

Conscientious objection, professional duty and compromise: A response to Savulescu and Schuklenk

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Abstract

In a recent article in this journal, Savulescu and Schuklenk defend and extend their earlier arguments against a right to medical conscientious objection in response to criticisms raised by Cowley. I argue that while it would be preferable to be less accommodating of medical conscientious than many countries currently are, Savulescu and Schuklenk's argument that conscientious objection is 'simply unprofessional' is mistaken. The professional duties of doctors should be defined in relation to the interests of patients and society, and for reasons set out in this article, these may support limited accommodation of conscientious objection on condition that it does not impede access to services. Moreover, the fact that conscientious objection appears to involve unjustifiable compromise from the objector's point of view is not a reason for society not to offer that compromise. Arguing for robust enforcement of the no-impediment condition, rather than opposing conscientious objection in principle, may be a more effective way of addressing the harms resulting from an over-permissive conscientious objection policy.

KEYWORDS

complicity, compromise, conscientious objection, professional duty, professionalism

1 | INTRODUCTION

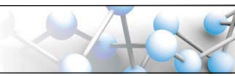
Savulescu and Schuklenk are proponents of what has been termed the 'incompatibility thesis' regarding conscientious objection in healthcare: the view that 'the professional duties of healthcare practitioners are not compatible with a request for conscientious objection' and that 'healthcare practitioners should always perform any legal, safe, and beneficial (from the patient's perspective) treatment that a patient may request'.¹ In a recent article in this journal, they defend and extend their earlier arguments for this view, focusing specifically on criticisms made by Cowley.²

¹Minerva, F. (2017). Conscientious objection, complicity in wrongdoing, and a not-so-moderate approach. *Cambridge Quarterly of Healthcare Ethics*, 26(1), 110. <https://doi.org/10.1017/S0963180116000682>. Minerva draws on an earlier formulation by Wicclair, according to which the incompatibility thesis maintains 'that it is contrary to the professional obligations of physicians, nurses, and pharmacists to refuse to provide any legal good or service within the scope of their professional competence. See Wicclair, M. R. (2011). *Conscientious objection in health care: An ethical analysis*. Cambridge: Cambridge University Press, xi. Retrieved from <http://ebooks.cambridge.org/ref/id/CBO9780511973727>.

²Savulescu, J., & Schuklenk, U. (2017). Doctors have no right to refuse medical assistance in dying, abortion or contraception. *Bioethics*, 31(3), 162–170. <https://doi.org/10.1111/bioe.12288>; Cowley, C. (2016). A defence of conscientious objection in medicine: A reply to Schuklenk and Savulescu. *Bioethics*, 30(5), 358–364. <https://doi.org/10.1111/bioe.12233>

In contrast with the incompatibility thesis, the 'compromise approach' holds that a conscientious refusal to provide a legal good or service within the scope of the practitioner's competence is compatible with her professional duty 'only if it does not present an excessive impediment to a patient's timely or convenient access to the good or service'.³ Clearly this covers a range of views, depending on what is taken to count an 'excessive' impediment. I start from a position of agreement with Savulescu and Schuklenk that in many cases conscientious objection does excessively impede access to services and that it would be preferable to be less accommodating of conscientious objection than many countries currently are. However, I will argue that there can be justified compromise between a society concerned with the interests of patients and conscientiously objecting doctors. Instead of rejecting conscientious objection as 'simply unprofessional' or morally inconsistent, as Savulescu and Schuklenk attempt to do, those who are concerned about the harmful effects that conscientious objection can have for patients should argue directly for policies that limit those harms. Such an approach can support strong restrictions on conscientious objection, but is consistent with accommodating it in some circumstances.

³Wicclair, *op. cit.* note 1, p. xi.



2 | THE 'LACK OF TRACTION' ARGUMENT

Cowley's criticism of Savulescu and Schuklenk begins by focusing not on the substance of their arguments against conscientious objection in healthcare but on their impact. Their arguments, he writes, 'have failed to move legislators or professional bodies'.⁴ Cowley thinks that this 'lack of traction' (as Savulescu and Schuklenk term it) calls for an explanation, and that without an explanation the arguments are somehow undermined.

