches promote strategic investment in specific areas, inform education and accreditation, and allow for the sharing of ideas and resources.

In Australia and Aotearoa New Zealand we currently lack a shared understanding of the fundamental considerations and skills required to implement person-centred, safe communication in healthcare and have not consistently disseminated or implemented the findings of valuable work which has occurred. Communication in a clinical context is a core skill which operationalises safe and effective healthcare. We do not attempt to describe every aspect of it here, but rather consider the values and influences which underpin the complexity of communication relevant to clinical practice and describe the Australian and Aotearoa New Zealand context and status quo. While frameworks exist in other parts of the world, the unique and complex nature of the Australia and Aotearoa New Zealand contexts precludes the direct application of frameworks from other settings into ours.

The goal of the paper is to introduce a framework to facilitate development of a common understanding of the considerations relating to healthcare communication in Australia and Aotearoa New Zealand, and to start a conversation with relevant stakeholders about the fundamental principles of healthcare communication relevant to teaching, research, policy, and practice. This framework is explored from core considerations, working outwards to describe the key elements of communication in these contexts for application to four areas: research, teaching, policy, and practice.

1.1. Background

1.1.1. History, environment, and population

Australia and Aotearoa New Zealand both have long Indigenous histories – Aboriginal and Torres Strait Islander peoples have more than 60,000 years of continuous culture, whilst Māori people have a millennium of history in Aotearoa New Zealand. These cultures and histories were significantly marginalised during colonisation and the social and health systems in both countries have perpetuated this marginalisation [11-13].

Geographically, Australia is characterised by a populous east coast and large distances between rural and remote towns the further inland one travels. Aotearoa New Zealand, while smaller, also has rural and remote populations, with mountainous terrain adding to the distance. Both countries are at risk of extreme environmental events, with droughts, bushfires, and floods an increasingly frequent occurrence in Australia, and earthquakes and floods in Aotearoa New Zealand. Both countries are home to diverse ethnocultural groups including both First Nations and diverse migrant populations while also having small populations [14-16]. Importantly, both consumers and healthcare providers come from diverse backgrounds, adding complexity to interactions and both the expectations of, and the ability to achieve, person-centred communication [17-20]. Aspects of geography and population influence how healthcare is delivered and accessed, including communication within healthcare.

1.1.2. Communication in healthcare

Australian and Aotearoa New Zealand health systems follow the Beveridge model [21] of tax-payer funded universal healthcare. These public health systems include medical and pharmaceutical funding as well as systems designed to support marginalised populations [22-24]. Both systems include private health insurance; however this is more prevalent in Australia, where 53% of the population have private health insurance [25], as compared to 35% in Aotearoa New Zealand [26]. Although people are encouraged to have private health insurance in Australia through an additional levy, those with insurance still utilise public health services.

In Australia and Aotearoa New Zealand, there is some existing policy work relating to practice, such as the Australian Commission on Safety and Quality in Health Care standards [9] and Health Quality and Safety Commission New Zealand indicators [10]. Most accrediting and professional bodies of healthcare professions (e.g. the Royal Australian College of General Practitioners) include reference to use of effective communication skills to facilitate person-centred care and interprofessional practice among graduates [27]. Postgraduate training programs are, however, less consistent in how they teach communication competencies and continuing professional development activities focused on communication are predominantly opt-in. While the Australian Commission on Quality and Safety in Healthcare (ACQSHC) includes 'Communicating for Safety' and 'Partnering with Consumers' among its standards for care [9], and the Health Quality and Safety Commission New Zealand has some relevant indicators and tools [2,10], these focus largely on the mechanics and processes of communication to maintain consumer safety, rather than the nature of the interpersonal interactions.

Pockets of research are occurring across both countries, focusing on the educational approaches to teaching healthcare communication skills (Table 1) and on communication policies and approaches in clinical settings. An important opportunity exists in the dissemination of research findings and translation of work about communication into practice more consistently across these settings. Some existing examples support the potential for widespread translation of findings, with earlier work about handover having led to the integration of standard protocols throughout clinical practice [28-30].

Teaching practice to students and healthcare providers is highly varied, with aspects of communication training captured in different parts of the curriculum, such as cultural competency training [e.g. [31]] and interprofessional education [e.g. [32]] as well as specific

Table 1
List of some of the healthcare communication research groups in Australia and Aotearoa New Zealand.

