Diagnosing and managing anorexia nervosa in UK primary care: a focus group study

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Co-designed the study, authored the focus group materials, initiated participant recruitment and helped develop and revise the manuscript.

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Background. Anorexia is a leading cause of adolescent hospital admission and death from psychiatric disorder. Despite the potential role of general practitioners in diagnosis, appropriate referral and coordinating treatment, few existing studies provide fine-grained accounts of GPs’ beliefs about anorexia.

Objectives. To identify GPs’ understandings and experiences of diagnosing and managing patients with anorexia in primary care.

Methods. Case-based focus groups with co-working general practitioners in the East Midlands region of England were used to explore attitudes towards issues common to patients with eating disorders. Group discussions were transcribed and analysed using corpus linguistic and discourse analytic approaches.

Results. Participants’ discussion focused on related issues of making hesitant diagnoses, the utility of the body mass index, making referrals and overcoming patient resistance. Therapeutic relationships with patients with anorexia are considered highly complex, with participants using diagnostic tests as rhetorical strategies to help manage communicative obstacles.

Conclusions. Overcoming patient repudiation and securing referrals are particular challenges with this patient group. Successfully negotiating these problems appears to require advanced communication skills.

Keywords. Anorexia, body mass index, corpus linguistics, focus groups, primary care.

Introduction

Despite a relatively low prevalence compared with other mental health problems, anorexia nervosa has the highest rate of mortality among psychiatric disorders and around a quarter of patients demonstrate no long-term recovery. While treatment for anorexia is typically within specialist services, general practitioners are likely the first health care professionals with whom patients with anorexia come into contact. They also play a central role in assessment, coordinating care and facilitating access to specialized care. It is surprising, therefore, that there is a dearth of research offering granular analysis of GPs’ understandings of anorexia nervosa and their experiences of conducting these primary care-specific tasks. Given the role of GPs in establishing diagnoses, the definitions and meanings they attach to eating disorders will be of direct clinical relevance in shaping routine interactions with the patient and the treatments they receive. This in turn has clear implications for establishing a therapeutic alliance with the patient as well as their subsequent experience of treatment and uptake of services.

To our knowledge, there is currently only one existing published qualitative study specifically detailing GPs’ perspectives on managing eating disorders, indicating a clear need for additional research in this area. This study identified themes of difficulty in recognizing patients’ eating difficulties due to lack of knowledge of signs, and a belief that patients actively hide their disordered eating. Patients with anorexia were perceived to be demanding and to require skills beyond those which GPs have to offer, with participants recognizing a need for specialist psychological services. However, this was tempered by an awareness of limited availability of specialized services and long waiting times for patients who may already be reluctant to pursue treatment. These findings cohere with interview studies examining specialist eating disorder teams who report professional anxiety towards treating patients with anorexia as...
well as recurrent examples of patient-professional conflict and frustration over service capacity. They also elaborate upon foregoing quantitative studies indicating variable knowledge of eating disorders amongst general practitioners and their concern over ability to treat patients successfully.

The current study used patient vignettes to explore general practitioners’ understandings and experiences of diagnosing and treating patients with anorexia. This was part of a larger project which also investigated GPs’ experiences of diagnosing and managing patients with depression and patients’ discussions of suffering from anorexia and depression respectively. The wider project also aimed to identify areas of similarity and difference between practitioners’ and patients’ respective understandings of anorexia and depression and their implications for health care practice. Findings from the GPs’ discussions of depression and patients’ interactions are in preparation. In the GP studies, vignettes were used as part of open-ended focus groups that allowed participants to discuss their own patients and additional issues that they perceived to be relevant. This open-ended design was intended to capture discussion of practice-related issues that are meaningful to the participants, but which may fall outside of researchers’ pre-formulated questionnaires and interview schedules.

Methods

Design and Participants

Potential participants were identified from a list of all practices in the study’s approved research area, a city in the East Midlands region of the UK. A minimum of three participants is needed for a focus group interaction and practices with fewer than three GPs were excluded. As part of the wider study outlined above, the remaining practices were assigned to either the anorexia or depression side of the project and GPs from 14 practices across the city were then invited by letter to participate. Participation required at least three GPs from the practice to be available at the same time for the focus group discussions, a logistical factor that curbed the total number of participants. Twelve GPs from three practices took part in the focus groups, including four participants practising at a university health centre.

