Patients’ experiences of being touched by their general practitioner: a qualitative study

Louise Devillers 1,2, Amélie Subts,1 David De Bandt,1 Pierre-Louis Druais,1 Julie Gilles de la Londe2

ABSTRACT

Objective This study aimed to explore patients’ experiences and perceptions of touch, as practised by their general practitioner during their medical appointment.

Design Qualitative study using grounded theory method, based on individual interviews. Data collection and analysis occurred iteratively; themes were identified using constant comparison.

Setting Recruitment among general practitioners’ private practices and health centres in Ile-de-France.

Participants Twenty-one patients aged 19–88 years old, interviewed between June 2018 and May 2019.

Results Physical examination was described as a ritual enabling the establishment of patients’ and doctors’ roles, the verification of the doctor’s skills and the construction of a caring experience. Touch was also a media for the doctor to exercise power that the patient authorised. Finally, it had relational and emotional value.

Discussion and conclusion Physical examination is so internalised by the patients that it becomes unquestionable. It may be inappropriate when this touch does not belong to physical examination or on the contrary represents a proof of the doctor’s humanity. The patient is not necessarily aware of the relational dimension that underpins touching and, in particular, clinical examination. This raises the question of why should doctor use it and how they can communicate about it, so that it may become an active tool in favour of trust and the construction of the relationship.

INTRODUCTION

According to Anzieu and his concept of ‘skin-ego’, any psychological function originates and develops from a bodily function. The skin is both a container, a protection from the outside world and an interface, which function is to communicate with other people.1 As Andrieu puts it, ‘tactile sensitivity is the result of a reflection about one’s skin’2 explaining that health professionals (doctors, nurses, physiotherapists, osteopaths…) experience touch differently,3 as also do patients.

From Merleau-Ponty’s3 perspective, body and mind coexist. Flesh is the materiality through which humans subjectively experience and come to know the world. This recognition of the embodied nature of human experience challenges the scientific objectivity that may lead clinicians to treat patients’ bodies as objects of palpation, cleaning and suturing. The body–subject concept challenges the way health professionals are taught to focus on the body–object to set personal and professional boundaries.

Thus, being in contact with a patient, through touch, is not to be dealt, it lightly as it bears significance, both on a personal and interpersonal scale and on a broader cultural spectrum.

Touch in the medical field is a learnt tool,4 it has a specific function: that of diagnosing.56 It, hence, carries technical baggage7 and a necessary distance, even perhaps a coldness.68 The way medical knowledge has been built throughout the century has taught doctors to be able to ‘read’ with their fingers, but as Balint states it, this is not the sole purpose of the medical touch. The latter actually has a therapeutic function, touching a patient could, in itself, be treatment enough, which sometimes might question the general practitioner (GP) on the possibility of misunderstanding his or her gestures.69

These two apparent contradictory conceptions of touch—one being the technical tool to guide a diagnosis as taught to young doctors in their medical curriculum and the
other being a tool in itself to heal the patient as experienced by the patients themselves—offer a fruitful field to explore. In fact, while the literature widely explored caregivers’ points of view, there is much to be said for the point of view of the patient, which the present study aims at exploring.

**METHOD**

We conducted a qualitative study, following a grounded theory approach with a postpositivist approach according to Strauss and Corbin. The research question being set, the first two authors (LD and AS) spent some time clarifying their preconceptions about the subject, using The 7 question methodological tool (online supplemental file 1) to make sure they would not interfere with field data and that results would not be the only projections of the authors’ assumptions. These preconceptions included thoughts about the fact certain kinds of touch during physical examination could be misinterpreted by patients; that some touch could help build trust and relationship; that notions like good or bad touch would come up. The interviewer and leading researcher used a reflective journal throughout the research process. In the ladder, she wrote down all these preconceptions, thoughts, findings and her operational, theoretical, field and coding reports. It was a tool to assist her in making conceptual leaps: from raw data to abstractions that explained the research phenomena in the context in which it was examined.

To facilitate the field access and to be able to recruit the participants, the interviewer met some GPs from private practices and health centres in Ile-de-France who accepted to get her in touch with some of their patients. GPs from three private practices let her stay in their waiting room in order to recruit volunteers. Among these patients, she purposively sampled participants based on specific and various criteria such as gender, age and occupation, their GP’s gender and type of practice (rural, semirural and urban practice) to maximise the sample variation. Some participants gave ideas of people who could be contacted for further interviews (snowball sampling).