Savulescu and Schuklenk offer two responses: first, that there is an explanation for the lack of traction, namely the influence of organized religion, and second, that in some countries with a strong secular tradition, such as Sweden and Finland, arguments against conscientious objection *do* seem to have traction as laws accommodating conscientious objection in healthcare have not been passed.⁵

Plausible as these responses are, they give the lack of traction argument more credence than it deserves. It is politically naïve to think that whether or not politicians are moved to act by an argument is a marker of its soundness. There are so many political and procedural reasons why legislators reject good arguments, or never even get to debate them, that their failure to act on any particular argument is no reason at all to judge that argument to be flawed. Thus, even if Cowley's claim about lack of traction were true, this would be no reason for critics of medical conscientious objection to abandon their position.

On the contrary, it is *because* legislators and professional bodies have not responded to their arguments that critics of conscientious objection have reason to continue developing and defending their arguments. Savulescu and Schuklenk, along with others, offer strong reasons for a more restrictive policy on conscientious objection than exists in many jurisdictions. However, it is the contention of this article that they overreach in arguing for a complete rejection of conscientious objection based on the supposed unprofessionalism and moral inconsistency of its practitioners. Arguments for restricting conscientious objection are more likely to be successful (or to have 'traction') if soundly based on premises shared by those whom they aim to convince. Thus, a position that allows in principle for compromise but insists on strict harm-based limitations may be more effective in limiting conscientious objection than one that attempts to rule it out altogether.

3 | THE PRAGMATIC ARGUMENT AND THE NO-IMPEDIMENT CONDITION

The first substantive argument presented by Cowley in support of accommodating conscientious objection is what he calls the 'pragmatic argument':

If the proportion of GPs who want to object is relatively small in a densely populated area, and if the objection concerns only a small proportion of their job, and if the

⁴Cowley, *op. cit.* note 2, p. 359.

⁵Savulescu and Schuklenk, *op. cit.* note 2, p. 162.

GP's objection is strong enough that she would leave the profession if it was not accommodated, then we might as well make a *small* accommodation in order to keep her on. . . Accommodating conscientious objection in this way would be akin to accommodating a GP with back pain by providing a special office chair at relatively low cost.⁶

Cowley considers this to be a 'weak' argument in the sense that it has limited scope: it will not apply to remote areas where it is not feasible for the patient to be seen by a different GP, and it may not apply to obstetrics, where abortion (the focus of most conscientious objection) is a larger part of the workload. Moreover—although Cowley does not say this—even in the multi-GP practices typical of densely populated areas, the impact on a patient of being transferred to another practitioner may be non-negligible⁷ and the cost to the health service of ameliorating this impact is likely to be much larger than the cost of buying a special office chair. It follows that even if the pragmatic argument is sound, it only justifies accommodations of conscientious objection under a very restrictive set of conditions.

For Cowley this is a problem because he wants to justify a much wider accommodation of conscientious objection. For example, Cowley thinks Canadian doctors should be allowed to refuse participation in the recently legalized practice of assisted dying despite Schuklenk's objection that the effect of such refusal on the availability of assisted dying in remote rural areas could be very significant and costly to ameliorate.⁸ However, from another perspective it is precisely this restricted scope that makes the argument plausible. It takes seriously what I have elsewhere called the no-impediment condition: the widely held (and in my view correct) view that conscientious objection should only be accommodated where it does not significantly impede access to medical services.⁹ With this condition made explicit, the pragmatic argument allows for strong restrictions to be placed upon conscientious objection to protect patients' interests, without ruling out the possibility that accommodation is justified in some cases.

4 | MONOPOLY AND PROFESSIONAL OBLIGATION

While Cowley wants a wider accommodation of conscientious objection than the pragmatic argument can support, Savulescu and Schuklenk want to reject it in principle. One of their arguments is based on the notion of professional obligation, and can be expressed as follows.

⁶Cowley, *op. cit.* note 2, p. 359.

⁷Hughes, J. A. (2017). Conscientious objection in healthcare: why tribunals might be the answer. *Journal of Medical Ethics*, 43(4), 215. <http://dx.doi.org/10.1136/medethics-2015-102970>; McLeod, C. (2010). Harm or mere inconvenience? Denying women emergency contraception. *Hypatia*, 25(1), 5. <https://doi.org/10.1111/j.1527-2001.2009.01082.x>

⁸Cowley, *op. cit.* note 2, p. 359, 364; Schuklenk, U. (2015). Conscientious objection in medicine: Private ideological convictions must not supercede public service obligations: Editorial. *Bioethics*, 29(5), ii–iii. <https://doi.org/10.1111/bioe.12167>

⁹Hughes, *op. cit.* note 7, p. 215.