Each focus group consisted of four co-working GPs and was held in their respective surgeries to minimize disruption and to enable discussions to be contextualized as much as possible within normal practice. The focus groups used two hypothetical patients to catalyse discussion of anorexia and its management. The use of patient vignettes was intended to offer some parity between the focus group discussions and participants’ common working practice of discussing patient management issues in team meetings. Vignettes are also useful for eliciting views on anorexia, which presents infrequently in primary care and so can be difficult to discuss if GPs are asked to recall their own patients.

The hypothetical patients were authored by RC in response to clinical experience and issues identified in existing literature including diagnosis in borderline and/or comorbid cases, patient denial and conflict between the patient and family members. Other than the case scenarios, the focus groups were not moderated. This allowed the participants to determine the duration and trajectory of the subsequent discussions and focus on aspects of patient management that were relevant to them. Accordingly, the discussions were not limited to the vignettes, with participants also discussing their own patients and eating disorders more generally.

<table>
<thead>
<tr>
<th>Anorexia Scenarios</th>
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<tbody>
<tr>
<td>The following scenarios are intended to trigger discussion about the problems raised. What else would you like to know? How would you feel about this situation? What would you think about doing? Have you had patients similar to this in the past and what happened? Are there any issues arising in the management of anorexia which you would like to discuss?</td>
</tr>
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**Case Scenario 1**

Julia Bryant is 18 and is an administrative assistant in a solicitors office. Her mother comes into the consultation with her. Julia wants another prescription for the contraceptive pill, but her mother then tells you that she is worried about her weight. Julia has apparently been losing weight over the past few months by ‘dieting’. However her mother feels that she is ‘overdoing it’ and wants her to stop. There is clearly tension between the two of them and you ask to see Julia on her own.

Julia says that she doesn’t know what the fuss is about—she is just trying to look good. She used to be quite overweight as a young teenager but now feels that she is getting to the weight she wants although she still thinks she is fat. She admits to missing meals and tries to avoid eating at home because her mother tries to push her to eat more. You check her weight and she has a body mass index of 17.

**Case Scenario 2**

Ellie Cobb has just been discharged from hospital following taking an impulsive overdose of fluoxetine. She had been assessed by the on-call mental health care team as low risk. However they commented on the fact that she shouldn’t have been on fluoxetine as she wasn’t suffering from depression and actually may have an eating disorder.

You know that Ellie has suffered with depression on and off for years; you suspect that Ellie has been abuses in the past but there has been no disclosure. She was started on fluoxetine by a GP in the past. Every time she stops it her mood deteriorates and she stops eating.

When you see her today with her grandmother Ellie has low mood and regrets taking the overdose following an argument with her boyfriend. She admits that she feels fat when she gets low and takes laxatives to help her lose weight as well as making herself sick if she feels she has eaten too much. Her BMI is 21.
With participants’ written consent, the discussions were audio recorded and transcribed in detail in accordance with corpus linguistic conventions,10 with details of all individuals rendered anonymous during transcription. The study was evaluated and approved by the local National Health Service R&D and Research Ethics Committees.

Analysis
The focus group transcripts were initially interrogated through corpus linguistic techniques using the WordSmith 5 software.11 Corpus linguistic techniques have seen a steady uptake in qualitative studies of interpersonal communication in health care contexts.12 Keyword calculation, in particular, has been demonstrated to illustrate salient themes in language data through identifying those lexical items and phrases used with comparatively high frequency by speakers in a particular communicative context.13 In this respect, keyword analysis performs a process analogous to the initial coding used in thematic analysis, though does so solely by ascertaining those words and phrases repeatedly deployed by participants.

