



ORIGINAL

Self-perception of primary health-care staff about physical activity on prescription: A qualitative semi-structured interview



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KEYWORDS

Focus group;
Exercise prescription;
Health promotion;
Primary care

Abstract

Objective: This study aimed to analyze the self-perception at primary health-care (PHC) nurses and general practitioners (GPs) toward PAP implementation in PHC centers.

Material and methods: Two semi-structured group interviews were performed separately, with five GPs and nurses working in the PHC system in the region of Madrid (Spain). An expert psychologist guided each semi-structured session. The interviews were transcribed verbatim and consensually analyzed using a content analysis.

Results: Half of the PHC staff considered themselves physically active and were convinced that physically active staff behavior could facilitate PAP with patients. Both GPs and nurses showed a lack of knowledge of exercise prescription but were interested in PAP and motivational training courses, as well as leadership or to collaborate under a multidisciplinary or interdisciplinary PAP approach. Some of the most relevant self-perceived PAP barriers were a confident method to measure sedentary and physical activity levels. Besides lack of staff awareness, time of consultation, and improving local community relationships and PAP policies strategies.

Conclusions: There are some common self-perceptions, barriers, and facilitators among PHC nurses and GPs for PAP implementation. Following a socio-ecologic approach, this organizational data provides further insight to design a future cost-effective policy strategy to improve patient health and health-care system sustainability.

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PALABRAS CLAVE

Entrevistas grupales;
Prescripción de
ejercicio físico;
Promoción de la
salud;
Atención Primaria

Autopercepción de los profesionales sanitarios de Atención Primaria sobre la promoción y prescripción de ejercicio físico: entrevista cualitativa semiestructurada

Resumen

Objetivo: Este estudio tiene como objetivo analizar la autopercepción de las enfermeras y médicos de Atención Primaria para implementar la promoción y prescripción de ejercicio físico en sus centros.

Material y métodos: Dos entrevistas grupales semiestructuradas, con cinco enfermeras y cinco médicos que se encontraban trabajando en ese momento en el Sistema de Salud de la Comunidad de Madrid (España), fueron desarrolladas de forma independiente. Un psicólogo experto guio cada una de las sesiones. Las entrevistas grabadas, fueron transcritas y analizado su contenido de forma consensuada.

Resultados: La mitad de los profesionales sanitarios entrevistados se consideraron a sí mismos físicamente activos y convencidos de que dicho comportamiento podría facilitar la promoción y prescripción de ejercicio físico hacia sus pacientes. Ambos grupos mostraron una falta de conocimiento para prescribir ejercicio físico, pero se sentían interesados en adquirir la formación mediante cursos, así como de recibir formación para entrevistar de forma motivacional a sus pacientes. También mostraron liderazgo o colaboración para implementar la promoción y prescripción de ejercicio físico bajo un enfoque multi o interdisciplinar con otros profesionales. Algunas de las barreras sugeridas por ambos profesionales fue la falta de un método seguro para comprobar los niveles de actividad física y sedentarismo de sus pacientes. Además, de la falta de concienciación de sus compañeros de profesión, el limitado tiempo de consulta que poseen con cada paciente, y mejorar la colaboración con otros recursos comunitarios y desarrollar estrategias políticas adecuadas.

Conclusiones: Existen autopercepciones, barreras y facilitadores comunes entre los médicos y enfermeras de Atención Primaria para implementar la promoción y prescripción de ejercicio físico. Siguiendo un enfoque socio-ecológico, los datos de la dimensión de organización del Sistema Sanitario obtenidos podrían servir para diseñar en el futuro una estrategia costo-efectiva para mejorar la salud del paciente y la sostenibilidad del Sistema Nacional de Salud mediante la promoción y prescripción de ejercicio físico.