1. When society makes a controversial practice legal it is because we judge it to be a social good. (Savulescu and Schuklenk use the example of oral contraception, but that should not affect the argument.)
2. When professionals have a monopoly over the provision of a social good they have an obligation to provide it.
3. Therefore: 'For GPs, obstetricians and pharmacists to refuse to provide the oral contraceptive pill is simply unprofessional.'¹⁰

Parts of this argument need clarification, and once the clarification is given it is not clear that it gives us reason to reject the kind of very limited accommodation of conscientious objection that the pragmatic argument supports.

It is not clear that in a liberal society something's being legal implies that it is judged to be a social good. Given the presumption of liberty, it could merely be that there is insufficient reason to prohibit it. Even if the legalization of X implies a belief by legislators that *the freedom to X* is a good thing, it might be that *the doing of it* is not, and that there is no reason for the state to act as a provider. We might, for example, interpret a state's decision to legalize prostitution or certain recreational drugs in this way.

The fact that healthcare practitioners have a monopoly over abortion and certain forms of contraception is a stronger reason for asserting that society judges the actual availability of these things to be a social good. We think it would be unsafe to allow just anyone to provide these services but rather than banning them we make an exception for professionals with appropriate training because we think people should be able to access these services.

However, it is still not clear how we get from here to the conclusion that a doctor seeking to be exempted from providing these services is 'unprofessional'. *Collectively*, the medical profession has a monopoly on a service that society considers ought to be available. We might say, therefore, that it has a collective obligation to provide that service. But it does not follow that every individual within the profession (or within the relevant specialties) has that obligation. They do not individually have that monopoly (not even locally, if the no-impediment condition is met). So, in these circumstances, objectors are not preventing anyone from accessing a social good.

A plausible view is that individual professional obligations have a contractual basis. Savulescu and Schuklenk suggest that a requirement to provide services such as contraception and abortion should be made clear in medical programmes and written into doctors' employment contracts, creating such an obligation.¹¹ However, this leaves two questions. First, as a matter of policy, should that contractual obligation always be enforced? And second, what exactly should the contract say?

Savulescu and Schuklenk assume that the contract should require the controversial services to be provided by every doctor. However, the underlying rationale is a consequentialist one, based on ensuring availability of services judged to be social goods, and this might equally support a contract that restricted conscientious objection to an

(admittedly narrow) range of cases where the objection is consistent with maintaining those services without excessive cost. Interpreted in this way the idea of professional obligation does not support the view that conscientious objection is always unethical, irrespective of its effects on service provision.

5 | COMPROMISE, COMPLICITY, AND THE OBJECTOR'S PERSPECTIVE

Savulescu and Schuklenk are rightly critical of an argument they describe a 'last resort' for supporters of conscientious objection. The argument is that objectors can withhold an intervention such as assisted suicide when they judge that it is 'not the most appropriate "treatment"'.¹² Savulescu and Schuklenk condemn the paternalism inherent in this argument, arguing that doctors have no right to withhold a legal treatment that is consistent with resource allocation criteria and in accordance with the stable wishes of a competent patient.¹³ It is surprising, then, that Savulescu and Schuklenk themselves put forward an argument that could be regarded as similarly paternalistic towards conscientiously objecting doctors.

Savulescu and Schuklenk argue that existing forms of provision for conscientious objection, which include an obligation to refer a patient to another practitioner who is willing to carry out the procedure to which they object, are not a viable compromise from the objector's point of view. Like the argument about professionalism, the point of this argument seems to be to show that conscientious objection is in itself morally unacceptable. As Schuklenk puts it:

Looked at from a conscientious objector's perspective, this compromise is anything but a compromise. If I object to abortion because I believe that abortion is akin to murder, as Christian objectors happen to believe, surely my moral responsibility is barely smaller if I knowingly pass a pregnant woman looking for an abortion on to a colleague who will commit the act rather than if I do it myself.¹⁴

Cowley's response fails to extricate the referring doctor from this complicity. He writes that in making a referral, the GP:

is not responsible for her colleague's free actions, she is merely describing a fact – a widely available fact, and hardly a secret – of what her colleague is willing and able to do.¹⁵

But if referral to a non-objecting colleague really were nothing more than telling the patient something they already know, then there would be no reason to impose a duty to refer on conscientiously objecting

¹²Cowley, *op. cit.* note 2, p. 363.

