


BMJ Open Exploring discrimination and racism in healthcare: a qualitative phenomenology study of Dutch persons with migration backgrounds

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ABSTRACT

Objective To explore and characterise the discrimination and racism experienced in healthcare from the perspective of Dutch patients with a migration background.

Design This was a qualitative phenomenological study incorporating an inductive thematic analysis of the answers provided to a free form online survey. Descriptive and differential analyses were conducted for the closed-ended questions.

Setting This study used an online survey distributed in Dutch about experiences of discrimination and racism in healthcare to the general population in the Netherlands.

Participants The survey was completed by 188 participants ($M_{age}=39.89$, $SD_{age}=10.2$). Of whom 80 ($M_{age}=37.92$, $SD_{age}=10.87$) met the eligibility criteria for thematic analysis (ie, has a migration background or a relative with a migration background and experienced discrimination in healthcare based on their background) and were thus included in the analysis.

Results From the total sample, women, relative to men, were 2.31 times more likely to report experiencing healthcare discrimination ($OR=2.31$; 95% CI 1.23 to 4.37). The majority of the participants (60.1%) had a Moroccan or Turkish background. Six themes were identified relating to experienced discrimination in healthcare based on one's migration background: (1) explicit discrimination, (2) prejudice, (3) not being taken seriously, (4) discriminatory behaviour, (5) language barriers and (6) pain attribution to cultural background. Some participants reported that their attire or religion was linked to their migration background, thus contributing to their experiences of discrimination.

Conclusion Dutch patients with a migration background may experience discrimination based on their ethnic identity or other factors related to their backgrounds, such as their faith, culture and skin colour. Discrimination manifests as intersectional and may take different forms (eg, discrimination based on the intersection between race and gender). Therefore, healthcare discrimination may increase health inequities and lead to unequal access to healthcare services. Implicitly or explicitly discriminating against patients is immoral, unethical, illegal and hazardous for individual and public health. Further research on the magnitude of discrimination in healthcare and its relation to health is needed.

STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ The main strength of this study was the substantial sample size and comprehensive range of responses, which significantly contributed to the investigation of how discrimination is perceived through intersectional lenses.
- ⇒ The dominance of responses from Moroccan and Turkish participants may have resulted in sampling bias, potentially limiting the diversity of perspectives in the data.
- ⇒ The survey's Dutch language and online format have led to sampling bias of individuals who are not proficient in Dutch or lack digital literacy, thus overlooking their lived experiences.

INTRODUCTION

The Netherlands has a legal obligation for its citizens to have healthcare insurance and to provide equal access to healthcare services.^{1–5} Nonetheless, ethnic health disparities persist, and people with a migration background have poorer health outcomes than the native population.^{1–5} The non-European migrant population accounts for approximately 14.5% of the population of the Netherlands, primarily comprising individuals from Morocco, Türkiye, Suriname, Indonesia and the Dutch Antilles.⁴ This population group is at higher risk for and shows a higher prevalence of mental health problems, communicable and non-communicable diseases and higher mortality rates than those with a Western or Dutch ethnic background.^{1–4}

Various factors contribute to ethnic health disparities, including contextual variables such as educational level, access to healthcare services, community health and factors related to the healthcare provider and patient. While current literature often attributes ethnic health inequities to low socioeconomic status, ethnic background and comorbidities such as obesity and diabetes,^{5,6} disparities persist even

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Box 1

This paper adapts the American Psychology Association (APA) Dictionary of Psychology definition (<https://dictionary.apa.org>) of the below listed terms.

Discrimination: 'The differential treatments or outcomes that are unfavourable towards a group or an individual according to some aspect of their actual or perceived identity, such as race, religion, nationality, physical ability, gender, sexual orientation, class, or social status'.

While discrimination is a broader term encompassing unfair treatment based on aforementioned characteristics, racism specifically focuses on unfair treatment based on so called race, skin tone ethnicity.

Racism: 'A form of prejudice that assumes that the members of racial categories have distinctive characteristics and that these differences result in some groups being inferior to others. Racism generally includes negative emotional reactions to members of the group, acceptance of negative stereotypes, and racial discrimination against individuals; in some cases it leads to violence'.

Ethnicity: 'A social categorisation based on an individual's membership in or identification with a particular cultural or ethnic group'.