Group	Institution	Website
Sydney Health Literacy Lab	The University of Sydney	https://sydneyhealthliteracylab.org.au/
Applied Research on Communication in Health	University of Otago, Wellington	https://www.otago.ac.nz/wellington/research/arch/
Institute for Communication in Healthcare	Australian National University	https://slll.cass.anu.edu.au/centres/ich
Sydney School of Public Health	The University of Sydney	https://www.sydney.edu.au/medicine-health/schools/sydney-school-of-public-health.html
Clinical Communication Group	Macquarie University	N/A
Queensland Aphasia Research Centre	University of Queensland	https://shrs.uq.edu.au/qarc
iValidate	Barwon Health	http://geelongcriticalcare.com/ivalidate-program

[1] Throughout this article we use the word "consumer" to capture terms such as patient and client along with consideration of consumers' families, carers, and support persons. We recognise the complexity that each of these words hold and the preferences of different professions.

[2] Again, we use "healthcare providers" and "providers" as a catch-all term for healthcare professionals across numerous disciplines and professions as well as a variety of levels, from students to accredited providers.

communication skills teaching [e.g. [33,34]]. While in many cases it is supported by research evidence suggesting its likely effectiveness [35], communication training is often hindered by resource limitations. There is anecdotal evidence to suggest that most of those who teach communication skills have had very little, if any training to do so. Various training programs do exist for healthcare providers wishing to improve their own clinical communication skills, or their skills in teaching communication and providing feedback to students [e.g. [36,37,38]]. Most of these programs incur a cost and require support from employers, which is not guaranteed. Even when policy changes occur and healthcare providers are expected to implement new approaches in communication, training has not been routinely provided [39].

By virtue of their healthcare training, it may be assumed that clinical providers are able to teach communication skills to students and colleagues. However, faculty development programs are generally optional and only a handful focus specifically on communication skills or the teaching of these skills [40]. Speech pathologists often engage in communication partner training [41] and other health professions such as dietetics also emphasise the importance of communication skills in their training [42].

There are high-level models and frameworks designed to facilitate healthcare communication such as the Calgary Cambridge guides to consultation skills [43], SEGUE [44], and FOUR Habits [45]. These generally focus on discrete, specific skills and processes that are centred around communication between the consumer and the healthcare provider. These models and tools can serve as a common ground, both for communication itself, and for structuring curricula in healthcare professional training, providing clinician-educators with a common language for discussing communication, and strategies for teaching, assessment, and feedback. There are fewer models and similar structured approaches specifically developed for healthcare professions other than medicine or for other modalities, such as online communication, which may impact translation of research evidence to training and practice [46]. Additionally, many of these models are imported from other countries with different health systems and cultural and linguistic considerations compared to Australia and Aotearoa New Zealand. Complementing these dominant frameworks are a range of contextually relevant tools designed to facilitate provider-provider and team communication, including recognised handover structures such as ISBAR [47], IMIST-AMBO [48], graded assertiveness [49], and crisis management tools [50,51].

Inconsistent approaches to healthcare communication across policy, research, and teaching, can lead to discordant practice with variations in expectations across organisations, role-modelling which fails to match pre-registration teaching and learning, and gaps in the translation of research findings across clinical contexts. This framework seeks to provide a foundation for a more consistent approach across all areas.

2. Methods and framework

The Framework (Fig. 1) was developed through a deliberative dialogue approach; a collaborative, iterative design process, involving the 15 authors who were brought together to represent the breadth of health professions and research traditions. The initial core group of authors was expanded to achieve appropriate diversity. In bringing together a team to address this, authors were identified through International Association for Communication in Healthcare (EACH) membership as well as from related networks to ensure interprofessional representation. Initial discussions identified the purpose and objectives of the process and included a presentation (by SW and CG) of a summary of the literature including existing related frameworks established for different settings or purposes. This foundational work led to a deliberative dialogue approach to facilitate development of the framework, using iterative drafts and open discussion to achieve consensus among the group. The concepts and framework were workshopped by authors across a series of virtual meetings, with all authors participating in at least one synchronous meeting. Subsequent asynchronous email communication was used for written contributions to the initial draft and comments and edits on subsequent versions.