In the present study, a keyword analysis was conducted by comparing relative word frequencies in the focus group transcripts with a 10-million-word collection of spoken interactions in the British National Corpus. The resulting keywords were organized into themes by the first author. Thematic categories of keywords were initially derived from the meaning of the keywords themselves, such as ‘anorexia’, ‘bulimia’ and ‘depression’ referring to medical conditions. Instances of keywords were then viewed in the transcripts to refine the thematic categories. For example, the keyword ‘mental’ repeatedly appeared as part of the phrase ‘Mental Health Act’ during discussions of patient management, rather than during discussion of mental illness as a medical condition. It was therefore categorized to reflect this use by the participants. Similarly, ‘adolescent’ featured in reference to adolescent psychiatric services rather than patient characteristics and was therefore categorized under a ‘Treatment and referral’ theme rather than ‘Diagnosis and symptoms’ theme.

These keywords are then scrutinized in their contexts of use to identify their function when used by speakers.14 This close, qualitative analysis draws on discourse analysis15 to consider the ways in which speakers use keywords to construct particular understandings of anorexia, patients and their professional role through talk. In doing so, the initial ‘top-down’ view of the focus group transcripts provided by frequency and keyword analyses is complemented by ‘bottom-up’ textual analysis that demonstrates how important thematic areas are introduced and negotiated by the participants in context.16

Results
Twelve general practitioners took part in the study. Six participants were female and six were male. Three participants were aged 30–34, two aged 35–39, three aged 40–44 and four aged 45–49. Participants had a mean of 12.8 years of experience as a GP (range 1–21 years).

Based on the keyword analysis, Table 1 presents the salient themes of the focus groups along with their top corresponding keywords.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Themes and attendant keywords</th>
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<tbody>
<tr>
<td>Theme</td>
<td>Associated keywords</td>
</tr>
<tr>
<td>Medical conditions</td>
<td>eating, anorexia, disorder, overdose, depression, anorexics, bulimia, disorders, problem, depressed, bulimic, thyroid, anorexic, anorexia’s, illness,…</td>
</tr>
<tr>
<td>Diagnosis and symptoms</td>
<td>BMI, weight, impulsive, low, bloods, problem, BMI’s, purging, unwell, underweight, potassium, laxatives, thin, digestion, weight…</td>
</tr>
<tr>
<td>Treatment and referral</td>
<td>Fluoxetine, referral, referred, therapy, secondary [care], prescribe, antidepressants, therapies, psych [team], prescribing, Sando-K, psychoeducation, refer, adolescent [health team], family [therapy]…</td>
</tr>
<tr>
<td>Patient management</td>
<td>patient, problem, difficult, normal, mental [health act], GP, patients, rapport, secondary [care], mum, engage, denial, adolescents, family, GPs,…</td>
</tr>
<tr>
<td>Abbreviations</td>
<td>BMI, BMI’s, ENT</td>
</tr>
<tr>
<td>Modality markers</td>
<td>maybe, kind of, probably, quite, suppose, really, actually, often, obviously, sort of, anymore, you’d</td>
</tr>
<tr>
<td>Response tokens</td>
<td>mm, yeah, hm, mmm</td>
</tr>
<tr>
<td>Scenario-related words</td>
<td>scenario, Julia, mum, grandmother, scenarios</td>
</tr>
</tbody>
</table>

The keywords cluster into themes relating to substantive issues in the management of anorexia. These include defining anorexia and other health problems, identifying diagnostic symptoms, treatment and referral and patient management. There are also keywords that are less specific to discussing medical care such as the abundant use of verbal hedges ‘maybe’, ‘quite’ and ‘sort of’ to attenuate claims, as well as minimal response tokens (‘mm’, ‘yeah’) used during spoken communication, and lexical items relating to the patient scenarios. The following analysis focuses on the first four themes, considering the related issues of defining anorexia, diagnosis, treatment and referral and patient management.

Diagnosis, ‘eating disorder’ and ‘anorexia’
Examination of the participants’ use of ‘anorexia’ indicates it is frequently used during their discussion of diagnosis. As the following two extracts suggest,
participants related diagnostic statements to patients’ emotions, behaviour and physical state:

S8M: I’m more reading that she feels low and that’s when she feels she’s overweight and that’s when she takes laxatives.
S7F: Right.
S8M: That’s not necessarily bulimia that sounds more
S7F: Mm-hm.
S8M: anorexia.
S12M: [...]I mean sometimes it’s easy you can tell they look skeletal thin and think ‘Yeah the diagnosis is likely to be anorexia’