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Introduction

In 1986, the WHO Ottawa Charter proposed reorienting health promotion initiatives to enhance physical, mental, and social health.¹ Unfortunately, physical inactivity and sedentary behavior have steadily increased.² Data registered from 2001 to 2016 and based on 1.9 million participants of 168 countries, established a 27.5% global age-standardized prevalence of physical inactivity.³ Physical inactivity behaviors are strongly related to many non-communicable chronic diseases (NCDs).⁴ Despite the well-known health-related benefits of physical exercise,^{5–7} over 30 years after this first meeting, physical activity on prescription (PAP) is not well implemented worldwide.^{6,8} In fact, only one-third of patients are counseled with PAP by their health-care professionals.^{9,10} Over recent years, a huge amount of evidence has emerged regarding the added value of PAP for public health^{11,12} and its effectiveness on treatment of NCDs,^{6,13,14} even reducing the need for pharmacological treatments for some.^{15,16}

Policy actions to increase people activity in multiple settings have been launched by the WHO, such as the recent physical activity (PA) strategy for the European

Regions 2016–2025, which, includes in the priority area 3: “Promoting PA for all adults as part of daily life, including during transport, leisure time, at the workplace and through the health-care system”.¹⁷ Furthermore, nurses can promote physical activity in patients and optimizing the mobility, physical activity levels and functional status of patients in different care settings during daily nursing care.¹⁸

Health-care settings seem to be a potential well-considered resource to increase PA in patients.^{6,8} It is estimated that up to 80% of adults visit their general practitioner (GP) at least once a year, and patients trust their health-care professionals.⁸

Many countries are implementing strategies to introduce PAP at PHC such as the Canadian health-care system¹⁹ and the USA health-care centers,²⁰ both following the Exercise is Medicine® initiative launched by the American College of Sports Medicine.^{12,21} In 2015, the European Initiative for Exercise is Medicine® was created to help to promote widespread implementation of PAP at health-care settings.²¹ One year later, this initiative was launched in Spain, where a well-functioning, universal and free health-care system managed by the regional governments exists,

and interdisciplinary PAP approach, integrating efficacious evidence-based interventions.²¹

Previous reviews of physical activity interventions delivered in primary care have reported mixed findings and current national physical activity programmes have been ineffective in most countries.²² Furthermore, studies investigating the self-perception of PHC staff in Spain for implementing PAP under a socio-ecologic approach are lacking. In this sense, a descriptive qualitative study was developed to analyze the self-perception of GPs and nurses working at Madrid PHC centers for implementing PAP. Qualitative methods are those that emphasize the knowledge and reality from an insider perspective of this complex and unexplored research, capturing the meaning that each fact attributes to its own protagonist, and contemplating these elements as pieces of a systematic whole.²³ The aim of this study was to ask GPs and nurses working at Madrid PHC centers about feasibility of PAP and their self-perceived barriers and facilitators.

Material and methods

Five GPs (eventual and permanent staff of the Infanta Mercedes (Madrid), Colmenar Viejo, Miraflores (Alcobendas), Rosa Luxemburgo (San Sebastian de los Reyes) and Fuentelareina (Madrid) PHC centers), and five nurses (eventual and permanent staff with management responsibilities of the Barrio del Pilar (Madrid), Valdelasfuentes (Alcobendas), Fuentelareina (Madrid), Arroyo de la Vega and the Castroviejo PHC centers) working in the Madrid PHC system were randomly selected and invited to participate in two semi-structured interview sessions by a call phone of the Nursing and Public Health supervisors of the PHC System of the Region of Madrid (Spain). The selection included males and females of different ages, with accredited PHC experience, representing both urban and rural areas of the region of Madrid. According to Morgan,²⁴ this heterogeneity of the group generates a richer conversation and viewpoints from the lively collective interaction, facilitating more spontaneous expressive emotional opinions than an individual interview.¹³ No economic incentive was given for participation. Each group attended two sessions separately, which lasted 2 h on average, on different weeks. The interviews took place at the *Fuentelareina* PHC in the region of Madrid. Four semi-structured interviews were conducted by an expert psychologist (FF). At the beginning of the first session, participants were informed by the principal researcher (MG) about the procedure and signed an informed consent. The study was performed according to the principles established with the Declaration of Helsinki 1964 and further amendments and other national regulations for research projects involving human participants: Protection of personal data, Law 15/1999 of 13 December on the Protection of Personal Data provided in current legislation (Royal Decree 1720/2007 of 21 December). The protocol was approved by the Central Commission for research of the Region of Madrid and the Ethical committee of the Alcorcon Hospital, Madrid (Spain).

The main PAP facilitators and barriers found in the theoretical framework^{8,13,25–27} were used to guide the interviews.

The interview variables list was based on the theoretical framework (Table 1).