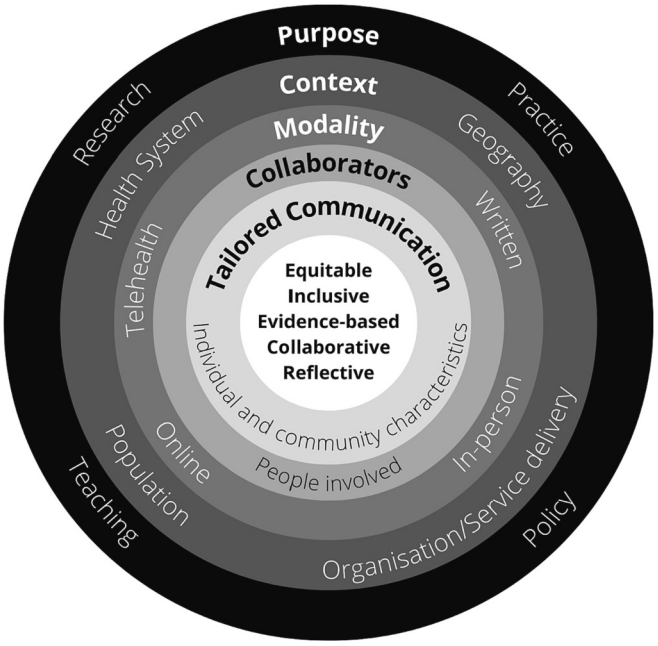

Fig. 1. Conceptual framework for enhancing effective healthcare communication in Australia and Aotearoa New Zealand.

The resulting framework can be visualised as six concentric rings, or wheels, where the outer three can rotate independently to generate multiple combinations of factors as relevant to the setting under consideration. This is reflective of other communication models presented in a similar format [52,53]. At the centre of the Framework are the underpinning *Core Values*: these demonstrate that all healthcare communication should aim to be equitable, inclusive, evidence-based, collaborative, and reflective. This circle and two around it, *Tailored Communication*, and *Collaborators,* are static. That is, they are not designed to rotate to align a single element at any one time. This recognises that consideration of all the elements within these rings are relevant in healthcare communication at all times and that there are likely many intersections and relationships between these in any given interaction. The three remaining circles, modality, context, and purpose are designed to spin. This illustrates how the different values in these three aspects can line up in different combinations and must be considered together, along with the principles in the three central circles. The elements in the three external circles may change as a result of further conversation and research about how to approach healthcare communication research, teaching, policy, and practice in Australia and Aotearoa New Zealand.

3. Results

3.1. Core values

The core values for enabling effective communication in healthcare are reflective of those required for effective healthcare more broadly. While these values are widely accepted as central to quality healthcare, they are not universally made visible in healthcare delivery. Important overlap also exists between practice, teaching, and policy. For example, evidence-based teaching approaches should ideally mirror the core values of best practice communication in healthcare settings.

We posit that healthcare communication should be *equitable*, in that approaches to development and improvement are responsive to the particular support needs of individual consumers and consumer groups,

as well as various professional disciplines.

The research, teaching, policy, and practice of healthcare communication should be *inclusive*, capturing a wide variety of world views, as well as the vastly different areas of clinical practice.

Healthcare communication should be *evidence-based*, in that research, specific to the local context, should be prioritised and that teaching, policy, and practice should be based on that research and on other high-quality evidence from studies conducted internationally.

Healthcare communication should be *collaborative*, with all relevant stakeholders involved throughout, to include the perspectives of providers in research, consumers in policy development, and communication experts and students in teaching. Further, it should support interprofessional collaboration, recognising shared goals of healthcare communication, as well as the unique contributions of each profession and the importance of teamwork in providing safe and effective healthcare.

Healthcare communication should be *reflective*, allowing an evaluative view on all aspects that enables critical reflection for quality improvement, adapting to new evidence, as well as to the people within the interaction.

These core values are at the centre of this framework as they shape and are shaped by communication. That is, the application of these values in research, teaching, policy, and practice can be seen (or not seen) in the interactions occurring within healthcare. These values also inform the other elements as we move through the different layers at play within the framework.

