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ORIGINAL RESEARCH

Perspectives and Practices of Healthcare Leaders in Supporting Healthcare Worker Well-Being: A Reality Check

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Introduction: The well-being of healthcare workers (HCWs) is a critical concern. While healthcare leaders can play a crucial role in influencing employees' well-being, it remains unclear how leaders are leveraging this influence. This study aims to unravel the current perspectives and practices of healthcare leaders in supporting HCW well-being.

Methods: Semi-structured interviews were conducted with healthcare leaders at various levels within a university medical center. The interviews focused on exploring three key topics: factors influencing HCW well-being, data sources utilized for information gathering, and strategies leaders employ to influence HCW well-being. Our study design was grounded in constructionist epistemology and adopted a phenomenological approach. The methodology primarily involved a data driven, inductive thematic analysis to discern patterns and themes from the collected data.

Results: Fifteen interviews with healthcare leaders revealed a multitude of factors influencing HCW well-being, categorized into three domains: personal, socioeconomic, and work-related factors. Leaders reported a variety of data sources, including "contact data", data derived from regular and sporadic interpersonal interactions, and "investigation data", entailing formal inquiries conducted within the healthcare organization. Interestingly, while leaders acknowledge their potential to positively influence well-being, particularly in work-related aspects, there was a notable trend of deflecting responsibility, often redirecting it towards other leaders or placing it back on the individual employee.

Conclusion: Healthcare leaders show a comprehensive understanding of factors affecting employee well-being. However, healthcare leaders have a predominantly reactive approach to managing employees' well-being. Data collection is often sporadic, lacking consistency, and there is a tendency to redirect responsibility for well-being, revealing a discrepancy between acknowledgement of influence and its actual implementation. We argue that it is essential for leaders at all hierarchical levels to assume responsibility actively and collectively for employee well-being, transitioning to a proactive approach in promoting and safeguarding the well-being of HCWs.

Plain Language Summary: Healthcare workers play a key part in the healthcare system, so their well-being is very important. This became especially clear during the COVID-19 pandemic. Healthcare leaders can help improve their employees' well-being, but it's not always clear how well they do this, or if they do it at all.

In this study, researchers looked at how healthcare leaders notice and affect the well-being of their workers. They talked to leaders at different levels in a hospital, asking what they think affects their workers' well-being, where they get their information about it, and how they try to improve it.

The study showed that leaders know many things that can affect well-being, like personal problems, money issues, and work-related problems. Leaders usually learn about well-being through informal chats or formal reviews in the hospital. However, even though leaders know they can make a difference, they often leave this to others or say it's up to the workers themselves.

The findings of this study suggest that healthcare leaders should be more involved in supporting their employees' well-being. By doing so, they can help protect health care workers and strengthen the healthcare system.

Keywords: healthcare worker well-being, employee well-being, leadership, healthcare leaders

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Introduction

Healthcare workers (HCWs) are the foundation of any healthcare organization. Prioritizing their well-being has long been recognized as crucial, not just for their personal health but also for achieving optimal organizational outcomes and ensuring high-quality patient care.[1,2] Extensive research has established that poor well-being among HCWs is associated with reduced patient safety, lower sustainable employability, and increased rates of absenteeism.[3–5] Despite this understanding, the well-being of HCWs remains a pressing concern, exacerbated by the challenges inherent in healthcare work environments.[6,7]

HCWs are exposed to numerous stressors, including high work demands, inadequate staffing and resources, and challenges associated with patient care, such as coping with patient suffering and death.[8] These stressors can significantly deteriorate their physical, mental, and emotional well-being, contributing to conditions such as anxiety, insomnia and depression.[9,10] The recent COVID-pandemic has only further these issues, pushing healthcare systems to the brink and highlighting the precarious state of HCW well-being.[11] Even before the pandemic, reports indicated that medical professionals were overburdened, and HCW well-being was recognized as an utmost priority, not simply an optional amenity.[12,13] In response, numerous studies have called for workplace interventions to enhance employee well-being, ensuring the sustainability of healthcare staff.[11,14]

Leaders in healthcare play a fundamental role in their staff's well-being.[15,16] Engaged leaders who inspire, empower, and connect with their employees are known to create a work environment where employees can thrive.[17] This importance is reflected by the integration of leadership into models such as the widely used Job Demands-Resources (JD-R) model, a cornerstone framework in the study of employee well-being.[18] The JD-R model highlights the importance of balancing job demands with adequate resources, such as supportive leadership, to maintain employee well-being. Despite the undeniable influence leaders can exert over their team's well-being and the increasing demand for well-being strategies, it is unclear how leaders are levering this influence emphasized in the JD-R model on HCW well-being.[16,19] This study aims to unravel the current perspectives and practices of healthcare leaders regarding HCW well-being. By doing so, this study can offer healthcare leaders guidance on further improving the well-being of their HCWs, thereby fostering not only employees' personal health but also the quality of care they deliver.