When comparing anorexia with other eating disorders more generally, speaker 12 presents additional criteria for distinguishing anorexia:

S11M: If you’re aware of the family structure and if it is a quite a chaotic family structure statistically alone she may well have a [pause] you know you might be thinking ‘well you might have been abused in the past’ cos [pause] you know.
S12M: And it’s interesting i= cos I think generally sort of bulimia EDNOS type stuff is much more [pause] is much more linked to external stuff and low self-esteem whereas anorexia generally sits much more within itself. Yes you know there might be some family issues
S9F: +Yeah but often there aren’t.
S12M: +Often there aren’t.

Here, speaker 12 claims that anorexia is not related to patients’ self-esteem and external factors such as familial abuse—which had been mentioned in the previous turn—before suggesting that ‘family issues’ are only a possible but not certain indicator of anorexia. Taken in sum, the participating GPs present a multifactorial picture of anorexia’s clinical diagnosis, relating it primarily to patients’ body mass and also to eating behaviours, emotional difficulties and possible social issues. However, a notable feature of these diagnostic claims is that they are expressed in a distinctly tentative fashion: speaker 12 prefaces his classification of anorexia with three hedges ‘I think generally sort of, the hypothetical patient’s eating behaviour is only ‘not necessarily’ bulimia and even when a patient is ‘skeletally thin’ anorexia is only ‘likely’ rather than more certain. The presence of these qualifiers indicates considerable expressed uncertainty when categorizing patients or anorexia in which patients’ weight, behaviour and family circumstances are presented as uncertain evidence for diagnosis.

The participants also negotiated the uncertain diagnosis of anorexia by repeatedly positioning it in relation to the keywords ‘eating disorder’. ‘Eating disorder(s)’ appears more frequently in the focus group discussions than ‘anorexia’, and is characteristically used by the participants to categorize a patient’s eating behaviours as problematic while avoiding more specific diagnoses:

S7F: And there= they’ll be such a huge proportion of young people that we wouldn’t see that might have similar
S6F: +Mm.
S7F: issues [to ‘Julia Bryant’] anyway because it’s so common. And it’s deciding I suppose when it’s an eating disorder and when it’s not.

Here, speaker 7 refers to the difficulty of determining pathological eating behaviour from many young women’s image-conscious weight loss. In this respect, the participant initially suggests an overlap or gradation between eating disorders and ‘common’ experiences of dieting. Nevertheless, the clinician’s decision between ‘when it’s an eating disorder and when it’s not’ is presented as a binary one; GPs must work with exclusive diagnostic categories even while recognizing their association with a widespread concern with weight and body image. Similarly, another participant suggested that classifying patients as eating disordered rather than anorexic was a hermeneutic rather than clinical decision, in which a diagnosis could be avoided if the GP felt they had little to offer patients with anorexia therapeutically:

S1F: So there are these weird eating disorders aren’t there mm.
S2M: Yeah.
S1F: They probably are anorexia rather we just we just don’t [pause 2 seconds] grasp the nettle

Other participants, however, invoked patients’ body mass index (BMI) as a means of differentiating ‘anorexia’ from ‘eating disorders’:

S12M: And first of all she [‘Ellie Cobb’] hasn’t got anorexia by any sort of definition has she she might have an eating disorder but
S9F: +Mm.
S12M: +not with a BMI of twenty one she hasn’t.

BMI was similarly invoked elsewhere as a criteria needed to ‘officially diagnose’ anorexia and as an objective marker that could either corroborate or undermine a patient’s account of their own eating behaviour. At the same time, one participant described BMI as a ‘difficult indicator’ and claimed to
be sceptical of discussing BMI with patients, believing that they may not share professional understandings of what constitutes a low body mass and may simply think ‘Maybe when I get down to ten I’ll start worrying’ (S2M).