3.2. Key elements

3.2.1. Tailored communication

This framework acknowledges that while provision of healthcare often calls for standardised advice on effective communication, tailored approaches are required to meet the individual needs of specific groups of people and specific areas of healthcare. Effective communication requires an understanding of the capacities of the interactants to comprehend provided information and the ability to further investigate the nuances of what has been conveyed. Communication may be tailored to individual characteristics such as age or neurodevelopmental status, educational background and those with superimposed barriers to communication such as hearing loss, acquired communication disorders (e.g. aphasia, or cognitive-communication disorders), those who require augmentative and alternative communication, those experiencing significant trauma, grief or distressing mental health symptomatology, or for people from culturally and linguistically diverse backgrounds or gender diverse communities. Similarly, communication may also be tailored to particular healthcare settings (e.g., aged care, disability, mental health etc.). While many models of communication training [43,54,55] emphasise somewhat abstract components (e.g., empathy, engagement, rapport, etc.) that are broadly applicable to the majority of consumers, there are differences in how people process and perceive healthcare communication behaviours.

An individual's understanding and perception is shaped by their background, culture, prior experience, language, and psychology. Cultures vary in their health beliefs regarding the cause of illness, how it might be managed, and by whom. For example, some believe in a strong spiritual basis to the management of illness, others in the biological approach of Western medicine [56].

The notion of person-centred care, with consumer-provider communication as a central focus, has been increasingly incorporated in healthcare models worldwide [57]. It is understandable, and professionally responsible, that today's healthcare providers and organisations seek to improve the quality of their communication by using person-centred communication standards [58,59]. These standards recommend strategies which encourage consumers and, where appropriate, their family member(s), to become active participants in the decision-making process about their care. The standards are a result of evidence indicating that active consumer participation and partnerships with healthcare providers can result in reductions in mortality and healthcare utilisation, as well as improved consumer outcomes, consumer satisfaction, and consumer self-management skills [60-66].

Achieving tailored communication in clinical settings involves acknowledging people's competence and valuing their opinions. It involves having the training, strategies, time, resources, and flexibility to create communication-accessible, respectful environments and enable tailored spoken and written information sharing, self-advocacy, and full inclusion in decision-making [67-72]. Specific strategies include attentive listening, reflective practice, paraphrasing, teachback, and questioning to facilitate knowledge sharing and develop meaningful collaborative relationships with consumers [73].

3.2.2. Collaborators

Teams are varied and dynamic and are integral to healthcare practice. Teams and collaborators can include consumers, families, carers, healthcare providers, health service professionals, researchers, educators, and policymakers. The composition of such teams and the roles of collaborators therein changes depending on the primary function of the team, be it teaching, research, policy, or practice. Most research on collaborators and communication in healthcare has focused on collaboration in healthcare delivery, which forms the focus of this section. Considerations from this article may be transferrable to other types of teams and collaborators, though additional work is needed.

Effective communication within the team should be reflective and collaborative to facilitate professional and inter-professional cooperation. Team dynamics, including the abuse of power and role hierarchies, can pose a hazard to communication within a team. In clinical practice, transitions of care form the majority of between-team communications with 'handover' [29] and 'escalation of care' [74] identified as high-risk processes that require education, research, and policy development. Coordination of care for consumers by multiple providers, or teams, involves complex and extensive provider-provider communication which is often the subject of errors, or problems, and represents substantial scope for improvement. Provider-provider communication is vital to overcoming the competing priorities of different teams and establishing common goals. While the best outcome for each consumer is a shared, high-level goal, different teams often place significance on different aspects of the consumer's health and wellbeing, meaning that plans of care from each team are not always compatible. Maintaining clear, collaborative, and reflective provider-provider, and provider-consumer communication is paramount to the quality of care [75].

In an individual clinical consultation, a provider generally communicates with an individual consumer and possibly their family or carer, but all health professional groups also have a role in population-level communication and are faced with the challenge of navigating the tension between the two. For example, it is likely to be more straightforward to communicate risk to an individual whose comorbidities and psychosocial context is known, than to a population with a range of risk factors. More universal, population-level communication may therefore have greater social benefit and this needs to be complemented with more targeted messages for those at increased risk [76]. The COVID-19 pandemic laid bare the difficulties of broadcasting clear, consistent healthcare communication in the public domain. Inconsistent messaging resulted in confusion over how to prevent spread, and obtain vaccinations, and led to vaccine hesitancy [77]. The added complexity of aspects captured in the tailored communication section, communicating with those who speak a different language, or from differing ethnic and cultural groups was also apparent, highlighting that the style, language, content, and delivery of communication needs to be carefully considered to fit the setting and context in which the episode of communication occurs, if a shared understanding is to be achieved.