Material and Methods

Study Context and Setting

This qualitative interview study was conducted with healthcare leaders from a single academic university hospital, one of the largest hospitals in the Netherlands. The hospital's size and status as a leading institution make it representative of other hospitals in the Netherlands, allowing us to capture a wide range of relevant experiences. This setting was specifically chosen as we believe that the complexities and challenges faced in a large hospital are reflective of those encountered in other hospitals across the country.

The study was conducted from December 2020 to January 2021 and adhered to the ethical principles outlined in the Declaration of Helsinki. Ethical approval was obtained by the Central Ethics Review Committee (CTC) (RR202000498), and all participants provided written informed consent. The manuscript followed the Standards for reporting qualitative research, as established by O'Brien et al, in its methodology and reporting.[20]

Study Design

A constructionist epistemology approach was adopted, as the authors believed knowledge to be a subjective, personal, and unique product of the specific interactions between researcher and subjects. This contrasts with the essentialist approach, which assumes that language simply reflects our articulated meanings and experiences.[21] As the purpose of this qualitative research was to understand leader's everyday experience in HCW well-being, with the aim of reducing it to a central meaning, this led us to adopt a phenomenological qualitative approach, namely interpretive phenomenology.[22] Our methods consisted of a predominantly data-driven, inductive approach, using a multitude of semi-structured interviews.

Study Sample

Semi-structured interviews were conducted with a variety of healthcare leaders. We identified a leader as someone providing hierarchical leadership and direction to either the organization, or to divisions, departments, unions, or units within the organization.[23] To ensure a diverse data set, we purposively sampled leaders from all different hierarchical levels within the organization.[24] Figure 1 represents an organigram of the hierarchic levels of leadership included in our data set.

During the interview, participants were questioned on HCW well-being regarding three main topics: 1) the factors they perceive to affect HCW well-being, and signs of both positive and negative well-being; 2) data sources currently utilized to gather information on HCW well-being; and 3) which well-being factors healthcare leaders can influence, using which strategies. All interviews were held in Dutch. During the interviews, the term vitality was used. We refrained from providing a specific definition of vitality, aiming to minimize any imposition of our own perspective, and instead aimed to observe their interpretation of the term. However, as in the Netherlands, the term vitality (in Dutch "vitaliteit") is commonly used when referring to employee well-being, we will from here on exclusively use the term "well-being" for reference. Face validity was ensured by having the research team, which included both academic experts and healthcare professionals, reviewing the interview questions prior to the study. The interview guide was also pre-tested with a sample of medical experts to assess clarity and relevance. Content validity was ensured through an iterative process, where responses were analyzed after each interview, and the interview guide was adapted as needed.

Data Collection and Analysis

All interviews were conducted by the first author (IMR). Using the approach by Guest et al, thematic data saturation was reached after 14 interviews.[25]

Two primary transcribed interviews were independently analyzed and coded, and results discussed by two researchers (IMR, JKGW) to facilitate a richer interpretation of the data. The methodology of this study followed Byrne's worked example of Braun and Clarke's approach to reflexive thematic analysis, a well-established approach for analyzing data in