At the beginning of each topic, the experienced psychologist presented an open question to facilitate the answer of participants, making sure that all topics in the theoretical framework were covered, and that all group members had the chance to speak. At the end of the second session, participants were invited to add any comment or question they thought had not been covered and should be discussed. Both sessions were recorded using a H2next handy recorder (Zoom Corporation, ITOHPIA Iwamotocho 2chome Bldg. 2F, 2-11-2, Iwamoto-cho, Chiyoda-ku, Tokyo 101-0032, Japan) and transcribed verbatim by the assistant guide (SC); and confidential information was coded. The principal researcher and the assistant guide were adding any perception and relevant information developed in the interviews in a field notebook. Qualitative data from the semi-structured group interviews were analyzed with content analysis. According to Taylor and Bogdan²⁸ the discourse analysis was carried out following these steps: The literally transcribed interviews were full reading, extracting the first sensations, ideas and intuitions and making annotations and underlining comparing with the annotations and the perceptions of the field work by a focused process. Several initial readings were carried out in order to create some first schemes with the first intuitions. After this first step, was initiated the code data process, meaningful text fragments were identified, coded, and clustered by two researchers (FF and SC). The meaningful text fragments were identified as a first stage and were labeled and coded. The coding was compared between both reviewers (FF and SC), and differences were discussed to reach consensus about the assigned codes.²⁹ The code process was completed and results discussed within the research team (FN, RP, MG, FF and SC) who played the role of 'critical friends'.³⁰ According to a recently published study,³¹ this final data analysis method improves the quality of data analysis, increasing inter-rater reliability of the qualitative analysis. Finally, a phase of data relativization was carried out, reconstructing them, generating the interpretation of the study phenomenon, understanding its context, writing a report presenting and explaining the relationships found. Reasoning was also used to identify the categories-codes and subcategories-descriptions according to the methodology performance by Persson et al.¹³

Results

A summary, with shared common points of view, about the results analyzed at the semi-structured interview sessions performance with the PCH staff, is organized by categories-codes and subcategories-descriptions, is shown in Table 2.

Self-perception of their PA pattern

Over 40% of the participants indicated to be physically active. Active subjects recognized the whole health benefits related to a better fitness status. The physically inactive ones were said to be as healthy as the physically active ones, according to the last blood tests done.

One nurse commented: "I believe sport habits are closely related to the stage of life you are actually in. It is not the

Table 1 Variables in the semi-structured group interview with nurses and physicians.

Semi-structured group interviews	Variables
1st session	Project presentation. Participant presentation and sign of informed consent. Self-perception physical activity pattern and relationship with health and exercise promotion. Self-perception and possibilities to implement exercise promotion and prescription in their professional group and health-care centers. Knowledge to promote physical activity and prescribe exercise. Chronic illness and exercise prescription. Exercise training courses: types, methodologies, preferences, necessities. Professional, academic, and economic incentives in the health-care system.
2nd session	Review of the last session. Main issues of the health-care center and system. Main issues related to space, material, management, time, personal resources, assessment, etc. Facilitators and barriers to promote physical activity and prescribe exercise in Madrid PHC centers. Interrelationship with other professionals: sport sciences and sport medicine professionals. Specific areas of physical activity - exercise intervention inside of the health-care centers. Relationship with other resources: town hall, public sport centers, etc. Free comments.

same when you are a young person without family responsibilities than if you are a person who has just become a mother or have familiar support to give” (Translated from Spanish).

Another nurse said: “At some moments in your life you do not have enough time to do many things, but for instance at the sports center that I go, you have a babysitter service to care for your child while you are doing your exercise class” (Translated from Spanish).

Cultural and educational aspects were adduced by many interviewed assistants in both PHC groups to justify the insufficient PA levels (PAL). For instance, one professional indicated, “Men are more PA conscious and more physically active than women” (Translated from Spanish).

PAP background

The awareness of both PHC professionals about the importance to promote PA was evident, although GPs would prefer nurses to do it. However, they indicated to not having enough knowledge to prescribe exercise, nor correctly manage the training loads in the long-term and with specific patients. Only one PHC professional recognized the need to be prepared to do it, because he had been riding on a bike since childhood at elite levels.

There was a common agreement related to the difficulties in behavior changes despite the social awareness of physical exercise benefits.

“The key is to adapt the guidelines regarding to the preferences of patients” (Translated from Spanish).