3.3. Modality

Modality (the medium through which communication is conducted) changes the ways educators, providers, researchers, and policy makers engage with consumers and with each other. Just as communication approaches need to be tailored for the needs of individuals and various consumer groups, they must be tailored to suit the modality of communication, with consideration given to the breadth of target audience in terms of needs, health literacy, and accessibility. Here we consider the influence of different modalities on communication.

While much of the focus of teaching, research and practice relating to healthcare communication is on in-person interactions, including spoken and signed languages, as well as other in-person communicative activities, these represent only a proportion of the total volume of communication occurring in this space. Written healthcare communication, including that associated with electronic health records, conducting research, and disseminating findings needs to be carefully considered in light of the target audience, meaning that several versions of the same information may need to be created. Regardless of the target audience, authors need to consider readability [78,79], literacy levels [80], and design principles [81,82] to ensure that written communication is clear, understandable, actionable, complements associated graphics, and is at a level the majority of the target population can understand.

Online healthcare communication, that is, synchronous or asynchronous multi-modal communication, requires similar consideration to written communication, which relies upon consumer accessibility to the online environment. Online communication has the ability to connect healthcare providers, researchers, and policymakers dispersed across different time zones and locations to support optimal care for consumers [83]. That said, it can present particular challenges for consumers as it relies on assumptions that all consumers have access to a web-connected computer, or other internet-capable device, including financial capacity to purchase adequate data, [84] as well as the digital and health literacy skills to access and interpret information. Importantly, evidence suggests a disruption to body language cues, such as facial expressions and subtle voice inflections, can negatively influence communication between new collaborators [85,86] and therefore the presence of video is important, to facilitate communication when people are unfamiliar with one another [87].

Telehealth refers to "a health care activity supported at a distance by information and communication technology services" [88] and has a long history in Australia and Aotearoa New Zealand, due to the geographical needs and relatively small populations [89,90]. Typically occurring via telephone, or video conferencing platform, telehealth allows remote, synchronous interaction between providers and consumers. This can be advantageous for access to health services, particularly for those living rurally and remotely; however there may be unintentional issues, such as reduced access for migrant populations [91], or those with disabilities. Changes to practice, such as the mass uptake of telehealth recently during the COVID-19 pandemic, need to be supported by policies, research, and teaching focused on facilitating effective communication taking place via this modality.

This first spinning circle in the framework identifies how different modalities impact healthcare communication, with each modality changing how key values and tailored communication are implemented in practice. The examples of different modalities will increase and change over time as technological advancement and digital health literacy, as well as health system prioritisation and funding, shift healthcare practice.

3.4. Context

While communication is ubiquitous in healthcare encounters, these encounters occur within a range of contexts, each with unique considerations. Organisational structures, processes, and both consumer and provider expectations differ across contexts. For example, community-based primary care is often the first point of consumer contact with the healthcare system and is often associated with more holistic considerations, long-term relationships, and wide-reaching topics of discussion than those experienced in hospital and specialist environments [92,93]. Structural differences exist in consultations occurring in primary care compared to those in outpatient surgical settings [94]. It is possible that consumers have different expectations of communication with specialist physicians compared to general practitioners. For example, there is some evidence suggesting that consumers may express satisfaction with clinical encounters, despite specialists demonstrating limited use of skills promoting person-centred care and empathy [95]. Other evidence supports the importance of rapport and genuine interest from practitioners in impacting consumer satisfaction in some contexts [96-98].

Some consumers have the choice to access public or private healthcare systems. Consumer expectations of care may differ across these contexts [99], however, the roles of health providers, their tasks, and their capacity to deliver person-centred care and communication remain relatively consistent, even with differing workloads and other expectations.