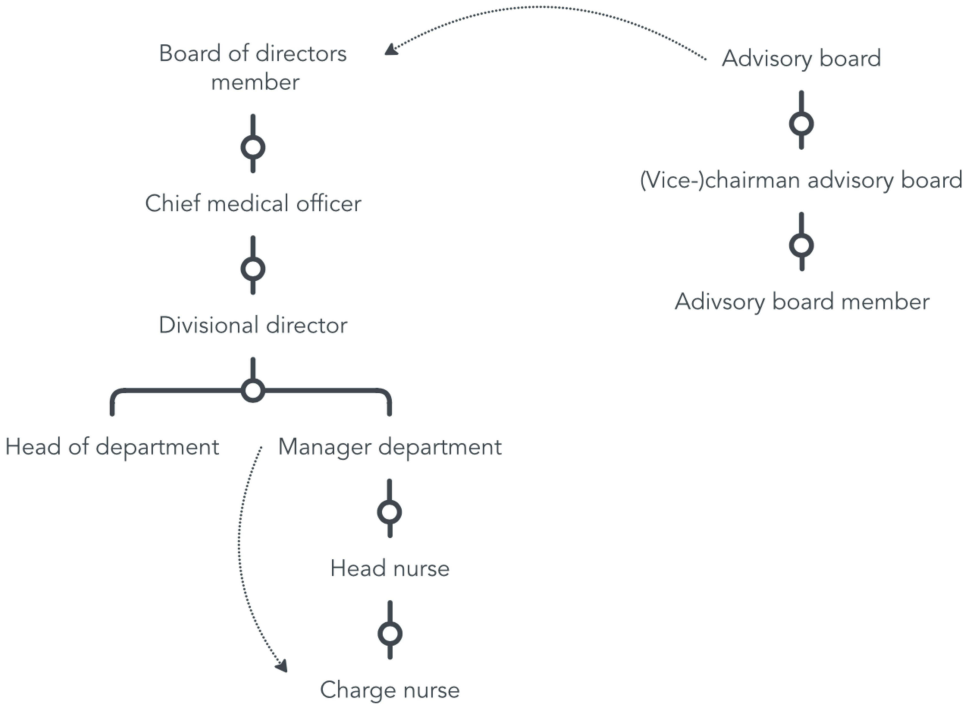

Figure 1 Organizational structure and leadership hierarchy of study participants. Illustration of the organizational structure and leadership levels of the participants involved in the study. Solid lines represent the formal hierarchical relationships of leaders within the university hospital, and within an advisory board. Dotted lines indicate the direct influence of one level upon the other.

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qualitative research.[26] First, the first author (IMR) gained familiarization with the dataset by transcribing the interviews, after which data was systematically coded using an inductive approach. Throughout this process, as she advanced through the dataset, new patterns emerged, prompting revisits to earlier interviews to identify newly discovered codes or discard previously defined ones. In the third and fourth phases, the first author reviewed earlier identified codes, merging them to create (sub)categories influenced by (sub)drivers. These merged codes were then discussed between two researchers (IMR, JKGW) to examine potential categories and relationships among subcategories and (sub)drivers. Final (sub)categories were named and defined, and the results underwent discussion with the other members of the research team (MJL, FS), allowing for final revisions if necessary.

Researcher Characteristics and Reflexivity

Members of the research team consisted of both insiders and outsiders of healthcare leadership. The first author responsible of the primary coding of the data set was a PhD student with no specific leadership experience (IMR). This convenience of an outsider performing the primary coding is that assumptions will less likely be made. To ensure rigidity, notes were made after every interview, and discussed with a second researcher (JKGW), academic program director. This discussion allowed fresh insights into potentially overlooked topics.[27] Final results underwent discussion with others from the research team (MJL, FS), a program director of the surgical residency program, and a dean of an academic center.

Theoretical Framework

To analyze and interpret our findings, we employed the newest modification of the JD-R model as our theoretical framework. This model is particularly suitable for understanding leaders' knowledge concerning HCW well-being. The JD-R model posits that employee well-being is shaped by the balance between job demands, job resources, and regulators.[28] Job demands encompass aspects of the job that require physical or mental effort and incur physiological or psychological costs, like work overload and work-life interference.[29,30] Conversely, job resources are positive aspects of the job that facilitate goal achievement, alleviate job demands and associated costs, or foster personal growth, such as autonomy and fair, authentic management.[29,30] Lastly, regulators include regulatory strategies and capacities by various actors, such as the individual (eg personal resources), family (eg social support), leader (eg engaging leadership), and team or organization (eg shared responsibility), which influence employee well-being. By employing a theory-informing inductive approach, starting with an inductive thematic analysis, allowing themes to naturally emerge from data without being shaped by preconceived theories. As we progressed through the analysis, we incorporated theoretical insights from the JD-R model to inform our interpretation, allowing us to analyze healthcare leaders' perspectives on HCW well-being within the context of job demands, resources and regulatory influences.