Each participant gave oral consent to participate in the study before the beginning of the interview. She conducted semistructured individual interviews in person using a loose structure consisting of open-ended questions and defining the issues to explore, at least initially, and from which she might depart to pursue an idea in more detail. Interviews took place in a quiet place right after the medical encounter, within the structure of the medical practice, with no time limit. All interviews were audio-recorded and subsequently transcribed anonymously.

The authors (AS, LD and JGdlL) initially created the interview guide and adjusted it after the first three interviews according to data emerging after each interview (online supplemental file 2).

The authors sent back the results to participants to check for accuracy and resonance with their experiences.

**Patient and public involvement**

The development of the research question did not involve patients. The authors are all GPs and as a matter of fact have a good knowledge on how consultations are conducted. Despite our best intentions as physicians, we may not always know or cannot assume patients’ expectations. To prevent potential bias, the first three interviews allowed the investigator to obtain information from the participants about the wording of the questions, their understanding and their relevance to the topic. These exchanges helped the interview guide evolve.

No patients were involved in the design of the study, but some participants helped with recruitment by suggesting names of people they knew to the investigator and built the sample by snowball effect.

The authors showed the results to two participants to check for accuracy and resonance with their experiences. The first author will send the article to the participants who requested it.

**RESULTS**

The first author (AS) interviewed 21 participants between June 2018 and May 2019 (table 1), including 11 women and 10 men, active or retired workers aged from 19 to 88 years. All participants were native French speakers.

The interviews lasted between 6 min and 54 min. Sufficiency was reached after 17 interviews. The first author presented final results to two participants during dedicated interviews.
'With my GP, it’s always quite repetitive in the end. It’s that’. The repetitive nature of the ritual was highlighted:

>… That is what the patient did not give the same credit anymore to the diagnostic if physical examination was not done. ‘We were used to different kinds of medical habits and exams. It is difficult to imagine that some of them [the doctors] know where the problem comes from just by looking at you’. Some part of the physical examination had special value such as blood pressure, for example. It could be expected as the minimum of the standard parameters.

Roles beyond humans

Beyond humans, the individuals were reduced to their roles of doctor and patient. On the doctor’s side, the role took it over the gender: ‘But here, with the young one, I really feel comfortable. Even if they are locums, seeing a man or a woman makes no difference to me. I let them do their thing’. On the patient’s side, it worked the same. The role (of being a patient) took it over the individual: ‘In that context, I am a body being examined’.

Knowledge is asymmetrical

This power was built on the fact that knowledge was asymmetrical. The doctor was the only one who knew whether an act, during physical examination, was necessary or not and even whether this act might have a clinical justification.

‘On our [patients’] level, we cannot know, we have no information. As we’re not qualified, we never know whether the way the doctor manners is appropriate or not. We totally trust the professional and this is all we can do. All the more as the Internet may provide all kind of information and its opposite… What I notice is the lack of information. With all the medicines that exist, it’s complicated and even impossible to get
it all. Anyways [about the gastroscopy], there was no way I could have known if it had been well executed or not. All I know is that it was very unpleasant.’

This asymmetry in knowledge creates the asymmetry in power: the doctor on the knowing side, that is, the empowered side and the patient on the ignorant side, that is, the powerless side.

**Demand is asymmetrical**

As one is asking for help from the other, the relationship is by essence, asymmetrical, which confers even more power to the doctor. In other words, if the patient wanted to get something, it had to summit anyway. Therefore, a domination system was set up: the one who acted on the other and the one who accepted it. ‘When you are sick, you want to be treated, so if you don’t accept [being touched] then you cannot get better.’; ‘I know it’s something that has to be done so I don’t see why I should object’.

**An exercise of power authorised by the patient**

The set up of roles, the asymmetry of knowledge and of demand, conferred the power to one protagonist: the doctor. As long as the examination was mentioned as justified by the doctor, it seemed that the latter might do anything on the patient. The patient gave an implicit authorisation for the doctor to act on him/her. ‘Because it all seems consistent […] I think they can simply explain why they are looking and what they are looking for […] The intention behind the gesture is therefore clear […] Problems often come from misunderstandings. As long as the gestures are explained, there should not be any problem’.