Treatment and referral
The presence of the keywords ‘denial’, ‘difficult’, ‘problem’ and, less frequently, ‘manipulative’ clearly signals that the participants consider the management of anorexia and anorexic patients themselves to be challenging. ‘Difficult’, for instance, appears 32 times throughout the transcripts (equivalent to once every 3:20 minutes of talk) compared with only five occurrences in comparable discussions of depression in a related arm of the wider study. Examination of the uses of ‘difficult’ indicate that participants repeatedly identify difficulty with the related issues of making referrals to specialist treatment and encouraging resistant patients to accept medical care. For example:

S7F: I suppose the other thing is you know when [pause] what kind of help are we able to offer? Is something I sometimes find difficult and also when they should be referred and not referred and they= there are guidelines and things and

S6F: Mm.

[pause 2 seconds]

S7F: But I= I sometimes worry about checking people’s weights and things about how what influence that’s having on on their eating disorder.

This participant’s account of referral illustrates a clear double-bind for the GP who is both sceptical of the effectiveness of services available in primary care while simultaneously cautious of ascertaining patients’ weight for the purpose of referral. This in turn indicates a problem with acting in accordance with clinical guidelines in practice, where obtaining the information required to refer a patient is believed to reinforce a concern with weight that is characteristic of the condition itself. Even when confident of the need for referral, all participants identified difficulty with persuading patients to accept specialist care, and each group discussed existing patients who refused referral or missed appointments with specialist eating disorder services. As the following extract demonstrates, the source of the difficulty is perceived to be the tension between the GPs’ preference for referral and patients who ‘don’t admit there’s a problem’:

S2M: you’re kind of thinking well ‘She’s reached the threshold of my referral so how can I [pause 2 seconds] persuade Julia that she needs referral or what what tools would I have’ and again that’s where I’d probably come up against a bit of a wall really [pause] with my sort of communication in this area.

Similarly, other participants claimed that ‘it’s difficult [...] to know how to approach’ discussions with patients with anorexia (SSF) and that admission would be ‘really quite a difficult thing to talk about’ (S3F). Faced with this communicative obstacle, GPs in each group consistently mentioned using blood and ECG tests as an interactive ‘hook’ or ‘tools’ for responding to patients’ denial that their weight is a problem and persuading them back for further appointments. Rather than primarily clinical diagnostic aids, the GPs explicitly construe these forms of professional assessment as rhetorical resources offering objective evidence of physiological malfunction to overcome patients’ subjective beliefs about their eating; as speaker 2 goes on to say ‘maybe that’s going to add weight to your argument that, you know, in the same way that “your BMI is low your salts in your blood are low and you’re are anaemic so”’.

Finally, although not explored in detail above, it is worth noting that there is little talk of successful patient recovery in the corpus (‘recover’, ‘recovery’, ‘recovered’ and ‘recovers’ each appear once in the transcripts). Rather, the doctors’ talk is replete with the challenges of encouraging patients to ‘acknowledge there’s a problem’ (SSF) and accept interventions that may precede recovery, with patient cooperation rather than clinical acumen the key to improvement. As speaker 6 remarks, ‘until I think they’ll admit there’s a problem what do you do?’

Discussion
This study used case-based focus groups to illuminate the views of GPs regarding anorexia. Using a statistically driven corpus linguistic analysis of the discussion transcripts, four overlapping themes of the participants discussions were highlighted: defining anorexia, diagnosis, the difficulty of treatment and referral and overcoming patient repudiation.

The participants consistently emphasize low weight and treatment resistance as central characteristics that distinguish patients with anorexia from other eating disorders. In particular, BMI numbers offer the participants an objective measurement on which to base their diagnostic reasoning and discern between anorexic and non-disordered patients who may have ‘similar issues’ such as over-estimating their body weight. However, the participants do not appear to agree on other diagnostic evidence and variously cite family difficulties, dieting practices and laxative use as only possible indicators.

The hesitant way in which the GPs offered descriptions of anorexia and diagnoses of the scenario patients offers tentative support for previous research that found low levels of knowledge about eating...
disorders among health care professionals. However, it is necessary to see these hedged claims as occurring during a group interaction in which participants may also be reluctant to commit strongly to assertions that could discourage others from expressing alternative accounts. Within one focus group, such an unmarked contradiction between two participants’ claims did arise, with anorexia described as both disassociated from ‘external stuff’ (S12M) and as often ‘triggered by something’ external (S11M). These differences in clinicians’ accounts of anorexia likely reflect the variety of perspectives available in professional literature and may also have a significant impact on the consistency of anorexia’s diagnosis and treatment between professionals.