Results

Seventeen healthcare leaders from different levels throughout the organization were contacted via email. Fifteen agreed upon participation and were interviewed, while two did not respond to the invitation. Characteristics of participants are enlisted in Table 1. Interviews lasted 23–62 minutes.

We analyzed leaders' answers regarding three topics: 1) the factors influencing HCW well-being; 2) the data sources currently utilized to gather information on HCW well-being; and 3) the strategies employed to influence HCW well-being.

Well-Being and Its Influencing Factors

A large multitude of factors influencing HCW well-being were mentioned by leaders. (Supplementary Table 1) These could be broadly categorized into three categories (Figure 2):

1. *Personal factors*, person-bound factors influencing HCW well-being. These encompassed one's fitness to the job, including physical and mental health, as well as personality traits and abilities, attitude towards their job, and outlook on life, namely one's sense of purpose and hope.

Table 1 Participant Characteristics

Attribute	Number of Participants
Gender	8
Female	7
Male	
Role[(A)]	1
Board of directors member	1
Divisional director	1
Chief medical officer	3
(Vice-)Chairman advisory board	2
Advisory board member	5
Head of department	2
Manager department	2
Head nurse	1
Charge nurse	

Notes: (A) Three participants execute two leadership roles, namely (1) vice-chairman advisory board and charge nurse; (2) manager department and head nurse; and (3) chairman advisory board and head nurse.

2. *Socioeconomic factors*, factors related to one's socioeconomic status. These consisted of one's domestic situation, such as going through a divorce, financial situation, or social situation, such as one's network outside of work.
3. *Work related factors*, factors related to one's work situation. Most of the well-being factors described were linked to one's work. These were primarily related to the physical and psychological work environment (such as the work culture and the safety of the work environment), work demands, and availability of both psychological and job-specific resources. Furthermore, leaders mentioned practices of one's team, immediate manager or leader, and the organization as contributors to the well-being of HCWs.

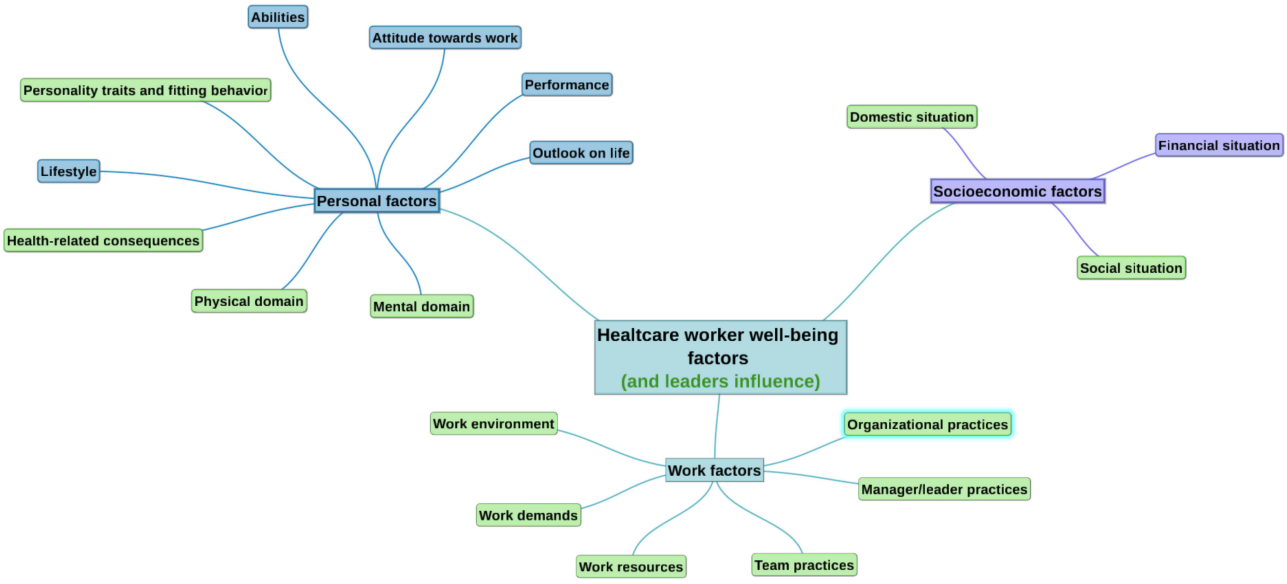

Figure 2 Overview personal-, socioeconomic- and work-factors influencing HCW well-being, its subcategories, and leaders' influence on well-being influencing factors. This diagram illustrates the various subcategories of personal, socioeconomic, and work factors influencing HCW well-being, as identified by the leaders in our sample. Green-marked subcategories indicate areas where leaders believe they can exert influence. Specifically, leaders reported having an impact on 44% of all subcategories related to personal factors, 67% related to socioeconomic factors, and 100% related to work factors.