This power could be accepted by the patient, who submitted him/herself: ‘I do what needs to be done based on what the doctor tells me’. Someone even told that they did not want to say too much not to complicate the doctor’s job: ‘The guy [i.e. the doctor] is already working. I’m not going to make it any harder for him!’

This illustrates how the patient is his/her role may even be willing to take care of the professional.

It was up to the GP to determine whether the examination was needed: ‘It is his call to examine me or not’. The participants agreed to ‘give in to the doctor’. Most participants adopted a submissive attitude, relied on the GP and obeyed him/her: ‘I do not feel I have the legitimacy to give the doctor any advice’. The patient accepted to endorse a role, which might need to dissociate oneself: ‘I’m not comfortable with touch in general. When it comes about medicine, I endure! I go because I have to and because something is wrong about me. I try not to think about it. I tell myself it’s an awful time but it’ll pass. I do what I have to according to what the doctor says. I put my feelings aside and I do what I’m told to’. Some participants explained that the relationship could end because of this power. Some others considered that nothing was unacceptable from the doctor, which could be an other way of expressing that they authorised the exercise of power of them; they just could not consider it was power we were talking about. Some others authorised it with conditions: ‘I need a soft touch, and to feel respected as a body too. Then it is easier to let go, to expose myself and my body’.

**Part 3: a relational function outside the scope of physical examination?**

**Clinical touch: an unquestionable gesture**

The physical examination touch was described as a technical act almost devoid of humanity. It had been so internalised by the patient as a doctor’s ritual that it held an unquestionable dimension. It was not the part of the consultation that could then be criticised. Even when they told awful stories of how traumatising physical examination might have been, some participants rationalised as if words were the only leverage by which the doctor could show his humanity. The fact that the gesture had been terrible was not the problem. The problem was the fact that words should have made up for it. For example, a mother told how her child had been through a very hard time being infused. The doctor who had operated came back several times trying to reach a vein. At the end, the child was clearly injured and the mother rationalised as if a medical gesture could not be condemned. For her, the fact that words did not make up for it was more unacceptable than the fact that the gesture was not correctly performed. As if inappropriate gestures were more forgivable than inappropriate words. ‘I have to admit I have a harder time with a doctor that is frankly unpleasant in his speech’.

Therefore, as clinical touch was untouchable, relational touch seemed to be the only touch that might be either appreciated or despised by the patient.

**Relational touch makes the doctor human again**

Physical examination could be related to human contact, as if it was necessarily engaging to examine someone: ‘We are losing human contact […] I mean, we cannot stand behind a window to examine the patient’. Someone else was comparing it with a tender gesture from a parent: ‘I don’t know, I would say that in a long-term relationship, a little hand on the shoulder of miss Y, it makes sense. In my job [hairdresser], I often have these gestures with my clients. The customers you like, you show them. A hand on a shoulder, it does a lot! It’s a bit like a mommy’s kiss that can heal anything’. It referred to the tender we may have received as kids when touch and healing were completely associated. What this participants says may evoke the regression pleasure linked with total reliance of someone on the other one. The doctor–patient relationship belongs to the kind of relationship that can make people feel supported and cherished again, like a child.

Touching could be seen as a way of setting back some balance or equivalence within the doctor–patient interaction. The hand shaking was an example of physical interaction that supported the relationship between two protagonists standing on a common ground, on a same level. ‘When the doctor shakes my hand or puts his hand
on my shoulders, I tell myself that he acts like a classical human being and that he does not set boundaries to push me away, as if to assert his function to me. If the doctor feels how transparent I am and how at ease I feel, then he gets to behave like the human being he is naturally.

A female participant described how the absence of some kind of touching gesture might be interpreted as a lack of humanity and even cause trauma. ‘I was 11 when the doctor told me I had thyroid cancer. I was sitting in front of her [the doctor]. She looked at my mother straight in the eyes, as if I didn’t exist myself: «if your daughter isn’t operated on quickly, she’ll die.» Back then and beyond words, I’m sure there must have been something else to offer us… I mean, for my mom… but also for me: I was 11… Honestly, it took me years to get over this verbal shock. Back then, I wish she had come closer to me, I wish she had put her hand on my shoulder, saying: “ok then, we have to operate on you»’. She pointed out how a gesture might be a way of giving empathy and of expressing one’s humanity in front of an other human being we could easily relate to.