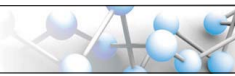
¹³Savulescu and Schuklenk, *op. cit.* note 2, p. 170.

¹⁴Schuklenk, *op. cit.* note 8, p. ii.

¹⁵Cowley, *op. cit.* note 2, p. 362.

¹⁰Savulescu and Schuklenk, *op. cit.* note 2, p. 163.

¹¹Ibid.



practitioners. In reality, the duty to refer is one of the means by which the no-impediment condition can be satisfied, and is necessary for this (though not sufficient) because patients will not always know which practitioners will provide the service that the objector refuses, or how to access them. In making a referral the doctor is, therefore, facilitating the act that they consider to be wrong.

Cowley is perhaps aware of the weakness of his argument, for he acknowledges that referral involves moral compromise, saying that the objector must 'accept the reality of a genuine moral pluralism, as well as her status as a minority in a reasonably democratic society'.¹⁶ For Savulescu and Schuklenk, this is not a defensible position:

If you believe that abortion constitutes the murder of a human person, a 'compromise' that would oblige you to pass the pregnant women on to a colleague who you know would be willing to commit the 'murder', evidently does not constitute a viable compromise.¹⁷

On the contrary, they claim, 'If [a] practice is evil, the individual should not be any part of it, even by being a member of that speciality or profession.'¹⁸ There are, however, three problems with this view.

First, it seems too strong. There is, as has just been indicated, a genuine issue about whether it is morally consistent for a doctor to refuse participation in abortion but refer patients to another doctor. But to insist that they must not be part of a profession or specialty in which a practice they consider morally objectionable occurs seems to take the requirement for 'clean hands' to excess. To take two of Savulescu and Schuklenk's own examples: Should a doctor in Ireland during the period when symphysiotomy was widely practiced have resigned from the profession rather than merely refusing to conduct the procedure? And did the nurse who refused to force-feed patients at Guantanamo fall short of her moral duty by not resigning from nursing and/or the navy?¹⁹

Second, Savulescu and Schuklenk are mistaken to say that conscientious objection only makes sense from the objector's point of view on the assumption of moral relativism. They write that current conscientious objection policies 'only succeed if we agree to ethical relativism', and that 'If abortion were not just something that an individual happens to disagree with but is objectively evil, then [the doctor] should do everything she can to stop her patient having an abortion.'²⁰ In fact, it is not necessary to be a moral relativist to question whether one is morally obliged to do everything in one's power to prevent wrongdoing by others. That belief depends on an acceptance of negative responsibility that is associated with consequentialist thinking. A deontological perspective can incorporate the idea of objective but agent-relative duties, according to which the doctor's (primary) responsibility is to refrain from doing evil herself rather than to prevent evil from happening. We may

believe that this is a mistaken view but it is one that the antiabortionist doctor might hold, and it is not the same as moral relativism.

Third, although much has been written about the degree of closeness to an action that a person can have before being morally complicit in it,²¹ this does not help Savulescu and Schuklenk's argument, because even if we judge that the conscientious objector's compromise is incoherent, this does not entail that it is wrong to accommodate it. Just as the doctor who conscientiously objects to assisted dying should not try to impose a value-based judgement about what is in the patient's best interests, so opponents of conscientious objection should not try to dictate what compromises should be acceptable to the objector's conscience. It is inherent in the nature of conscientious objection that, from society's point of view, a conscientious objector always has a false moral belief about some substantive aspect of medical practice. In making provision for conscientious objection, society is offering a compromise that has some advantage to patients and/or the wider society, and to the objecting individual. If the objector finds the compromise acceptable it should not matter to society whether this is consistent with their false belief, nor should it matter whether they hold further false beliefs about the nature and limits of moral responsibility.