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> That Is someone who, naturally, finds pleasure in their work, has found the right balance between work and personal life, who feels supported by an organization, by a supervisor who understands the person as an employee, or better yet, the other way around, the employee as a person, where, to give an example, an employee, for a supervisor, always clearly goes through different phases of life. [Int. 13]

Data Sources

Leaders utilized various sources to gather data on HCW well-being, broadly categorized as "contact data" and "investigation data". Contact data involves information collected through (inter)personal interactions with HCWs, typically acquired through spoken conversations or inferred from non-verbal signals. While contact data may be documented on a regular basis, such as in yearly assessment, spontaneous oral conversations were notably emphasized as a frequent data source.

Investigation data, on the other hand, involves formal inquiries within the healthcare setting. These data were often collected systematically and could span various levels, ranging from department-wide to nation-wide. Organization-wide studies, such as employee satisfaction questionnaires, or organization-wide metrics, particularly human resource (HR) metric resulting from negative well-being, such as number of (impeding) absents, were frequently mentioned (Supplementary Table 2).

Numerous leaders expressed dissatisfaction with current data sources, citing concerns about data availability due to a lack of structural insight, or the types of data accessible. Additional substantiation was desired by several leaders, to facilitate intervention selection, assess implemented interventions, identify well-being issues, and gain a deeper understanding of organization-wide metrics (Supplementary Table 2).

Influence and Strategies

While numerous leaders acknowledged their potential to impact HCW well-being, some expressed uncertainty and ambiguity in their impact or approach.

> …like I just said, you have relatively little insight, not only into everything that's going on, but also into what you can do about it and how effective that is or isn't. So, I still find it all quite vague and unclear. We're just doing something. [Int. 2]

Moreover, some leaders stated conditions determining the effectiveness of their influence, namely their regulatory authority, the financial resources at their disposal, and the size of their staff.

> Well, if you look at the actual workload and the balance between work and private life, I hope to have an impact on that in the long term. The only problem is that there's a bit of a shortage of money in healthcare. And so, time is running out. In that sense, I have little confidence that it will improve significantly in the coming period when it comes to more time, more space, more reflection. [Int. 8]

Leaders indicated their ability to influence various factors related to worker' well-being, with a predominant focus on work-related factors and a lesser emphasis on personal and socioeconomic aspects (Supplementary Table 3).

Regarding personal factors, leaders predominantly highlighted their influence on health-related elements, employing a wide array of strategies, from workplace fruit provision to organization-wide health promotion programs. Additionally, some leaders emphasized their role in fostering employees' pro-active behavior, for example by encouraging to think about well-being matters themselves.

Concerning socioeconomic factors, only a few leaders claimed influence, mainly by taking an interest in matters beyond the workplace or implementing initiatives related to the social domain, specifically those affecting at-home caregivers.

Lastly, leaders emphasized their substantial influence across all work-related subcategories. Table 2 offers illustrative examples of the diverse strategies currently employed.

When discussing leaders' influence on HCW well-being, a common theme that emerged was the perceived responsibility. Within our sample, there was ambiguity regarding the responsibility for HCW well-being. Some leaders

Table 2 Illustrative Examples of Strategies Within Each Subcategory of Influenceable Work Factors

Subcategory	Examples Proposed Strategy
Work environment (physical and psychological)	• Providing on-call and lactation-rooms • Providing free massages or bicycle arrangements • Regularly check with employees whether they feel safe • Training on inclusivity / diversity
Work demands	• Agreements on maximum numbers of patients • Providing ability to indicate boundaries in workload • Individualizing work schedules
Work resources (psychological and job-related)	• Expressing appreciation by means of free food on the ward • Providing expert support (eg, psychologist) • Provide opportunities for career development • Leadership programs
Team practices	• Calling on staff to pay attention to each other • Open communication while discussing problems during staff meetings • Clarity in policy, no waving policy
Leader practices	• Have understanding for personal situation employee • Working together with other leaders • Connect to employee
Organizational practices	• Making sure that things are put on the map • Show involvement by means of workplace visits •Providing logistics to improve organization-wide communication

perceived it as a shared responsibility involving employees, managers, and the organization, while others believed employees should primarily shoulder the responsibility.