When relational touch is considered as inappropriate

When participants were asked about how it would be, if the doctor used touching and non-verbal communication to give them empathy or support, some did not seem to wish for it. ‘The practitioner should not touch any parts of the body other than those that need to be touched, either to formulate a diagnosis or to ensure care. That’s it.’ One person associated it with depression, as if an important mental condition was needed to require this behaviour from a doctor. ‘No doctor ever did this to me. It’s clearly inappropriate. As for me, I have never seen anyone do this.’

Some others evoked touching as normal within the physical examination but were clear about the fact that it would be inappropriate otherwise.

‘These kinds of touching shouldn’t be! Doctors have strict ethical rules to follow. When doctors start touching in—what we could call—a social way, it’s a bit different. In my opinion, it’s useless and that could make people uncomfortable. People are not used to receiving physical interaction indeed. Some people may be sensitive, may hold it inside without saying anything, which could cause further problems. It’s clearly inappropriate. As for me, I have never seen such a thing. In my case, it has always stayed medical and I’m glad about this; but I don’t know how I would have reacted to this. But it stayed medical; I did not have this kind of situation.’

This participant elucidated the dichotomy between a neutral clinical touch (acceptable because necessary) and a social or relational touch (unacceptable because unnecessary), as if they were completely different and separate from each other.

A participant wondered if questioning the doctor’s touch might be a symptom of how society became suspicious of malicious gestures. ‘Because of problems in the past, there is now a trust issue. Everyone is afraid of everyone. I think there is a problem with touching. People are suspicious.’ This illustrated the link between power given to the doctor and inappropriate touch. Trusting the doctor had limits for this participant saying: ‘There are people who hold things inside because they trust medicine and sometimes this trust may be blind and this can be harmful. I think it’s important to stay alert and not to pass things like this. I don’t want to be suspicious of everything either but there may be people who… a doctor stays a human being and some of them might be driven by overwhelming impulses that lead to disrespect of deontology.’

Relational touch may stay invisible from the patient’s point of view

When people were asked about specific non-verbal communication elements (eg, touching) that they could have noticed during encounter, it was surprising how they mostly could not see what the interviewer was talking about: ‘I don’t see which gestures could be inappropriate’. Participants always referred to physical examination as if it was the only existing and valuable touch happening during encounter.

DISCUSSION

Summary

Touch was described as a normative ritual happening between two protagonists who endorsed their well-known roles of doctor and patient: the sequence was known in advance, repetitive and was expected by the patient, through physical examination no matter what. This ritual enabled a mutual recognition of each other’s roles and it could be considered as a verification ritual for this purpose. Once the roles had been assigned, the doctor might—through touch—exercise a kind of power, authorised by the patients themselves. The clinical gesture seemed so unquestionable that only relational touch could be questioned by the participants. It was described either as a way of setting back some equivalence in the relationship because it helped to see the doctor as a human being again, or described as uncomfortable and inappropriate, because not serving the physical examination directly. We were surprised that it could also be a non-topic for some of them, as if this relational touch was completely invisible from a patient’s perspective.

Goffman’s theory is relevant to offer a theoretical framework to our results. He argues that individuals who perform in a certain social context exert a ‘moral demand’ on their audience, encouraging them to respond in an expected or appropriate manner. In the medical field, this concept is actually relevant as well: the private stage of the GP’s practice urges both patient and doctor to play roles within a script that both the actors of the scene know very well, and which could be, thus, summed up: presentation of the ailment by the patient (and acceptance of it whole and unredacted by the doctor), physical examination by the doctor, diagnosis or prescriptions of further
exams by the doctor, closure of the scene. Touch is, thus, a prop of the whole scene, an ingredient that is expected by the patient and which endorses the value of healing, as it will probably yield to a diagnosis, which is waited for by him or her and the object of that particular scene, which the patient himself/herself initiated and paid for.

