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The physician-to-physician health-care barriers—a phenomenological study

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Abstract

Objectives: This study examines attitudes consisting of thoughts, feelings, and behaviors (T-F-B) chains experienced in imagination by physicians before and during their own treatment as patients and before and during the treatment of other physicians as patients. Methods: Ninety-six physicians from three countries completed a questionnaire about their imagined attitudes in four situations: "before and during your visit to a physician as a patient" and "before and during a visit to you, as a physician, by another physician in the capacity of a patient". These questionnaires were retrolectively and qualitatively analyzed. Results: All four situations evoked negative and/or stressful T-F-B reaction chains. Some of these chains were related to the context of two physicians meeting, such as feelings of shame when asking for medical care from another physician and fear of failing as the consulting physician. Conclusion: There are specific barriers to physicians seeking treatment from and providing treatment to other physicians, particularly feelings of shame on both sides. A questionnaire based on these results could be used to study larger and more diverse populations. Aspiring physicians can learn what it means to ask for medical treatment as a physician, potentially reducing anxiety or insecurity, and fostering greater compassion for their patients. Attention to these issues could be incorporated into communication training within the medical curriculum.

Keywords: *physician-to-physician health-care barriers*, *attitudes*, *qualitative*, *seeking treatment*, *providing treatment*, *communication in medical curriculum*

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1. Introduction

In this study, we investigate why physicians struggle to seek medical treatment from another physician and to provide treatment to another physician.

People often tend to avoid seeking help for physical or psychological complaints [1]. The intention to seek help depends on one's attitude toward the behavior, the subjective norm, and the perceived behavioral control over engaging in that behavior [2, 3]. Asking for help can imply incompetence, negatively impact a person's public image, or undermine their self-esteem, as it may be perceived as admitting incompetence and inferiority [4]. After receiving help, a person may feel guilty toward the helper because they were unable to succeed without assistance [5]. Barriers to seeking help can include shame, a negative attitude toward health professionals, negative experiences, and poor recognition of health problems. Stigma and negative beliefs toward mental health services and professionals are barriers for adolescents seeking help for mental health issues [6]. Facilitators to seeking help include positive previous experiences, good symptom recognition, and familiarity with available sources of help [6].

Physicians are exposed to stress at work, resulting in an increased risk of burnout [7, 8]. Up to 80% of physicians experience symptoms of burnout [9]. Barriers to self-care and help-seeking are common among residents and may be more pronounced in those experiencing burnout [10].

Physicians are an at-risk profession of suicide [11, 12], as are nurses [13]. Due to their professional backgrounds, physicians may experience unique and significant barriers to seeking outside help and may find it difficult to assume the role of a patient [14–16]. Physicians often self-diagnose, self-medicate, and/or do not take the time to make an appointment with a (colleague) physician [16, 17]. Many health-care professionals prioritize the needs of others above their own [18].

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Another problem concerns shame [19]; about 70% of physicians are ashamed to see another physician [14], fearing they might present with a trivial illness or have made an incorrect self-diagnosis or treatment. They are also afraid of burdening another busy physician, creating a negative image of themselves, or risking the loss of their right to practice [20]. Negative feelings about a substance use disorder also serve as an important barrier to asking for help [21]. These barriers, in turn, can lead to a lower quality of treatment and a poorer prognosis, especially for mental health issues [14, 15].

There are also obstacles for the attending physician when treating a fellow physician. The attending physician may face significant challenges, such as guarding boundaries, avoiding assumptions about the physician-patient's medical knowledge and health behavior, and managing access to informal consultations and test results. The attending physician may also worry that their performance will be evaluated by the physician-patient [22].

Research into medical help-seeking or treatment-giving behavior does not always distinguish between gender, age, and cultural background. Women are more likely to seek help, including from medical professionals [20]. Before seeking treatment for depression, men's help-seeking behavior is negatively affected by internalized masculine norms [23]. The social costs of seeking help for men may be higher [4], making them less likely to seek help. Other determinants, such as occupational grade, may also play a role [24, 25]. Women under the age of 65 were the most likely to seek help and feel least ashamed of doing so. Senior physicians were more likely to seek help than their less experienced or younger colleagues [20], consistent with the positive association between older age and a higher need for help [4]. Cultural background can influence perceptions of health and disease, including explanations of diseases, treatment options, and help-seeking and help-providing behavior [26–28]. In some countries, patients first seek medical help from traditional healers and may have a more negative view of medical services, which can cause delays [29].