6 | REASONS FOR COMPROMISE

I have argued that Savulescu and Schuklenk's professional obligation and complicity arguments fail to show that it is wrong in principle for the authorities to accommodate conscientious objections that satisfy the no-impediment condition. The view that this is at least permissible, even if there is no obligation for them to do so (and therefore no right to such accommodations) is consistent with the Swedish model cited by Savulescu and Schuklenk. Under this model, managers *can* accommodate doctors' requests, although they are not under a legal obligation to do so, and are constrained by an obligation to provide effective services and use resources efficiently.²² This means that, given a sympathetic employer, there might not be much difference in practice between the Swedish model and one that grants a right of conscientious objection subject to a strict no-impediment condition. However, the arguments presented in this section will suggest that accommodating CO is not merely morally permissible, but that there are plausible

²¹Recent examples include Minerva, *op. cit.* note 1; Oderberg, D. S. (2017). Further clarity on cooperation and morality. *Journal of Medical Ethics*, 43(4), 192–200. <https://doi.org/10.1136/medethics-2016-103476>; Cowley, C. (2017). Conscientious objection in healthcare and the duty to refer. *Journal of Medical Ethics*, 43(4), 207–212. <https://doi.org/10.1136/medethics-2016-103928>; Lepora, C., & Goodin, R. E. (2017). On complicity and compromise: A précis. *Journal of Medical Ethics*, 43(4), 269. <https://doi.org/10.1136/medethics-2015-103149>; Trigg, R. (2017). Conscientious objection and "effective referral". *Cambridge Quarterly of Healthcare Ethics*, 26(1), 32–43. <https://doi.org/10.1017/S0963180116000633>. I make no attempt to summarise this debate, because as I argue below, it is not relevant to the question of whether conscientious objections should be accommodated.

²²Munthe, C. (2017). Conscientious refusal in healthcare: The Swedish solution. *Journal of Medical Ethics*, 43(4), 257. <https://doi.org/10.1136/medethics-2016-103752>

¹⁶Ibid.

¹⁷Savulescu and Schuklenk, *op. cit.* note 2, p. 168.

¹⁸Ibid.

¹⁹Ibid: 162, 167.

²⁰Ibid: 168.



circumstances in which conscientious objections that satisfy the no-impediment condition *should* be accommodated.

The most obvious, if not the strongest, arguments in favour of accommodating conscientious objections are based on the interests of the objectors themselves. Often couched in terms of moral integrity, such arguments rely on the idea that it may be seriously harmful to an individual to be forced either to act against their conscience (resulting, according to some, in 'strong feelings of guilt, remorse, and shame, as well as a loss of self-respect'²³) or to leave their profession. Savulescu and Schuklenk argue that, as professionals, doctors should put their patients' interests ahead of their own.²⁴ This, however, is already accounted for if accommodations are limited to those that satisfy the no-impediment condition. However, the scope of the integrity argument is further limited by the fact that in many cases the choices faced by practitioners will not be as stark as the argument implies, since they will be able to find alternative employment commensurate with their skills and experience in a field where they will not be called upon to undertake the activity to which they object. The integrity argument will have more force in relation to the withdrawal of conscientious objection rights when an individual is already well-established in their career, since in this case the costs of changing career path are likely to be greater, and can less plausibly be said to result from voluntary choice. Outside of this specific circumstance (which Savulescu and Schuklenk concede may warrant special consideration²⁵) the force of the integrity argument is more limited but not altogether void. Despite the duty to put their patients first, the interests of practitioners do count for something, so where accommodations can be made without any comparable costs to the patient or wider society it may be wrong not to do so, even if the interests at stake are not significant enough to ground a legal right.

There are also reasons for accommodating conscientious objection that derive from the interests of patients or the wider public. These can be seen as extending the 'pragmatic argument' discussed earlier. The pragmatic argument asserts that accommodating conscientious objection may enable doctors who would otherwise leave to remain in the profession, but does not say why this matters. One answer offered by Cowley is that the characteristics that lead people to conscientious objection make them better doctors. But as Savulescu and Schuklenk argue, there is no reason to believe this, and indeed the religious convictions that often motivate conscientious objection can lead to deeply flawed practices, such as symphysiotomy and refusal to support the use of condoms to prevent the spread of HIV.²⁶

A more plausible reason to be concerned with keeping conscientious objectors in the profession concerns the number rather than the quality of doctors. We might have reason to make accommodations if the departure of conscientious objectors would result in a shortage of doctors, either generally or within a particular specialty. Savulescu and Schuklenk claim that there is an oversupply of capable people wanting

to become doctors.²⁷ However, it is not clear on what basis they make this claim, and even if it is true, an oversupply of qualified applicants does not guarantee sufficiency of qualified doctors in all specialties, given that it takes time to train, and that some specialties are more popular than others.²⁸ It is not certain whether allowing conscientious objection would make a significant difference to recruitment or retention, but these are matters for empirical enquiry, the results of which may vary over time, location, and specialty. Given this contingency, it is preferable to acknowledge that conscientious objection can in principle be accepted as a pragmatic compromise to protect patients' interests in the event that the supply of doctors becomes a problem, rather than rejecting it out of hand on the basis of an assumption that there is no shortage.