Race: 'A socially defined concept sometimes used to designate a portion, or 'subdivision', of the human population with common physical characteristics, ancestry, or language. The term is also loosely applied to geographic, cultural, religious, or national groups. The significance often accorded to racial categories might suggest that such groups are objectively defined and homogeneous; however, there is much heterogeneity within categories, and the categories themselves differ across cultures. Moreover, self-reported race frequently varies owing to changing social contexts and an individual's possible identification with more than one race'.

Depending on the context (Europe vs the USA or Global North vs the Global South), the social construct of race is often used interchangeably with the social construct of ethnicity when discussing racism. While racism and ethnicity-based discrimination are two slightly different concepts.⁶

after controlling for these variables.^{3 7 8} There is a prevalent assumption that the heightened risk of poor health outcomes among non-Western ethnic groups stems from genetic or ethnic differences.⁶ However, race and ethnicity are sociopolitical terms and do not inherently indicate biological differences that increase disease risk among populations.⁶ Therefore, attributing health disparities to race or ethnicity is problematic.⁶ Many underlying societal factors contribute to these health inequities,⁹ including the significant role of racism and discrimination (see [box 1](#) for definitions).^{10–14} However, the key role of discrimination and racism in accounting for health inequities is often overlooked.^{8 11–13 15 16} Discrimination, whether implicit, explicit or institutional, negatively impacts the quality of healthcare services and contributes to poor mental and physical health and inequalities in accessing healthcare.^{8 11 16–22}

A worldwide commission on Racism, Structural Discrimination and Global Health worked on the manifestations of discrimination and racism in healthcare and their potential effects on health. Manifestations and impact varied per region or country and had yet to be fully understood.²³ A recent Lancet Series has provided

empirical evidence of the relationship between racism, xenophobia, discrimination and health, underscoring the need for further research on their impact on healthcare.²⁴ There is no evidence that findings from this Series would not be valid in the Netherlands. It is, therefore, pivotal to document the manifestation of discrimination and racism from a patient perspective rather than relying solely on theoretical concepts. The lived experiences of patients who faced discrimination and racism in healthcare settings have provided valuable perspectives that theoretical concepts alone cannot fully explain.²⁵

Little European research has been available on the characteristics and contribution of discrimination and racism towards ethnic minorities and how this has been perceived from a patient's perspective.^{26–29} The same applies to the Netherlands, where on a government level, policymakers have aimed to provide equal access to healthcare, fight discrimination and institutional racism and reduce ethnic health disparities. Therefore, this study has two main objectives. The first objective is to identify characteristics and manifestations of discrimination and racism in healthcare as perceived by Dutch patients with a migration background. The second objective is to examine how the aforementioned form of social injustice impacts the participants. An online survey was administered to obtain these goals, enabling the collection of a relatively large sample size for qualitative research.

METHOD

Study design

The study used an exploratory qualitative research design employing a descriptive phenomenology approach, utilising open-ended surveys to examine participants' experiences of discrimination in healthcare.³⁰ This research methodology allowed us to understand and learn from individual experiences.³⁰

Study population

We conducted this study in the Netherlands, targeting Dutch participants with a migration background. The Netherlands has a diverse and multicultural society with first, second and third-generation citizens from all over the world. The survey was advertised with the purpose of sharing experiences about discrimination in Dutch healthcare. The participants were recruited via social media platforms (Twitter, Instagram, Facebook and LinkedIn), word-of-mouth advertisement, snowball sampling by asking participants to share the questionnaire with others and they were invited to complete the online survey. We applied convenience sampling for easy accessibility, time efficiency and cost-effectiveness.

Survey

To obtain insight into participants' experiences with healthcare discrimination, they were asked to fill out a survey, accessible from June until July 2022 via the website of STATERA (the funding institute of this study). This

Table 1 Survey questions

#	Question
1	What is your sex (M, F, X (other such as intersex))?
2	What is your age?
3	What is your ethnic background? (Options: Dutch, Moroccan, Turkish, Surinamese, Antillean, Afghan, Bosnian, Egyptian, Pakistani, Chinese, Syrian, mixed or other)
4	Have you or your relative ever experienced discrimination in a healthcare setting for example at the hospital, physical therapist or at your general practitioner? (yes/no)
5	Could you please elaborate on the experienced discrimination?

survey consisted of four closed-end questions assessing participants' demographics, one close-ended (yes/no) question assessing participants' experienced discrimination based in healthcare, and one open-ended question which prompted participants to elaborate on their perceptions of discrimination with no character limit (see [table 1](#)). By including the latter question, we aimed to capture written answers that may reveal participants' experiences and opinions. All survey questions were presented in Dutch.