In this study, we aimed to examine more closely why physicians find it difficult to ask for or provide medical treatment to another physician. We examine this problem from the perspective of cognitive behavior therapy (CBT), as CBT may help individuals eliminate avoidant behaviors that prevent self-correction of faulty beliefs, thereby facilitating stress management and reducing stress-related disorders [30–32]. The thoughts, feelings, and behaviors (T-F-B) chains we are examining align well with the concept of implicit attitudes, defined as introspectively unidentified (or inaccurately identified) traces of past experience that mediate favorable or unfavorable feelings, thoughts, or actions toward social objects [33]. In the rest of the article, "attitudes" and "T-F-B chains" will refer to the same phenomenon. The main question is what specific chains are triggered in the context of the relationship between two physicians, where one is the patient and the other is the attending physician.

2. Materials and methods

2.1. Design

This qualitative convenience sampling study concerns a retrolective [34] phenomenological study [35] into the meanings that physicians attribute to seeking treatment from a fellow physician or providing treatment to a fellow physician. We adopted a phenomenological approach to understand the essence of the barriers that exist when two physicians interact, one of whom is the patient. A questionnaire with open-ended questions was used as an assignment in CBT training; these questionnaires were later analyzed to explore patterns in the responses as described by the participants. The respondents recorded their answers based on memories of personal experiences or on their imagination, if they lacked such experiences.

2.2. Participants

Table 1 shows sociodemographic characteristics of the convenience sample, i.e., cases that are easily accessible and inexpensive to study. The sample consists of completed questionnaires from 96 junior doctors attending introductory psychotherapy courses, 37 residents in psychiatry from Indonesia, 42 residents in addiction medicine from the Netherlands, and 14 residents in psychiatry from Lithuania. The data were collected in 2019 and 2021.

2.3. Procedure of data collection

In preparation for a one-day introductory CBT workshop (taught by CDJ), physicians were asked to complete a questionnaire with open-ended questions and send it to the trainer. Analysis of the assignments could also provide important information about physician-to-physician health-care barriers. Analysis of the data was ethically justified because no mark was given for the assignment; answers were initially used during the workshops, for example, in role-play exercises, meaning that filling out the form was not an additional burden; and the workshop trainer had no hierarchical relationship with the students. For this research, he anonymized the data, after which the other researchers entered it into the software. The study was approved by the Institutional Review Board (IRB) of the Lithuanian University of Health Sciences in Kaunas (PK 19-01). We monitored the quality of the study by using the complete checklist of the Consolidated Criteria for Reporting Qualitative Research (COREQ) [36, 37] (**Table S1**, Supplementary materials).

2.4. Questionnaire

In our study, we did not use a questionnaire in the strict sense with historical data on its reliability or validity. Instead, as is common in interviews in qualitative research, we used four structured questions. Furthermore, the open-ended questionnaire was based on the core principles of CBT; the questions were posed in the following order: thoughts, feelings, and behavior (T-F-B) and were fourfold:

> *"Imagine you are a patient: I go to the physician as a patient: BEFORE/DURING the consultation I have the following thoughts, feelings, and behavior": ... and "Imagine Being a physician, I will meet a colleague-physician as a patient in my office: BEFORE/DURING the consultation I have the following thoughts, feelings and behavior":....*

Before using this method with the respondent groups, we asked colleagues who were not involved in the study or the courses if the way we posed these questions was acceptable and understandable, and they agreed. We stress that asking for help is meant in a general medical sense and is not limited to help for psychological or psychotherapeutic problems. We assumed that almost every participant has at some point in their life, as a patient, sought health care from a physician. Since providing help to another physician may not be an experience shared by everyone, the question for that scenario was: "Suppose you have a consultation with another physician:...". The Indonesian and Lithuanian respondents were asked to write their answers in English. The Dutch questionnaires were translated into English by one of the researchers (ES).

Table 1 • Demographic data of the respondents

	Indonesia (n= 37/4)		Lithuania (n= 14/4)		The Netherlands (n= 45/8)	
	Total	Rich	Total	Rich	Total	Rich
Male or female (not available)	6/29 (2)	1/3	5/9 (0)	1/3	21/22 (2)	3/5
Age*						
20–29	4	(1)	13	(4)	2	(0)
30–39	24	(2)	0	(0)	16	(2)
40–49	7	(1)	1	(0)	11	(4)
Over 50	0	(0)	0	(0)	13	(2)

*The age of one of the cases from the Netherlands is not known.