Australia and Aotearoa New Zealand both have a significant proportion of their population living in rural areas. This means that there is some distance from major centres where specialist care is more readily available. With the number of full-time equivalent healthcare providers per 100,000 population declining with increasing remoteness [100], providers face unique challenges in these settings, conflated by the high proportion of international medical graduates working in these settings [101]. Consumers in such areas often rely on their healthcare providers for all-encompassing, holistic care, but providers are stretched in their capacity to adequately meet the needs of these communities.

3.5. Purpose

The outside wheel considers the primary focus of the work that is being done – policy, practice, research, teaching – and asks how it impacts the other layers of the framework. This can be framed as 'the conversation that needs to happen' - taking on board these considerations, how can we achieve effective communication? Application is explored in the discussion, capturing future directions and priorities for healthcare communication.

4. Discussion and conclusion

4.1. Discussion

With innumerable providers, consumers, researchers, and policymakers passionate about improving communication in healthcare, efforts to coordinate widespread change based on evidence will benefit from supporting dialogue tools. This framework has been developed in consultation with experts across Australia and Aotearoa New Zealand. It is cross-disciplinary in recognition of the diversity of consumers and health contexts. Through this article we have touched on the different core values, components, and aspects of healthcare communication to create a cohesive picture of the space, constituting a conversation starter that may be useful for policy, teaching, research, and practice. While the framework has been developed specifically for the Australian and Aotearoa New Zealand context, given the universal recognition and relevance of the core values promoting inclusivity, equity, evidence-based, collaborative and reflective practice, it is likely to be applicable in other contexts. This is the first framework of its kind to address the unique and diverse cultural considerations of these settings, but given the diversity within these settings, and the flexibility built into the framework, we expect that it could be applied to a range of others.

Policymaking influences funding and supports priorities at local and national levels, from curriculum design to research grant allocation. A

lack of prioritisation of communication in policymaking results in reduced investment in teaching and research, and, therefore, more disconnected work, an insufficient locally-developed evidence-base, and, ultimately, less effective communication in practice.

Teaching of communication skills, as core clinical competencies, should be supported through training and accreditation requirements, with shared resources, opportunities for benchmarking and faculty development, to ensure quality teaching and consistency between teaching and clinical role-modelling. Supporting integrated communication teaching, for both students and practicing healthcare providers, is central to improving practice. Having a healthcare workforce with an understanding of the facets of effective communication, combined with a consistent skill level, has enormous potential for improving quality indicators of healthcare, including consumer satisfaction ratings, measurable health outcomes, and healthcare workforce retention rates.

Much of the research cited herein has been conducted in countries other than Australia and Aotearoa New Zealand. Research specific to the organisational and cultural nuances of different settings should be prioritised, along with a focus on work conducted within our two countries. This will further define the current practices, contextual influences, and priority areas for healthcare communication in our region.

Across all of these activities, consumer engagement needs to be prioritised through the direct involvement of consumer representatives. This will facilitate more person-centred and authentic approaches to provision of care, policymaking, research, and teaching.

4.2. Innovation

This paper is a starting point for an Australia and Aotearoa New Zealand dialogue about connecting current work and developing new initiatives around communication in healthcare. In the healthcare professions represented, research, education, and guideline development have generally occurred in a discipline- or profession-specific, siloed manner. As such, this is a unique and much needed attempt to break down the silos and bring experts together to develop a model that supports common language. While involving representatives from all areas of healthcare was not possible for this paper, it is an effort to begin a cross-disciplinary conversation, which will require further input from wide-ranging stakeholders, including consumers, providers and policymakers.

Considering the importance of effective communication in healthcare, it is essential to keep an agreed conceptual framework in the forefront of people's minds. It is intended that this framework be used to trigger ongoing discussions about how best to promote effective communication across healthcare teaching, research, policy, and practice, such as through the development of region-specific position papers and strategy documents.

4.3. Conclusion

The framework presented here is designed to recognise the complexity in the space, while also attempting to map the key considerations, to help those working within the field of healthcare communication to navigate the landscape and apply the core considerations to their practice. It is designed, also, to better translate local research into teaching, policy, and practice. It is the beginning of a more connected body of work, drawing on the expertise of individuals in Australia and Aotearoa New Zealand. This paper provides a platform to build a sharing, benchmarking, and collaboration.

Declaration of Competing Interest

None.

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