PHC staff position to PAP

Both groups agreed that the leadership in PA promotion should be assumed by nurses; however, some GP said, “PA preventive strategies should be done outside PHC settings,

because patients come to PHC when they are already ill” (Translated from Spanish). Regarding exercise prescription leadership, nurses showed insecurity to do it and GPs demand teamwork with other specialists. Collaboration with other health professionals seem clearly accepted in PAP at PHC settings. A GP said: “Actually, many people practice running, and sport awareness and related health benefits are rising; however, few people know about the dangers of an excessive practice of physical exercise, and we receive many injured patients for this reason” (Translated from Spanish). Observing the many doubts in PAP for both professionals, it was considered necessary to treat the next point in more depth.

PAP training courses

Both PHC professionals indicated it mandatory, and with priority, to increase PAP training courses or workshops, however disagreed about the best methodology (online, personal, or mixed), although both agreed that it should be in work time and with special benefits offered to the PHC staff by the health-care system.

These training courses were proposed: Motivational interview, PA patterns and fitness status assessment, training in time management.

PAP as a preventive and rehabilitation resource

Recently, the patient and PHC staff on PAP awareness is rising. However, there is a lack of information about local sports resources and availability. This produces an ineffective synergy between them, in contrast to cost-effectiveness for the Government and the health status of patients. The GPs group proposed to establish similar strategies as used with smoking or obesity at PHC settings. Specifically, they said: “We had a main responsible for the smoking cessation

Table 2 Categories-codes, descriptors, and a summary of nurses and GPs during the semi-structured interviews.

Category-code	Subcategory-description	Summary of PHC staff quotes	
		Nurses*	GPs*
Self-perception of their PA pattern	Self-perception PA behavior of the PHC professionals	Almost 50% considered themselves physically active. The sedentary nurses thought they would be as healthy as if they were physically active.	60% are considered physically active. The sedentary physicians thought they would be as healthy as if they were physically active.
	Promotion use	Awareness and self-perception to promote PA.	Awareness and self-perception to supervise the PA promotion.
	Knowledge of PAP prescription	Self-perception in the lack of knowledge for exercise prescription.	Self-perception in the lack of knowledge for exercise prescription.
PHC staff position to PAP	Leadership to PA promotion	They should assume leading in promotion.	They think the promotion should be done outside of the health-care centers. The patient is ill when she/he visits us.
	Leadership to exercise prescription	The leading role in prescription is not clear.	They demand help by other specialists for individualized and effective PA treatments.
	Collaborative PA promotion	They assume the main role.	They need help by staff inside and outside of PHC settings.
	Collaborative exercise prescription	They demand help from specialists in patients with co-morbidities or specific pathologies.	They demand help from specialist physicians, mainly in some specific patients.
PAP training courses	PAP training courses	Need of facilities offered by the manager staff and the system. Kind of training courses: motivational interview, assess PA and fitness patterns, time management.	Mandatory and must have priority to the training courses by different methods (online, face-to-face, etc.) Kind of training courses: Motivational interview, time management.
PAP as a preventive and rehabilitation resource	PAP awareness by PHC staff	Lack of academic training in some PHC professionals.	To transfer similar strategies used with smoking, obesity, treatments in PHC settings.
	PAP awareness by patients	Lack of awareness and education on PA benefits in some patients.	Lack of information in some patients and awareness for any health professionals.
PAP barriers	PAP anamnesis vital sign tool	Need to change the tool to assess PA/sedentary behavior and fitness as a vital sign to patient.	Inefficient tool and no relationship with informatic staff to assess PA patterns and fitness.
	Improving consultation time management	Lack of time in consultation.	Lack of time. Elevated patients' ratio attended by physicians daily.
	External policies relationships in PAP	Lack of knowledge about external PA resources. Lack of individualized treatments and follow up to change dangerous lifestyles behaviors in patients.	

Table 2 (Continued)

Category-code	Subcategory-description	Summary of PHC staff quotes	
		Nurses*	GPs*
PAP solutions	Lack of space resources Lack of material-economic resources	Space should be reorganized. Lack of material to assess PA patterns and fitness. Professional, academic, and economic incentives are not always according to the professional category.	Lack of knowledge about external PA resources. Doubts about how PA promotion and prescription is considered by the rest of physicians. Space should be reorganized and clarify the tasks. Lack of material to assess PA patterns and fitness.
	Modify PAP vital sign tool	Improve relationship with informatic staff through a face-to-face each week to know the exact problems.	The app should be improved and optimized for health professionals.
	News space resources	Space resource management in each health-care center. Use of external spaces or manage the actual ones.	Space resource management in each health-care center. Use of external spaces or manage the actual ones.
	To create PAP networking	To maintain Spanish PHC philosophy: no specify professional task and multi-training among nurses. Use of network team and public resources outside the health-care center: Sport medicine physicians and inside with psychologists and physiotherapists. Help from specialists in patients with co-morbidities or specific pathologies. Send patients to public sport centers using economic offers through health-care prescription.	To maintain Spanish PHC philosophy: no specified professional task and multi-training among physicians. Network team and public system relationship: Community and Town hall. Use of nurses as a physician assistant to PA promotion and prescription. Help from specialists in patients with co-morbidities or specific pathologies.