Note: The number of information-rich cases per group is indicated in the Rich columns.

2.5. Analysis

Two of the authors (EMS and LVR) identified information-rich cases by combining intensity sampling and maximum variation sampling [38]. These were the questionnaires that were completed in more detail, either with more in-depth answers or with multiple T-F-B for each imagined situation. For each information-rich case, T-F-B were recorded and examined for reaction chains, i.e., thoughts that led to a certain feeling or behavior, with special attention to those related to being a physician. When no new answers were found, the data were considered saturated. The data from the other questionnaires were thoroughly analyzed with ATLAS.ti (version 9: ATLAS.ti Scientific Software Development, Berlin, Germany) for possible additions to the information-rich cases and to determine whether these led to new insights.

3. Results

In the total group of 96 respondents, we identified 16 as information-rich (Lithuania 4, Indonesia 4, and the Netherlands 8). After analyzing these information-rich questionnaires, we considered the data saturated. Assessing the remaining 80 cases revealed no new themes in the T-F-B chains and confirmed what we had already found. Eleven of the rich cases were written by women and five by men. Five were written by respondents aged 20–29 years, four by those aged 30–39 years, five by those aged 40–49 years, and two by people aged 50 years or more.

Different thoughts lead to different feelings, resulting in different behaviors. The most reported feelings in both conditions were anxiety, fear, insecurity, and nervousness. Some of the T-F-B chains seem to be related to cultural background, gender, or age. Positive feelings were also reported “during the appointment”.

In the following sections, we describe the T-F-B chains in detail. **Table 2** summarizes doctors’ general and specific thoughts in the four situations: before and during a consultation where one person assumes the role of doctor and the other that of patient. “General” refers to thoughts that any patient might have, while “specific” refers to thoughts that only occur when both individuals are doctors.

Before visiting a physician as a patient, thoughts, such as “I thought about my illness, is it severe or not?”, “Can I be treated well by this doctor?”, “Need help”, “Don’t know what to do anymore”, or “Have done everything”, led to feelings of fear, nervousness, and anxiety. These negative feelings—regarding a diagnosis, uncertainty about treatment success, or physician competence—led to submission or willingness to be helped. We referred to these reaction chains or attitudes as general attitudes in meeting a physician.

Some of the attitudes specifically refer to the situation in which two physicians meet. Anxiety and doubt were preceded by thoughts, such as “Can I trust this colleague?”, “I am a doctor; What will he think about me?”, or “I hope this won’t change how he sees me as a colleague”, and were followed by attentive, quieter, or more cautious behavior. The thought “I hope I don’t seem too demanding” led to insecurity and was followed by thorough preparation for the consultation, either by considering a differential diagnosis or by trying to gather as much information as possible about a diagnosis. The thought “I should have solved this problem myself" led to insecurity, especially their professional identity. A thought like “the colleague will say I’m overestimating my symptoms” led to fear of being judged as a physician and resulted in delays in seeking help. We referred to these attitudes as specific attitudes in the context of physicians meeting another physician as a patient.

Thoughts, such as “I hope I’m not belittled but addressed in medical jargon”, occurred only among the Dutch, while Indonesians often had thoughts like “Can I trust this doctor?” and Lithuanians often had terrifying thoughts, such as “The doctor will say I overestimate my symptoms and I will be judged”. Women often doubted whether they would be judged as a physician-patient and were afraid that the treating physician would downplay their symptoms. In contrast, men indicated that they would downplay their symptoms themselves and diagnose themselves. It was noted that concerns about confidentiality, being judged, and being misunderstood were reported by respondents aged 20–29 years. Among respondents aged 20–29 and 40–49 years, it was noted that they thought their symptoms would be downplayed, that they should have resolved the issue themselves, and that they questioned the adequacy of the physician’s skills. Those over 40 often self-diagnose or prescribe medication. Respondents aged over 50 and under 30 years prepared thoroughly for the meeting, determined to ask many questions and develop their own solutions.