Data analysis

Descriptive analysis

Descriptive statistics were employed to analyse the closed survey questions. Non-parametric tests were conducted to evaluate variations in experienced discrimination across diverse groups, both the Kruskal-Wallis test (for comparisons involving more than two groups) and the Mann-Whitney U test (for pairwise comparisons) were utilised. Odds Ratio (OR) was derived through cross-tabulation, indicating the likelihood of outcome differences two groups. When significant differences emerge among multiple groups, post-hoc analyses were conducted. Statistical significance was set at a 5% level (alpha value). All statistical analyses were performed using SPSS V.18 (IBM).

Thematic analysis

Participants' responses to the open-ended question were included for thematic analysis if they met the following criteria: (1) They answered all survey items by providing comprehensive answers; (2) had a migration background or a relative with a migration background, and reported that they or their relative experienced discrimination in healthcare (answered yes to question 4). Answers to the open-ended question 5 consisting of a single word, incomplete sentences or missing data were excluded for thematic analysis. The free-form answers from question 5 were thematically analysed in Excel. The answers were approached inductively using the six-step plan of Kiger and Varpio:³¹ (1) becoming

familiarised with the data; (2) generating initial codes; (3) searching for themes; (4) reviewing themes; (5) defining and naming themes and (6) producing the manuscript. The analysis was conducted by CZ and checked by AK. Both researchers have a migration background in Africa, lived experience and expertise with the effect of discrimination in health, healthcare and research, which played a role in identifying codes, themes and data interpretation. Any discrepancies were resolved through consensus.

The frequency of themes was calculated by counting how often a theme occurred in the survey. Several citations were selected for the results section to provide an example of the theme. Answers were analysed in Dutch and translated into English for this publication.

Ethics considerations

The study consisted of an online survey on a website which did not collect participants' data such as names, addresses, ID numbers or any traceable information leading to the participant. Since this was not a medical, scientific study in which persons were subjected to an intervention, the BETCHIE checklist of the Vrije Universiteit Amsterdam, indicated that this research did not raise ethical concerns and did not need further evaluation, under the Dutch Medical Research Involving Human Participants Act and, therefore, ethical clearance.

Patient and public involvement statement

None.

RESULTS

Study population

The survey was completed by 188 persons ($M_{age}=39.89$, $SD_{age}=10.2$), of whom 39.4% identified as Moroccan, 20.7% as Turkish, 20.2% as Dutch, 13.6% had other or mixed background and 5.9% were Surinamese. Most participants were female (67.6%), and 53.7% reported experiencing discrimination in healthcare based on their social identity (eg, ethnicity, religion and gender). We observed no significant difference in experienced discrimination among the different migration background groups (Kruskal-Wallis $H=11.17$, $df=12$, $p=0.51$). Among all survey respondents, women compared with men were 2.31 times more likely to report experiencing discrimination in healthcare (OR=2.31; 95% CI 1.23 to 4.37).

Eighty of the 188 participants' responses were eligible for the thematic analysis. The 108 answers that were excluded were due to not having experienced discrimination ($n=100$), reported discrimination outside the healthcare setting ($n=3$) or left question 5 blank ($n=5$). The sample for thematic analysis was, on average, 37.92 years ($SD_{age}=10.87$) old, and most were self-identified as women (71.6%).

Experienced discrimination within healthcare

Six themes arose from the thematic analysis of the written responses. The complete set of answers from the selected answers is reported in online supplemental file 1: included open-ended survey answers. Due to the intersectionality and interpretation of the data, multiple answers could be categorised under multiple themes, and overlap might have occurred.

Explicit discrimination

The theme 'explicit discrimination' covered answers that showed deliberate and easily recognisable discrimination. The responses in this theme showed that explicit discrimination towards patients from the healthcare worker was related to the access and use of healthcare services. Explicit discrimination was experienced (30/80, 37.5%) based on racialised, ethnic or non-Western background, being of Islamic faith, being a woman and language proficiency.