Table 2 (Continued)

Category-code	Subcategory-description	Summary of PHC staff quotes	
		Nurses*	GPs*
	To offer PAP training courses	Modify the actual training course rules, offering more facilities to the professionals. Training courses in coaching, leading, and time management.	Training courses for everybody and with different modalities.
	PA advisement policies	Use of mass media to increase the awareness of PA benefits and PAP at health-care settings.	Use of population awareness to implant PA promotion in health-care centers.
	Progressive PAP implementation in PHC	Need of a pilot study to establish PAP in PHC settings.	Use of common protocol for PA promotion and prescription.
	To enhance material and economic resources for PAP	Increase economic resources to buy materials and HHRR. Weight machine, handgrip, and different materials to measure fitness level of patients.	Improve relationships inside and outside of the health-care centers.
	PAP leadership units at PHC	Increase HHRR to improve quality of treatments. To work with health professionals inside the system, like physiotherapist and specialist physicians. Mandatory relationship between a nurse and family physician.	Increase economic resources to buy materials and HHRR. Improve material and economic conditions to the adhered professionals to PAP. Mandatory and priority to the training courses by different methods (online, face-to-face, etc.) They demand help by other specialists to individualized effective PA treatments.
	Use of first consultation (nursing)	Use of first consultation by nurses.	Use nurse consultations as the first resource to the PA promotion and prescription in the current System.
	Use of external PHC resources	Mandatory relationship nurse - exercise professional of public sport centers. Improving relationship between Town Hall and health-care services.	Improving relationship with public institutions. Use of external resources: sports centers, town hall, and sport medicine schools.
	To increase PAP consultation time	To decrease the ratio patients attended by nurses daily or increase nurse staff.	To decrease the ratio patients attended by physicians daily.

GPs: general practitioners; PA: physical activity; PHC: primary health-care; PAP: physical activity on prescription; HHRR: human resources.

* Translated from Spanish to English.

strategy done at PHC setting years ago. They received the training courses and then they trained the rest of PHC staff, in the same way as the PHC system idiosyncrasy; however, if we want it works, some professionals and PHC should assume the responsibility and it will be not rewarded by the system” (Translated for Spanish language).

PAP barriers and solutions proposed

The main common barriers commented by the professionals were related to space, materials, and economic resources to assess PA and fitness status of patients, a high patient ratio in a short consultation time, staff, and synergies with other public resources. They proposed solutions to these barriers. The results are presented in 11 categories with the subsequent subcategories (Table 2).

Discussion

The results have been used to validate a choice-modeling questionnaire to analyze the feasibility of implementing PAP at PHC. Within a broader strategy to implement Exercise is Medicine® at PHC in Spain, this study explored the previous situation using semi-structured interview sessions about PAP self-perception of PHC nurses and GPs in the region of Madrid. This evidence-based intervention is a comprehensive implementation framework that provides an overarching view of application and the determinants that can influence PAP operation in health-care settings, according to the recent study proposed by Czosnek et al.³² It also analyses the interpersonal and organizational-related factors within various domains/levels of influence that can interact and/or reinforce PAP implementation in PHC settings, according to a social-ecological framework.³³ Likewise, this was conducted in the Netherlands to implement PAP in health-care settings.³⁴ Personal and professional data were considered necessary for post-analysis of the results. Following the trend of other projects, to analyze the PA stage of change in patients,^{13,25,27} we checked the stage of change on PAP behavior in health-care staff, considering health-care professionals behavior as important as the patients in relation with the healthy lifestyle medicine.³⁵ Besides, PAP knowledge should be measured in the PHC staff because the respondents indicated lack of knowledge and need for training about PAP, such as shown by other authors.^{13,25,36,37} In the last section where we introduced the main points of the semi-structured interviews results, we realized there are similar opinions between nurses and physicians related to PAP barriers such as lack of PAP knowledge, lack of time in consultations, of space to assess physical fitness, and of institutional support to collaborate with internal-external public resources such as has been shown in other studies.^{13,21,25,38} However, there are differences related to who should assume the main role of PAP at the health-care centers. Nurses, despite exhibiting lack of time in their consultations, considered themselves as the main staff in the center for implementing PAP properly in contrast to some barriers found in the literature.¹³ Both considered more training courses about counseling and motivational interviews, PAP, and time management necessary, in concordance with other studies.^{1,13,38,39}