Table 2 • General and specific thoughts of physicians in four situations: before and during a consultation where one person assumes the role of physician and the other that of a patient

Situation	Nature of the thoughts	Thoughts
1. The physician in the role of patient: before the consultation	General	A: "I thought about my illness, is it severe or not?" B: "Can I be treated well by this doctor?" C: "Need help" D: "Don't know what to do anymore" E: "Have done everything"
	Specific	F: "Can I trust this colleague?" G: "I am a doctor; What will he think about me?" H: "I hope this won't change how he sees me as a colleague" I: "I hope I don't seem too demanding". J: "I should have solved this problem myself" K: "The colleague will say I'm overestimating my symptoms" L: "I hope I'm not belittled but addressed in medical jargon"
2. The physician in the role of patient: during the consultation	General	A: "This doctor seems to be able to help me, he looks smart and his demeanor showed me that he cares" B: "She is nice" C: "She asks too many personal questions" D: "Is he going to let me finish?" E: "I have to explain everything again"
	Specific	F: "I could have come up with this on my own, I knew this!" G: "I hope he does not see me as someone too weak to do my job" H: "What would he think about me as a doctor now being a patient?" I: "The doctor doesn't trust me as a patient within my own medical specialism"
3. The physician meets a patient who is also a physician: before the consultation	Specific	A: "What can I recommend to my colleague, I should read more about it" B: "How will this doctor behave as a patient?" C: "What if he knows more than I do?" D: "Afraid I'll misdiagnose the colleague" E: "Am I an incompetent doctor?" F: "OMG, what if I'm not good enough as a doctor" G: "He knows more than me" H: "What if he gets into a fight with me, what must I do?" I: "This doctor has serious problems, so he wants to meet his colleague" J: "Quite the pity, that he has that problem, while being a doctor?" K: "It's easier to explain the circumstances to a colleague" L: "He may not be telling the truth or hiding symptoms" M: "What is the purpose of his visit?"
4. The physician meets a patient who is also a physician: during the consultation	Specific	A: "It must be bad to go to a colleague for help" B: "He really needs help" C: "He knows more than I do and will doubt my decisions" D: "Would my colleague agree to my assessment and treatment plan" E: "I'm afraid I will offend the colleague" F: "I want to put him at ease, I want to make it clear that I am not writing him off as a doctor in advance"

"General" refers to thoughts that any patient might have, while "specific" refers to thoughts that occur only when both individuals are physicians.

During an appointment, respondents had more hopeful and comfortable general attitudes with thoughts, such as "This doctor seems to be able to help me, he looks smart and his demeanor showed me that he cares" and "She is nice". These thoughts made them feel reassured and taken seriously, leading to relaxed behavior and acceptance of the situation. However, there were also negative general attitudes. Thoughts, such as "She asks too many personal questions", "Is he going to let me finish?", and "I have to explain everything again", led to irritation and behaviors, such as acting as a "perfect patient", pretending nothing happened, or trying to stay calm. One respondent said that he thought about what he did not want to hear from the treating physician, which upset him, but he also tried to remain calm. Another participant thought about what he wanted to achieve, which made him more determined.

During a consultation, there were also positive specific attitudes. One respondent, upon receiving confirmation from the physician of her own diagnosis and solution, thought "I could have come up with this on my own, I knew this!" and felt a sense of triumph. Another respondent felt relieved because she believed the treating physician did not need to hear a solution from her.

Negative specific attitudes were also found. Thoughts, such as "I hope he does not see me as someone too weak to do my job", "What would he think about me as a doctor now being a patient?", or "The doctor doesn't trust me as a patient within my own medical specialism", led to anxiety, shame, and insecurity, as well as to reluctance and anticipation in observing the physician during the appointment.

During the consultation, men seem to assess the treating physician's competencies, while women were more cautious and questioned whether they could trust the physician. Although both groups experienced more positive feelings than before the appointment, such as feeling comfortable and relaxed, women also reported anxiety, and men sometimes felt ashamed. It was noticed that respondents aged 30–49 years often anticipated feeling ashamed and insecure during the appointment, fearing that they would not be taken seriously, be judge, and be inclined not to tell everything.

Before a consultation with another physician who is a patient, the consulting physician reports specific negative attitudes for this situation. Thoughts, such as "What can I recommend to my colleague, I should read more about it", "How will this doctor behave as a patient?", and "What if he knows more than I do?", led to insecurity, fear, or anxiety. These feelings led them to prepare more thoroughly, for example, by scheduling additional time to review the file carefully, researching the patient on social media or seeking information from others. Additionally, thoughts, such as "I'm afraid I'll misdiagnose the colleague", "Am I an incompetent doctor?", "OMG, what if I'm not good enough as a doctor", "He knows more than me", and "What if he gets into a fight with me, what must I do?", evoked fear, anxiety, and confusion, making them nervous and prompting better preparation. Thoughts, such as "He may not be telling the truth or hiding symptoms" and "What is the purpose of his visit?", led to suspicion and made them more observant of the other person's behavior during the appointment.