Cultural discrimination and misinformation. Incorrect information provision. Not being referred well. And in a rehabilitation centre, I was approached by the healthcare workers and patients in a racist way. *Female, Moroccan background.*

I was once refused at the general practitioner's office because of my family name. *Male, Moroccan background.*

Prejudice

The theme 'prejudice' covered preconceived opinions, attitudes or judgements from the healthcare worker towards the participant's background that were explicitly reported in the responses. The theme of prejudice overlapped with the third theme, 'not been taken seriously'. However, we considered it as an independent theme, recognising prejudice as a potential starting point of differential treatment. Participants (14/80, 17.5%) experienced prejudice in the form of assumptions and discriminatory judgements about a person's background, religion or skin tone. According to the participants, prejudice resulted in healthcare workers dismissing the patient's concerns, assuming that a patient did not want to receive care or that a health problem was due to the patient's ethnic background.

Vitamin D deficiency because apparently, I wear a headscarf and cover myself too much! This was explained over the phone. I don't even wear a headscarf! But that assumption was made. *Female, Moroccan background.*

Because I am dark, I was psychiatrised (covertly drugging me with medication) for the fact (to them, a delusion of mine) that I reported my mother (CENSORED) as a medical antecedent. *Male, Antillean background.*

Not been taken seriously

The 'not been taken seriously' theme encompassed instances where participants (45/80, 56.3%) experienced

or felt that their physical concerns or need for healthcare were disregarded or not given proper attention or consideration by the healthcare worker. They noted that care was refused or information on their health complaint was not provided. Some participants believed that they were not taken seriously because they wore an Islamic veil (hijab), had a dark skin tone or had a different native language. The reported consequences of not being taken seriously by healthcare workers were not receiving diagnoses, deterioration of the disease, continued living with complaints, and not receiving appropriate healthcare.

The doctor did not take my complaints seriously, and I kept pushing for almost three-quarters of a year. Eventually, a doctor said that Turkish women exaggerate and have psychosomatic problems. In other words: I should not complain. *Female, Turkish background.*

At the dermatologist (a Dutch woman), I said that I had bumps on my skin. I had indicated that they arose suddenly after contact with a family member who suffered from water warts. She indicated that the bumps were just like Morgan Freeman's and that they would stay that way forever (I have tinted skin myself). *Male, Surinamese background.*

Discriminatory behaviour

The theme 'discriminatory behaviour' was related to engagement with and interaction from healthcare workers to patients and included demonstrated negative behaviour, practices or conduct. Study participants (29/80, 36.2%) reported experiencing this behaviour from healthcare providers, attributing it to their ethnic background. Such behaviour presented in various forms, including demeaning, derogatory and racist actions, as well as a lack of engagement or disregard for the participants' perspectives, healthcare needs and dignity.

I was at the dental surgeon who walked in without greeting and introducing himself. After they (healthcare workers) decided that removing my wisdom teeth was unnecessary, they left without explanation or saying goodbye. After I reported this to the assistant and told her I found this behaviour unacceptable, she said, 'This is how it works with him (the doctor) if you do not have a Dutch family name'. *Female, Turkish background.*

I was forced to eat pork as part of my rehabilitation. *Female, Turkish background.*

Language barriers

The theme 'language barriers' included experienced discrimination or derogatory remarks related to language. In this case, the language barrier could be experienced as not having the capacity to understand, comprehend or converse in Dutch, or that the healthcare worker assumed that a person had a language barrier based on their background. The participants (17/80, 21.2%) reported not receiving complete information and treatment options

or not been given due consideration due to language barriers. Some participants stated that providers sometimes questioned their fluency in Dutch or assumed they spoke another language because they had a non-Dutch-sounding family surname or wore a hijab.