Comparison with the existing literature
A normative ritual happening endlessly between two protagonists who endorse their well-known roles of doctor and patient

Our study reaffirms the importance of the clinical ‘ritual’. Verghese elucidates in his essay ‘A touch of sense’ in 2015 how the physical examination is really about one individual granting permission to another individual to touch his or her unclothed body. For him, the bedside examination, when viewed as ritual, is a reenactment of a healing scene that has played out through recorded history: one individual with expertise, anointed by society and a guild in that role, attempts to relieve the suffering of another. The patient has no such confusion about his or her role: the patient expects to be examined.

Verghese suggests that physical examination, even in its strict sequence of checking organs and functions, may be seen as a relational healing ritual: ‘When he saw me […], I realized that he was wanting to expose his chest to me: it was an offering, an invitation. I didn’t decline. I percussed, palpated, and auscultated. […]. Neither of us could skip this ritual, which had nothing to do with detecting rales in his lungs, or finding the gallop rhythm of heart failure’. It suggests that touch should not be seen as dichotomous (clinical or relational) but that maybe the physical examination holds this relational part in this ‘ritual dance’ itself, in which both parties play an active role (waltz metaphor); even if it does not come up to the patient’s mind, as if it stayed preconscious. That would enlighten our data and the reason why it was almost impossible having participants say it out loud in the interviews.

And yet, one can wonder: should we GP dance the waltz in every single consultation just because it is part of a necessary ritual? As a matter of fact, GPs do not have to examine people systematically for several reasons: either the reason for consultation does not require it, or the examination is succinct because patients are likely to have unspecific symptoms due to an early and indifferent stage of illness. Thus, our results suggest that physical examination, even if the GP does not expect anything from it, may be enriching the doctor–patient relationship. These findings suggest that if the physician decides not to examine the patient for good reasons, these reasons should absolutely be explained. Otherwise, it could cause the opposite and worsening the relationship instead of reinforcing it and making the approach more patient centred.

Other than this, physical examination could represent a verification ritual by which the patient checked the doctor’s skills, which is consistent with literature: Guegen et al found that touch was associated with an increase in the patients’ ratings of practitioner competence and practitioner concern for patients.

Our study seemed to show that touch is not gendered since roles could overcome individuals. This differs with existing nurse literature suggesting that barriers exist for male nurses who care for female patients.

Touch is common to all health professionals. We find similar results as ours among nurses’ studies, that is, the importance of communication, choosing the professional that provides an explained and adapted touch.

A setup that enables the exercise of power by the doctor on the patient

Our study showed that touch might exercise a power, which is consistent with literature. Touch recalls the paternalistic model of medicine and is most often initiated by people of higher status and allows them to control people of lower status. In our study, we suggested that the doctor represented the higher status with power, whereas the patient represented the lower status, submitting to power. The literature suggests that touch is least likely to exert undue power over patients when it occurs within established relationships. Indeed, some participants expressed limits to this reliance and said that they could leave the relationship if something did not suit them. Cocksedge et al showed that doctors who touched patients in a professional context did not expect to be touched in return, which corroborates what we called the asymmetry of demand, evidence that the relationship is uneven.

A relational function outside the scope of physical examination?

In their meta-ethnography, Kelly et al described touch as a medium of caring communication, which is consistent with our findings. It gives professionals a means of communication ‘beyond words’, which fundamentally expresses humanity. Little et al described relational touch as positive, especially what is happening at the beginning of the consultation. Though, this was not the most salient in our study, a participant described the benefits of the handshake. Others clearly mentioned the closer bonds they might feel with their GP built on their touch perceptions, even feeling like if they were relatives, which corroborates the emotional dimension of touch and its purposes: show signs of affection, building trust, empathy and relationship. It is described as Touch is reciprocal: one cannot touch without being touched. When words are not enough, the GP turns to human interaction through touch. The touching relationship is complex and can lead to a therapeutic relationship. The concept of infantilisation could even be used in studies in general and nursing practices.

The clinical examination can provide communication support, supporting healthy relationship when verbal and non-verbal communications are associated. Some studies mentioned the importance of visual contact in general and nurse practices. One participant told how she felt lack of humanity during encounter when she was
younger, not being looked at in the eyes whereas the diagnostic was about her.

Some other participants described how they found touch inappropriate outside the scope of objective examination, which could be close to haptophobia (abnormal fear of touching or being touched) that seems to be on the rise in present times. Studies showed that doctors could be reluctant to use touch then, fearing that it might be misunderstood.