There were also positive attitudes. Thoughts, such as "This doctor has serious problems so he wants to meet his colleague" or "Quite the pity that he has that problem, while being a doctor?", made respondents feel proud and prompted them to act professionally and with compassion. The thought "It's easier to explain the circumstances to a colleague" pleased them and resulted in a smooth meeting and detailed discussions.

Some women imagined whether they could help their colleagues and whether they would perform well. Some men thought about what was causing the symptoms, how to show empathy, and how to treat their colleagues like normal patients.

During an appointment, both were positive and negative attitudes were observed. Feelings of compassion and empathy followed thoughts, such as "It must be bad to go to a colleague for help" and "He really needs help". This led to efforts to put the patient at ease and work together to find a solution. Conversely, thoughts like "He knows more than I do and will doubt my decisions", "Would my colleague agree to my assessment and treatment plan", and "I'm afraid I will offend the colleague" led to insecurity and anxiety. This resulted in more cautious behavior, additional explanations than usual, and a greater effort to connect with the patient's prior knowledge and explicitly ask about it.

Some women still felt fear and anxiety during the appointment, whereas men reported these feelings less frequently. Instead, some men reported feeling more empathy, insecurity, and shame. Men indicated that they actively tried to be empathetic.

4. Discussion

The 96 responding physicians experienced a wide variety of attitudes, consisting of T-F-B across all four situations. First, there were general attitudes, similar to those any patient might have when seeing a physician, including feelings of fear and insecurity. Second, specific feelings were linked to the physician's identity and the associated doubts that arise when asking another physician for help or when providing help to a colleague. Further categorization was challenging because the chains of T-F-B were highly diverse. For example, agitated behavior was accompanied by feelings, such as anxiety or confusion, preceded by thoughts like "What's going to happen with me" or "Fear that the illness is incurable". We expect that with a larger study population, it may be possible to find more specific categories of attitudes.

In the role of a patient, their attitudes were mostly negative *before* the appointment. *During* the appointment, there appeared to be a slight shift toward more positive attitudes. The most commonly reported feelings were anxiety, fear, insecurity, nervousness, and shame, which align with general barriers to seeking medical care in diverse patient populations [1, 6]. Positive feelings, such as hope, relief, and pride, were associated with the physician's relaxed behavior and acceptance of the situation, while negative feelings were linked to distancing, concerns about the physician's reliability, and doubts about the confidentiality of the consultation.

The reported shame seems to be associated with thoughts of incompetence as a physician [19], eventually leading to fears about the impact on their right to practice [20]. Such feelings of shame and fear of disqualification are specific, noteworthy barriers for physicians asking help for themselves.

The physician providing treatment to a colleague also experiences negative feelings related to doubts about their competence as a physician. These problems differ from situations where the patient is not a physician. However, when the patient is a

physician, the consulted physician may be more vulnerable to avoidance tendencies, stress, anxiety, and shame, along with concerns about incompetence. In other words, a helping relationship between two physicians may be susceptible to the denial or avoidance of vulnerable and negative feelings, potentially leading to "patient delay" [39] on the patient's side and an increased risk of treatment dropout [40].

Although we mentioned some striking differences in the responses from the respective countries, we have refrained from examining these variables in detail in this study. However, our findings may encourage further investigation into possible differences in how physicians from various cultures seek and provide medical treatment.

The evaluation of the CBT courses is not part of this research design and is therefore beyond the scope of this article. However, most participants noted that discussing the four situations in pairs was a helpful experience. One participant expressed it this way: "I never thought that patients could feel the way I felt before and during a consultation. In fact, I've never thought about how I feel before or during a consultation with a doctor".

Our study has several limitations. The questionnaire started with "Imagine…", which limits the generalizability of the results to real-life situations. However, it allowed us to include physicians who have never had another physician as a patient in the consultation room. By asking respondents to recall a situation where they had to seek help from another doctor, we did not avoid recall bias. Nevertheless, this approach brings us closer to understanding why doctors find such situations difficult. Our study focused exclusively on rather young residents in psychiatry and addiction medicine, so it remains unclear whether the findings could also apply to older physicians or those in other specialties. Finally, Indonesian and Lithuanian respondents completed the questionnaire in a non-native language (namely English), which may have led to answers that did not exactly represent their true thoughts or feelings.