Another main finding related to PAP, was that it was not fully integrated into daily consultation routines by nurses and GPs, besides both being critical with the PA anamnesis tool used to classify sedentary and PA patterns.^{40,41}

Many assistants showed disagreement with the recent anamnesis tool to measure PA and sedentary levels. An assistant said, “IT programmers should be in consultation with us during an entire week to modify the tool, adapting it to our necessities” (Translated from Spanish). Thus, it is necessary to establish a cost-effective method to complete the anamnesis objective and quickly. Rose et al., proposed to measure PAL using a one-question survey.⁴² Other studies propose using mobile phone apps or wearable technology that could present a simpler method for clinicians to assess sedentary and active behaviors in primary care.^{25,43,44} In the UK, a national database will efficiently implement their exercise referral schemes in health-care settings to have a correct follow up with the patient and health-care team.⁴⁵ Sedentary behavior should be considered as important as PA, because they have interdependent risks on human health.⁴⁶

In our first interview session, around 50% of all participants in both groups identified themselves as physically active. If this self-perception has a relationship with the rest of PAP variables analysis should be conducted in a further study. Discussion was raised whether being active had an influence on PAP for patients.³⁹ In both groups, all considered the predisposition of the patient to receive PA counseling necessary and were very confident about exercise as a preventive and rehabilitation medicine, as it has been initially proposed by the Exercise is Medicine® strategy.^{21,47} According to the Exercise is Medicine® strategy, both groups declared to be interested to create a multi or interdisciplinary networking with other professionals and institutions with the aim to increase efficiency in PAP.¹⁹ Furthermore, they indicated to have a poor knowledge of the sports facilities and resources close to their PHC.

Material, economic, and staff support, to implement PAP efficiently, was especially important to the participants. This needs to be confirmed in a broader study, including whether solutions commented in the semi-structured interviews are considered necessary for them, as has been shown in other studies.^{8,13,48}

Creating an interdisciplinary network group inside or outside of the PHC settings should be an effective and cost-benefit resource, i.e., awareness by the patients, professionals, and PHC systems. Moreover, local and national health policies are needed to reduce physical inactivity levels to 10–15% by the years 2025–30, such as proposed by the WHO European strategies.^{17,49,50}

Semi-structured interview sessions have identified the main facilitators and barriers to implement PAP in PHC in the region of Madrid. Health professionals of primary care interviewed have indicated the need to introduce PAP and their willingness to participate, but that both material and human resources are not sufficient.

These findings are limited in that they only represent the self-perception of a reduced non-representative sample of nurses and GPs of the PHC system of the Region of Madrid, and the findings may not be generalizable to other PHC Systems in Spain or other countries.

Conclusions

There are some common self-perceptions, barriers, and facilitators among PHC nurses and GPs for PAP implementation. Following a socio-ecologic approach, this organizational data provides further insight to design a future cost-effective policy strategy to improve patient health and health-care system sustainability.

Ethical consideration

The study was performed according to the principles established with the Declaration of Helsinki 1964 and further amendments and other national regulations for research projects involving human participants: Protection of personal data, Law 15/1999 of 13 December on the Protection of Personal Data provided in current legislation (Royal Decree 1720/2007 of 21 December). The protocol was approved by the Central Commission for research of the Region of Madrid and the Ethical committee of the Alcorcon Hospital, Madrid (Spain) (RP1811600040).

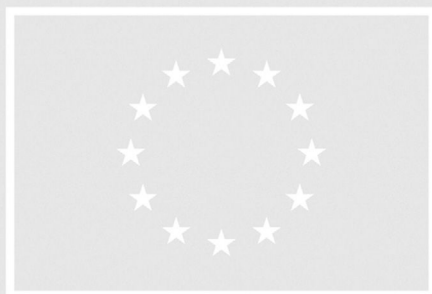
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Conflict of interests

None declared.

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