I was at the emergency care. A tumour or cloth behind my eyes was suspected. I could not see due to the pain in my head, and I could not lie down. I was left alone for hours without any supervision. I received care only when my sister arrived (who does not wear the hijab). The nurse spoke to my sister and responded to all her questions on my behalf. One of the questions she got about me was if I speak some Dutch. *Female, Moroccan background.*

In the hospital, they asked me if I came from 'Far-away-istan' or if I just lived in the Netherlands, which was a rather strange question, and if I spoke Dutch. Again, strange question and way of speaking/addressing, etc. Also, questions like 'do you speak Dutch?' and extra enunciating, etc. *Female, other background.*

Pain attribution to cultural background

The theme 'pain attribution to cultural background' encompassed how the healthcare professional related the patients' pain complaints to their background. Participants stated that healthcare workers believed that complaining and having pain were inextricably tied to the patient's ethnic background or culture. These participants (21/80, 26.2%) reported being told by healthcare providers that their complaints resulted from their cultural tendencies, which contributed to the perception that their pain was exaggerated. Persons with migration backgrounds were told not to exaggerate their complaints and that their pain was made up. Eating one's ethnic food was also seen as a reason for physical complaints. Moroccan and Turkish cuisine was reported to be perceived as greasy and unhealthy, and spicy food would lead to gastrointestinal complaints of the participants.

My wife had cancer and pain, and before we knew this, several doctors asked us if the pain was not made up. Also, they refused to scan her neck because she had cancer. We were told several times that people from the Caribbean often act dramatically. *Male, Dutch background.*

My problems were due to my Asian background (according to the doctor). *Male, Pakistani background.*

DISCUSSION

This study investigated the experiences of discrimination in healthcare of people with a migration background in the Netherlands using an online survey. Almost half of the participants reported experiencing discrimination, including racism, negative remarks about their background, not being taken seriously because of their background, negative attitudes from healthcare workers,

attribution of complaints to their culture and language barriers. The free-form answers showed that the discrimination was often intersectional, meaning multiple parts of a person's identity contributed and overlapped. For example, being a woman, wearing a hijab and having a particular ethnic background or skin colour frequently led to racist stereotyping. Some participants reported receiving poor healthcare, no healthcare at all or stated that their health problems deteriorated due to discrimination. The results from the survey were consistent with earlier published findings from focus groups and one-on-one, in-depth interviews in the Netherlands with patients with migration backgrounds^{26–28 32–34} facing discrimination on the same grounds as identified in this study. This consistency strengthens the findings of our study.

Language is often reported as a communication barrier in healthcare provision for the Dutch population with a migration background.^{26–29 34} However, our data revealed that even when patients spoke Dutch, some healthcare workers perceived language as an issue rather than the patients themselves. In some cases, healthcare workers assumed language deficiencies due to a person's last name or attire (eg, wearing a hijab), which led to an altered communication style that was sometimes perceived as condescending and disrespectful. Earlier research found that general practitioners would adapt their communication style, creating a barrier based on the patient's ethnic background, even without language barriers.³³ The reasons for this adaptation still need to be clarified. As reported in secondary data, language barriers were associated with inadequate healthcare for those who did not speak Dutch proficiently. This aligns with previous studies where healthcare workers described their communication or interactions with ethnic minorities as challenging, resulting in less frequent follow-ups and visits for these patients.^{23 35}

Xenophobia, racism and prejudice towards individuals with a migration background can explain the unjust care of patients who do not belong to the majority or native group of a country.^{8 35–38} Some of the survey participants reported that they received different healthcare than patients without a migration background. Several survey participants reported that their complaints should have been taken more seriously but due to their backgrounds they were not, resulting in missed opportunities care. This finding is supported by earlier studies reporting on ethnic Dutch patients receiving better care than Dutch patients with a migration background.^{32 33 39} Some papers report that healthcare workers confessed to ignoring patients with a migration background when they complained about pain because they believed it was part of their culture.^{35 36 39} This phenomenon is also known as 'the Mediterranean Syndrome'.^{40 41} It represents the myth that patients with a migration background complain because it is part of their culture.^{38 41} An earlier Dutch study provided examples of the Mediterranean Syndrome.³⁶ A female Afro-Caribbean patient missed her cancer diagnosis due to the physician assigning the physical

complaints to the patients background. A Moroccan male patient with kidney disease was removed from the transplantation list because his behaviour was mistaken for dementia without diagnosis.³⁶ Existing stereotyping and prejudice about persons with a migration background may be an underlying mechanism for this issue. Such attitudes and beliefs expressed by healthcare workers may result in inadequate care for patients of diverse backgrounds and highlight the importance of addressing cultural competence and sensitivity in healthcare settings.