Keywords in the ‘Patient Management’ theme indicated that the GPs consistently described anorexia as a ‘difficult’ condition with patients repeatedly described as ‘manipulative’ and unwilling to ‘engage’ in treatment or see they have a ‘problem’. While some areas of difficulty identified by the participants relate to making clinical decisions using the limited information in the patient vignettes, others refer to the management of anorexia generally. The patient scenarios were also designed as feasible presentations of anorexia in primary care, meaning that areas of difficulty identified in the hypothetical cases may well transfer to the participants’ real-life practice. Accordingly, these findings clearly support previous results that note GPs’ anxiety around the diagnosis and treatment of patients with eating disorders and the ‘difficult’ nature of their management. In addition to these foregoing studies, the findings also suggest that underdiagnosis may not simply stem from patient characteristics but also result from doctors being reluctant to ‘grasp the nettle’ and pursue diagnosis of a challenging condition. The study also illuminates specific aspects of management, such as weighing the patient and discussing BMI scores, which the GPs experience as problematic.

While the doctors consistently advocate referral of patients to specialist psychological services, they also identify a need for training in interviewing skills needed to overcome patients’ resistance to referral. The study offers insight into how GPs pragmatically attempt to overcome patients’ resistance in the absence of these communicative skills. Specifically, participants described utilizing medical assessments in which vitamin and electrolyte levels and body mass scores help legitimate the reality of the patient’s condition as a medical pathology and convince them of their need for specialist care. As demonstrated by the participants’ criticism of BMI, however, this medical information may not carry the same significance for the patient as the doctor, nor relate to the aspects of their eating behaviour that they experience as problematic.

### Strengths and Limitations

Participant recruitment and sampling was limited by the number of practices in the recruitment area with three or more GPs who were not already invited to take part in the depression side of the wider study, and a relatively low positive response rate (21%) from invitees. We hypothesized that this is due to the logistics of securing several GPs at one time for group discussion, the comparatively low incidence of anorexia in the general population affecting participant interests and the lack of available funding to reimburse participants. Although participants self-selected to join the present study there was no indication that they held particular interest in eating disorders, with several describing limited experience in the treatment of patients with anorexia.

The focus group discussions provided a valuable means of accessing the language, concepts and norms that are relevant to groups of participants in which the on-going production of talk (i.e. data) is less influenced by the researcher than during interview studies. The use of corpus linguistic analysis also highlighted consistent areas of experience between participants and groups across the dataset, and particularly how to broach the ‘difficult’ topic of referral with patients, which was not mentioned in the case scenarios. However, because data collection was limited by logistical factors rather than data saturation (in this case, complete saturation of the keyword list), saturation of the data cannot be ensured and additional groups may have supplied further keywords and themes.

### Conclusions

Analysis of the focus groups foregrounded a number of consistent tensions in the GPs’ experience of managing anorexia: using categorical diagnoses while regarding anorexia as continuous with non-pathological dieting; needing to make weight-based referral yet being anxious about weighing patients; and identifying a need for specialist skills in order to successfully refer patients on to specialists.

While the group discussion process exemplified here offered an opportunity for participants to work through these contradictions with their colleagues, the participants also identified further training as an additional solution. Additional qualitative studies could usefully investigate whether these experiences are shared among a larger number of general practitioners and may also identify further themes in GPs’ discussions. The study suggests the participants have developed practical methods for overcoming patients’ resistance to interventions. Using blood and ECG tests to encourage patients back for further appointments and to offer evidence of physical impairment may prove useful for other practitioners and we recommend that future
research focus on identifying further strategies for successfully managing patients’ repudiation.

Different models of care may also facilitate interventions with these patients. Using primary care mental health workers, for instance, may make the ‘referral’ step less difficult to negotiate with the patient. Providing GPs with ready access to specialist consultation by phone, without the necessity for referral (at least initially) may also enable GPs to monitor and care for a patient for longer until they become more receptive to formal referral. This builds on existing skills of GPs in risk management involving ‘holding’ and monitoring a difficult situation while persuading patients to accept intervention.

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