> Yes, what is well-being… And yes, I wonder because, in my opinion, as an individual, you can really do a lot about it yourself, maybe 80–90%. [Int. 5]

Conversely, some leaders argued that managers and leaders held the primary responsibility, either directed towards themselves, or, notably, towards leaders at different hierarchical levels. For instance, one advisory board chairman held the department head as primary responsible, while an advisory board member pointed to the board of directors. It was also noted that many healthcare leaders currently lack clarity regarding their specific responsibilities in this topic.

> Second is leadership: leadership is, of course, crucial in the well-being of employees and [leaders] genuinely have a responsibility there. But I think that many leaders don't realize that at all. [Int. 12]

Discussion

This study shows that healthcare leaders within the setting of a hospital possess a comprehensive understanding of employee well-being, considering personal, socioeconomic, and work-related factors. However, their approach to employee well-being is often reactive, with mostly unstructured and anecdotal data collection focusing on proxies like sick leaves. Furthermore, while acknowledging their influence on well-being, responsibility is often deflected, revealing a discrepancy between acknowledgement of influence and its actual implementation.

In 2008, the triple aim was introduced to improve the US healthcare system, including the enhancement of the care experience, improvement of population health, and reduction of costs.[31] Recently, the Institute for Healthcare Improvement (IHI) added HCW well-being as a fourth aim.[32] The role of healthcare leaders in this context has been consistently affirmed.[13,16,] To accurately address well-being, leaders must have a certain degree of understanding of what well-being truly entails.[15] When prompted to describe factors influencing HCW well-being, leaders demonstrated a broad

and nuances understanding. They identified a wide range of influencing factors, with a predominant focus on work-related and personal factors. This understanding largely aligns with the JD-R model, particularly in the domain of work factors. Notably, when discussing work-related factors affecting employee well-being, leaders emphasized the significance of leadership, highlighting the importance of the relationship and mutual trust between employers and employees, as well as the beneficial impact of a democratic and charismatic leadership style. This suggests that leaders recognize well-being as extending beyond individual issues to encompass organizational and leadership factors. Overall, leaders show a comprehensive understanding of HCW well-being and implicitly acknowledge their crucial role in enhancing it.

When assessing HCW well-being, leaders utilize various data sources to gather information, mainly relying on sporadic interpersonal contacts or investigational measures, particularly organization-wide metrics like absenteeism or the number of sentinel events. Many leaders expressed dissatisfaction with these sources, citing a lack of structural insight and uncertainty about the precise indications of the metrics used. There thus appears to be an unclear consensus on the type of data necessary for assessing HCW well-being. According to the IHI, three key measures are required for effective improvement: outcome measures, focusing on the desired outcome; process measures, tracking steps in the process leading to the outcome metric; and balancing measures, indicating metrics potentially influenced by the focus on the outcome measure.[33] When evaluating the data sources currently used, it becomes evident that most of the systematically collected data, ie the organizational metrics, primarily consists of process data, mainly reflecting the outcomes of negative well-being rather than proactively addressing the issue. In contrast, the collection of outcome data directly related to employees' well-being appears to be sporadic, as it mainly occurs through sporadic informal conversations. If it does occur systematic, it is only at large intervals, such as yearly assessments. While process measures offer insight into ongoing initiatives' progression, without the inclusion of frequent and systematic outcome measures directly linked to the core objective, it is impossible to know whether we are actually moving towards the goal of improved worker well-being.[34]

Existing literature consistently emphasizes the role of leaders and their leadership style in their employee's well-being, and leaders in our study indeed acknowledged their ability to impact various well-being factors, primarily work-related factors and to a lesser extent personal factors.[16,35] This emphasis on work-factors is of no surprise, as leaders tend to have more control over work-factors. Conversely, personal factors tend to be much more intricate, and can be deeply individual and multifaceted in nature. Noteworthy is the great diversity in strategies reported for enhancing or sustaining HCW well-being: strategies could range from calling on staff to pay attention to each other, to the integration of an organization-wide health promotion program. However, like data collection practices, there is no consensus on what strategies to prioritize. Many leaders express uncertainty about what actions to take, some even admitting to implementing interventions without a clear understanding of their impact ("*just do something*"). Additionally, leaders frequently shifted the responsibility for worker well-being, either back to the individual employee or to leaders at different hierarchical levels. Given that the goal of HCW well-being should be a shared responsibility between healthcare systems and individual physicians, we recommend all hierarchical leaders to be addressed on their knowledge, skills and leadership style concerning HCW well-being.[36] In essence, leaders serve as role models for their employees' well-being, and their demonstration of leading by example can directly impact employees psychological ownership of their work.[37]