Finally, a different sort of pragmatic reason for accepting conscientious objection arises from the difficulty of achieving changes in law and professional practice of the kind that Savulescu and Schuklenk favour. The views of medical associations carry a lot of weight in legislative debates about reforms such as the legalization of assisted dying, and they often demand that if such laws are enacted they must be accompanied by guarantees about conscientious objection. Since legislators often defer to medical opinion, this is a major obstacle to reform. There is, therefore, a *prima facie* case for supporters of assisted dying to accept a conscientious objection clause, at least as a temporary compromise, in order to get such legislation passed. Even if the presence of a conscientious objection clause causes some obstacles for patients wishing to access assisted dying, this will presumably be better than there being no legal access at all. If Savulescu and Schuklenk's argument against conscientious objection is ultimately consequentialist, it is hard to see why this compromise should be opposed.²⁹

7 | CONCLUSION

I have argued against Savulescu and Schuklenk's view that society should not grant doctors any right to conscientious objection. Whether or not conscientious objection is 'unprofessional' depends on the professional duties society has reason to demand from its medical practitioners, and I have argued that there are plausible reasons for society to permit conscientious objections that satisfy the no-impediment

²⁷Ibid: 163, 164.

²⁸For context, falling numbers of medical school applications and shortages of doctors in specialties including general practice have recently been reported in the UK. See Price, C. (2015, November). Medical school applications decrease as 'negative publicity' takes toll. *Pulse Today*. Retrieved from <http://www.pulsetoday.co.uk/your-practice/practice-topics/education/medical-school-applications-decrease-as-negative-publicity-takes-toll/20030395>. fullarticle; Kaffash, J. (2016, June). GP vacancy rates at highest recorded with one in eight positions unfilled. *Pulse Today*. Retrieved from <http://www.pulsetoday.co.uk/your-practice/practice-topics/employment/gp-vacancy-rates-at-highest-recorded-with-one-in-eight-positions-unfilled/20031836>. article

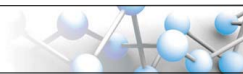
²⁹Munthe notes that 'the Swedish solution may impede reforms with regard to the introduction of contested practices, such as euthanasia or physician-assisted suicide', but while he views this as a reason for opponents of such practices to cease campaigning for the introduction of a right to conscientious objection, he does not apparently see it as a reason for supporters of such reforms to accept a conscience clause. See Munthe, *op. cit.* note 22, p. 258.

²³Cowley, *op. cit.* note 2, p. 360; Wicclair, *op. cit.* note 1, p. 26.

²⁴Savulescu and Schuklenk, *op. cit.* note 2, pp. 164, 169.

²⁵Ibid: 163.

²⁶Ibid: 164.



condition. The fact that this may involve a morally problematic compromise from the point of view of the objector is not a reason for society not to offer that compromise.

In practice, rigorous enforcement of a strict no-impediment condition within an approach that in principle allows for compromise would lead to a much more restrictive policy on conscientious objection than exists in many countries. More permissive interpretations of the no-impediment condition would only be justified where there is a net benefit for patients or society, for example, where it might realistically help to prevent a shortage of doctors or where a conscience clause might facilitate the passage of progressive legislation such as legislation on assisted dying.

The approach set out here does not assume moral relativism or a right of professionals to put their own interests before those of their clients, but is based on the interests of patients, doctors, and the wider society, with a particular focus on protecting patients' access to services. As such, it addresses the major concern of Savulescu and Schuklenk, and many other opponents of conscientious objection, about its impact on access to medical services. For those who are concerned about protecting access to services, arguing for a rigorous application of the no-impediment condition may be a more effective strategy than trying to oppose conscientious objection as a matter of principle.

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CONFLICT OF INTEREST

The author declares no conflict of interest.

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