5. Conclusions

In this section, we discuss two important leads for undergraduate training, continuing education, and follow-up research.

First, the practical application of our approach. In preparation for a one-day introductory CBT workshop (taught by CDJ), physicians were asked to complete a questionnaire with open-ended questions and submit it to the trainer. This exercise heightened their awarenessof the barriers to seeking help. During this and many subsequent training sessions, we also worked on recognizing and discussing personal barriers to asking for and offering help to another physician during the training itself. For example, participants are asked to discuss a personal physical or psychological problem with a colleague, paying close attention to the T-F-B that such an exercise evokes in both participants. Although we have not formally studied this, both our impressions and those of the participants suggest that discussing all kinds of barriers in a safe, one-on-one conversation, as reported in the results of our study, is highly enlightening.

The CBT principles on which the questionnaire in this study was based were also helpful in exploring the attitudes that contribute to physician-to-physician health-care barriers during training. There are specific attitudes that raise barriers for physicians both in seeking treatment from and in providing treatment to other physicians. As patients, physicians often experience shame associated with thoughts of incompetence. Similarly, physicians providing treatment to other physicians experience negative feelings related to doubts about their own competence. Positive feelings can develop in both roles during a consultation, potentially due to the acknowledgment of the complex dynamics involved when two physicians meet, with one assuming the role of the patient. Discussing these aspects of help-seeking behavior can help lower the threshold of these barriers.

Thought experiments, such as those used in our study, yielded a lot of valuable information into obstacles like negative attitudes experienced by physicians when seeking medical treatment from or providing medical treatment to other physicians. These insights can easily be incorporated into communication training within the medical curriculum. Young physicians can benefit from this, especially when their own T-F-B on this subject are explored and addressed using CBT principles. Furthermore, they not only learn what it means to ask for medical treatment as a physician but may also develop compassion for other types of patients who experience similar reaction chains. Such exercises are not only beneficial for undergraduate medical students and young professionals but can also be integrated into continuous medical education sessions. This approach can help prevent clinicians from becoming isolated when they need help and are unable to ask for it.

Based on the results of this research, we suggest that physicians who see another physician in the consulting room, whether as a patient or as a treating physician, should pay attention to the unique dynamics and resulting feelings of this situation. Discussing this context may help both the treating physician and the patient-physician reduce reciprocal anxiety and uncertainty and may promote suitable shared decision-making.

In our qualitative study, we collected participants' experiences, perceptions, and behaviors. It answers the "why and how" rather than the "how much or how many".

The next step could be to plan a more quantitative study, where the problems we have found are presented to a representative group of doctors via a questionnaire. This would answer questions about the frequency and types of barriers they experience in the roles of both patient and doctor. This can be achieved by incorporating the findings from this qualitative study into a questionnaire, which is a common method for studying larger groups.

Such a questionnaire would provide the opportunity to survey more diverse groups and gather detailed demographic, cultural, and contextual information about participants, such as their work environment, workload, and access to mental health resources or workplace supports like wellness programs. This information could help understand how different work contexts influence physicians' experiences and attitudes and could potentiallyinform the design of health-care systems.

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Author contributions

Conceptualization, C.D.J., D.J. and S.I.; methodology, C.D.J., E.S. and G.P.; software, E.M.S.; validation, C.D.J., L.V.R., E.M.S. and G.P.; formal analysis, E.M.S.; investigation, C.D.J., D.J. and S.I.; resources, C.D.J., D.J. and S.I.; data curation, C.D.J., D.J., S.I. and E.M.S.; writing—original draft preparation, E.M.S., C.D.J., G.P. and L.V.R.; writing—review and editing, C.D.J.; visualization, C.D.J.; supervision, C.D.J.; project administration C.D.J. All authors have read and agreed to the published version of the manuscript.

Conflict of interest

The authors declare no conflict of interest.

Data availability statement

Data supporting these findings are available within the article, at https://doi.org/10.20935/MHealthWellB7337, or upon request.

Institutional review board statement

The study was conducted in accordance with the Declaration of Helsinki and approved by the Institutional Review Board (or Ethics Committee) of Lithuanian University of Health Sciences, Kaunas, Lithuania (PK 19-01, approved on April 28, 2019).

Informed consent statement

The authors declare that human participants were involved in the study and have provided all relevant informed consent forms.

Sample availability

The authors declare no physical samples were used in the study.

Supplementary materials

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