However, mere knowledge and skills are insufficient. Well-being measures are essential for identifying the need for intervention and subsequently evaluating the effectiveness of interventions.[38] The current lack of consensus on data collection and subsequent strategies may make well-being seem too intangible, resulting in a shift in responsibility. We recommend transitioning towards more frequent and systematic data collection, with a focus on directly assessing current well-being rather than focusing on its subsequent negative outcomes. Additionally, future strategies should go beyond individual-focused approaches and instead adopt a multi-faceted approach considering various aspects of employees' networks, including their team, leader and organization, as suggested by the JD-R model.[28] To guide the formulation and integrations of these strategies, we propose following a quality-oriented approach similar to the Plan-Design-Check-Action (PDCA) cycle.[39] This step-by-step approach not only aids in designing effective well-being strategies aligned with the desired goals, but also enables the verification of their effectiveness afterwards. Finally, for leaders genuinely to be committed to supporting HCW well-being, we believe it is imperative for all leaders to collectively assume responsibility for maintaining and improving HCW well-being. Establishing a benchmark for leadership effectiveness

may help to identify the gap between best practices and current practices, offering a path to enhance leadership approaches and better support HCW well-being.

This study has some limitations. First, this study was conducted in a single university hospital, limiting the study sample. However, the focused approach allowed an in-depth exploration of leadership roles across various hierarchical levels within a specific context. Furthermore, the academic hospital studied closely resembles others in the Netherlands, potentially providing valuable insights into leaders' perspectives in other hospitals.

Second, as this study is qualitative in nature and adopts a constructionist epistemology approach, our background may have data interpretation. Nevertheless, the research team's diverse composition has enabled us to approach the question from various perspectives, reinforcing the trustworthiness of the provided arguments. Furthermore, our goal was not to offer a definitive portrayal of healthcare system leadership, but rather to present new perspectives into the roles and potential influence of leaders on the well-being of HCWs.

Third, this study was conducted during the challenging period of 2020/2021, when COVID-19 pandemic may have heightened the focus on HCW well-being, potentially skewing the representation of the typical scenario. Despite this, our results indicate that healthcare leaders still have room to improve their involvement in addressing HCW. Additionally, while the workforce landscape and awareness of well-being issues may have evolved since then, potentially providing new insights or emerging themes were not captured in this study. Nonetheless, as the fundamental issues related to HCW well-being have not significantly changed over the past three years, we believe that the core themes identified in our study remain relevant.

Conclusion

This study highlights that leaders collectively demonstrate a broad understanding of employee well-being and possess significant influence over various well-being factors. However, at the individual level, leaders often displayed a reactive approach towards the topic, as there is no clear consensus on what data to collect or strategies to prioritize. There is compelling evidence indicating that all leaders should collectively assume responsibility for the well-being of HCWs. We advocate for a shift towards more frequent and systematic data collection with a focus on preventive rather than reactive measures. Moreover, when formulating strategies, we propose embracing a multi-faceted approach that considers various elements of the employees' networks, as recommended by the JD-R model. Lastly, as all leaders serve as role models, we underscore the importance of leading by example and addressing leaders at all hierarchical levels on their knowledge, skills and leadership style concerning HCW well-being.

Abbreviations

HCW, Healthcare worker; JD-R model, Job-Demands and Resources model; IMR, Iris Margaretha Reijmerink; JKGW, Johann Klaus Götz Wietasch; MJL, Maarten Jurriaan van der Laan; FS, Fedde Scheele.

Data Sharing Statement

As informed consent was obtained for the use of the data within the context of this particular study solely, data sharing is not possible.

Ethics Approval and Informed Consent

This study was carried out in accordance with the Declaration of Helsinki. Ethical approval was obtained by the Central Ethics Review Committee (CTC) (RR202000498), and all participants provided written informed consent, which included permission for the publication of anonymized responses and quotes.

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Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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