An increase in Islamophobia in Western countries has extended to healthcare and affects patients from the Islamic faith seeking proper healthcare.^{42–48} Expressions of the Islamic faith, such as wearing the hijab, being a convert and having a husband with a long beard, were reported multiple times in the survey as factors for experiencing discrimination. Negative comments about a woman's hijab or prejudice about her being of Islamic faith led to negative care experiences for these women. Similar experiences have been found in two focus group studies with Turkish women in the Netherlands who felt doctors did not take them seriously because of their Islamic faith.^{26 33} Not unique to the Netherlands, comparable results of discrimination against patients of the Islamic faith by healthcare workers have been reported in the USA, the UK, Canada and France and associated with poor healthcare.^{44 45}

The differential treatment of Dutch patients with a migration background can be due to racism, discrimination, prejudice, implicit bias, lack of awareness of their behaviour or blind spots.^{12 35 39 49} Many healthcare workers are unaware of their discriminatory behaviour and prejudices, which are often unintentional. Here lie opportunities to educate healthcare workers on their unconscious beliefs and to improve their understanding of their behaviour.⁵⁰ However, it is unknown how much discrimination from a healthcare worker or healthcare setting contributes to health disparities and the deterioration of health outcomes. The challenge lies in measuring discrimination objectively and differentiating between implicit and explicit discrimination, but also in acknowledging the presence of discrimination.^{12 51} Discrimination or the blame for discriminatory acts are sensitive topics contrary to healthcare workers' medical ethics.¹² Addressing it may lead to tensions between the person who feels discriminated against and the person identified as the discriminator at the time. Therefore, more research is needed to explore and quantify the magnitude of healthcare and public health discrimination and tackle healthcare inequities.⁵¹ In addition, there is a need to safely address and combat discrimination in a way that is acceptable and received positively by all, including healthcare managers, educational institutes, and clinical practices.

Limitations

The current study has several limitations. The findings indicate that most of the participants are female and of Moroccan or Turkish background, which may limit our findings' generalisability. Although adequate measures, such as double-checking coding and discussing findings

and their interpretation, were taken to minimise subjectivity, the possibility of researcher biases cannot be completely ruled out. Since self-reported experiences are the primary data of interest, sampling bias may have occurred because only literate individuals who could complete an online survey participated. Language bias may have occurred because the survey was only in Dutch. The participants needed to answer in full sentences, which may have led to the exclusion of responses from participants with lower literacy rates or the capacity to express themselves fully. Another limitation occurred during the development of the themes, as some of the answers reflected intersectionality and were eligible to be categorised in more than one theme.

CONCLUSION

This study shows an extensive perspective of patients with a migrant background who have experienced discrimination in the Dutch healthcare setting. Qualitative data were collected through a survey with an open-ended question, allowing for in-depth insights into participants' lived experiences of discrimination. The findings can be summarised as followed. When Dutch patients with a migration background experienced discrimination in healthcare, it manifested in various forms, including overt forms of discrimination and racism, prejudice and not being taken seriously because of their ethnic background. The results showed that discrimination often occurred on the basis of multiple intersecting social identities, rather than one single social identity. People who experienced discrimination reported receiving lower-quality healthcare or being denied it altogether, which may have caused deterioration of their health. In closing, we emphasise that discriminating against individuals, whether implicit or explicit, in healthcare directly violates the human right to quality healthcare. Such discrimination sustains health inequities and poses a significant public health burden. Better health for all, strengthens society by making the population, social capital and economy more resilient.

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Contributors CZ is the acting guarantor of this study. CZ and GÇ designed the study. GÇ set up the survey and collected and extracted the data. CZ conducted the data analysis, which AK and ANK checked. AK and ANK were responsible for the sensitivity reading, the correct use of definitions and checked translations. All authors participated in data interpretation and implication. CZ wrote the first draft in cooperation. AK, ANK, WAdO and GÇ critically reviewed and revised the manuscript. All authors approved the manuscript for submission.

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Patient consent for publication Not applicable.

Ethics approval This study involves human participants. This study considers an anonymous online survey. Before the research, we performed a self-check from the Ethics Review Committee of the Faculty of Science (BETCHIE) from Vrije Universiteit Amsterdam, which indicates that it is not subject to the Dutch Medical Research

Act. The output has been updated as a separate file to this submission. Participants gave informed consent to participate in the study before taking part.

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