**Strengths and limitations**

One major strength of our study was to explore this central human experience that has yet been the focus of surprisingly little research in healthcare. Our findings enlightened important topics like the importance of ritual, the exercise of power and the relational dimension of touch. The data have been entirely reanalysed a second time (by LD and JGdlL) after suggestions of reviewers, which confirms to the results more credibility. The efforts of the research team to explore their preconceptions about the studied phenomenon is to be mentioned.

Some methodological limitations are to be exposed though. The recruitment of the participants within medical practices presented obvious advantages but could have caused less variability in the participants’ discourses because some participants shared the same doctor.

The interviewer chose to use a cover identity (sociology student) not to mention that she was a GP herself. First, she wanted to make sure people would feel free to criticise the doctor in any way. Second, she was hoping to avoid the pitfall of recreating a medical and overly conventional doctor–patient medical conversation. She conducted the interviews directly after medical consultations, which may have had different consequences. First, participants may have been in some kind of rush limiting their availability to the interview and the depth of their discourses. Second, they may have been inhabited by what had just happened during the consultation, which could have limited deeper thoughts or further memories about the subject.

We chose to conduct semistructured approach, which—we acknowledge—might have some limitations concerning the duration of the interviews and the depth of the findings (compared with in-depth interviews). Though she was a beginner in the interviewing process, the interviewer tried her best to highlight emotive touch points using increasingly open questions and focusing on participants’ experiences.

About the relational dimension of touch, we admit that we were surprised how difficult it was to discuss it with participants. Indeed, physical examination was almost the only sequence that emerged in the interviews. This could be explained by the fact that the interview itself did not enable participants to evoke how touch may have a relational value. This could have been supported by other strategies like evoking more precisely certain sequences of the physical examination (e.g., abdomen palpation) or using explicitation interviewing technique about all non-verbal elements within the consultation (e.g., handshakes, hand on shoulder, holding hands, etc). Unless it is because all these infra-verbal elements are unspeakable because invisible in the patient’s perspective. They are elements in favour of the relationship then we can imagine people feel it without being able to notice it and then to talk about it.

Participants were not included in the study design, for feasibility reasons.

**Implication for future research**

After this overview of patients’ touch perception, it would be interesting to explore the effect of the COVID pandemic especially with the multiplication of virtual visits, by phone or video link. The GP’s touch is a diagnostic tool. For doctors, the gnostic experience is as much as important as the pathic experience, but what about emotions and feelings communicated or understood through touch? Do patients and doctors agree on the meaning of touch?

**Conclusion**

Our study aimed at exploring the patients’ experience of touch in GP consultations. Physical examination was described as a ritual enabling the establishment of patient’s and doctor’s roles, the verification of the doctor’s skills and the construction of a caring experience. Touch was also a media for the doctor to exercise power that the patient authorised. Finally it had relational and emotional value.

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**Contributors**

LD (first author) is a GP and research and teaching fellow. She participated in every step of the work: from the initial questioning to the elaboration of the research question. She reviewed the transcripts after the interviews with AS, contributed to the triangulation of the analysis. She answered to the reviewers’ demands and remarks. She re-analysed the results with JGdlL after reviewers’ suggestions. AS (second author) is a GP and research trainee who carried out all the steps of this study under the supervision of LD. She was responsible for the ethics demands. DD (third author) is a general practitioner, general practitioner trainer and teacher. He contributed to this study from a practitioner’s perspective and participated in some analyse sessions. P-LD (fourth author) is a professor of general medicine and was asked to provide his expertise as a general practitioner and his perspective on the participants’ verbatims. His participation made it possible to question the first author’s preconceived ideas and to limit errors of analysis. JGdlL (last author) is a general practitioner, ex-research and teaching fellow, methodologist in qualitative research. She helped for the methodological design. She participated to the first analyse and re-analysed the data entirely with LD. LD as corresponding author is also responsible for the overall content as guarantor.

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**Patient consent for publication** Consent obtained directly from patient(s)

**Ethics approval** This study involves human participants and was approved by Approval for this non-interventional study was granted in July of 2018 by the South-Mediterranean II Commission for the Protection of Persons (RCB ID
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