Brazilian nurses' concept of religion, religiosity, and spirituality

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Brazilian nurses' concept of religion, religiosity, and spirituality: a qualitative descriptive study

ABSTRACT

Evidence points towards the impact of nurses' personal views and knowledge about religion, religiosity, and spirituality on healthcare. This qualitative research investigates nurses' concepts of religion, religiosity, and spirituality, and how they employ these concepts in practice. Thirty-four nurses were interviewed at a hospital in the state of São Paulo, Brazil. Content analysis was used to systematise the results. Three main themes generated from the interviews: 1. Religiosity/Spirituality as an Important Dimension in Life; 2. Notions of Religiosity and Spirituality; 3. Formal Knowledge of the Concept of Religion, Religiosity, and Spirituality. The results indicate that religion, religiosity, and spirituality should be incorporated into nurse training; in order to improve the comprehension and competence of nurses in these areas of practice. It is recommended that in order to ensure holistic and person centred care that there is constant reflection upon these concepts.

KEYWORDS: Spirituality; Religion; Nurses; Qualitative research.

1. INTRODUCTION

Religion, religiosity, and spirituality have been present in different cultures, being of particular interest to science in several fields, including health. In nursing, research around religion and spirituality has grown sharply in recent years (Cullen, 2016). Batstone, Bailey, and Hallett (2020) argued that nurses who provide spiritual

care act from a holistic standpoint, which develops from personal perspectives gained through spirituality, life experience and working in a clinical setting with palliative patients. This integrated holistic stance, when combined with advanced communication skills, shapes a relational way of caregiving that extends warmth, love and acceptance, thereby, enabling the patient's spiritual needs to surface and potentially be resolved.

Despite the subject being increasingly present in the scientific context, criticisms continue regarding the lack of definition and clarity around the concepts of religion, religiosity, spirituality, and the measuring instruments and implications for health-disease continuums (Reinert & Koenig, 2013). There is no consensus in the literature on the definition of religion, religiosity, spirituality (Koenig, 2012; Lavorato Neto et al., 2018); though some consensual definitions are found in literature. According to Koenig, King, and Carson (2012), religion involves beliefs and practices related to the sacred. Religion is practiced in the community or individually, but originates from a set of common traditions and is distinguishable from spirituality. Spirituality may or may not include a relationship with organised religion, but is defined individually.

According to Reinert and Koenig (2013), research in nursing can benefit from spirituality being considered as encompassing religious involvement, specifically intrinsic religiosity. Bjarnason (2007) clarifies that religiosity is part of religious affiliation and the activities stemming from it. Religiosity can be expressed in two different ways: extrinsic religiosity - which is part of public order (e.g. church attendance and Bible study); and intrinsic religiosity - which is personal, involving religious activities (e.g. scripture readings, prayers). Other reports in literature express simplified (although inaccurate) definitions suggesting that religiosity would be the experience of values and creeds related to religion (Tavares et al., 2018). McSherry and

Jamieson (2013) are more critical in determining how the terms are adopted in contemporary nursing literature. They state that the term spirituality has been little explored and discussed, often used uncritically, without analysing or exploring the real impact and implication for the nursing profession.

Given the complexity of these definitions, a more contemporary proposal is to use combined terminology, such as religion/spirituality (Peteet, 2017) or religiosity/spirituality (R/S) (Cunha & Scorsolini-Comin, 2019). Cunha and Scosolini-Comin (2019) justify that the use of the term R/S allows an understanding based on the subjectivity and experience of the individual/patient, in which one should not assume greater or lesser importance to religious or spiritual. Researchers using the combined term R/S do not disregard or neglect the importance of epistemological differentiation of the concepts, but they are often not specifically interested in the phenomena, rather in how people experience them and the possible impact upon healthcare. The use of the combined terms addresses the difficulties in accurately defining the two interlinked concepts. However, researchers may not be clear what measures are used to investigate the phenomena and may compromise the results and their comparisons between different investigations. Part of the problem is that people can consider themselves both religious and spiritual simultaneously (Koenig et al., 2012). In countries where a high prevalence of population belongs to a religion, as in the case of Brazil (Instituto Brasileiro de Geografia e Estatística [IBGE], 2010), adopting a single definition of the concepts may not encompass people's reality.

Associations, such as the World Psychiatric Association (Peteet, 2017), Brazilian Society of Cardiology (Précoma et al., 2019), and the International Council of Nursing (ICN) (ICN, 2012) recognise the importance of health professionals being able

to assess the R/S amongst patients. Moreover, they also recognise the role of health professionals in promoting an environment in which patients' values, customs and religious and/or spiritual beliefs are respected.

Literature highlights the importance of R/S for health, demonstrating the positive correlations between R/S and physical and mental health. Consequently, evidence suggests that R/S is related to health, well-being and concepts such as quality of life, positive care strategies and maintaining general health (Koenig, 2012). Despite the evidence of the positive impact R/S has on health, it is still difficult for nurses in clinical practice to meet and address the religious/spiritual needs of patients; potentially demonstrating that R/S is not given due consideration, in Brazil (Nascimento et al., 2016), or internationally (Cone & Giske, 2016). Additionally, the personal R/S based beliefs of health professionals can influence how R/S is comprehended and applied in clinical practice (Tavares et al., 2018).

Despite the positive association between R/S and health outcomes, there is a lack of research which addresses the impact of R/S on nursing practice. Therefore, this qualitative study focussed on Brazilian nurses in a general hospital to understand how the participants conceptualised religion, religiosity and spirituality and how they employed these concepts in practice.

2. METHODS

2.1. Design

In this qualitative and descriptive study, the main objective was to investigate how Brazilian nurses conceptualise the terms religiosity and spirituality and how they use them in practice. In this study, we followed the international protocol COREQ -

Consolidated Criteria for Reporting Qualitative Research (Tong, Sainsbury, & Craig, 2007).

2.2. Participants

We recruited 34 nurses from a large public hospital to participate in the research. The hospital is located in the countryside of the State of São Paulo and the data was collected between February 2019 and August 2019. The hospital serves a region with 34 municipalities and more than 1,700,000 inhabitants. Initially, the sample was selected through a nurse at the institution who acted as a gatekeeper. Thereafter, a snowballing technique was used and the nurses interviewed indicated other nurses who were willing to participate in the research until saturation was reached (Naderifar, Goli, & Ghaljaie, 2017); defined as when repetitions were found in the responses of different participants (Fontanella et al., 2011).

2.3. Data collection

Data collection took place in a single meeting, through semi-structured interviews with open-ended questions. This method covered all the research questions, but also enabled new questions based on the participants' answers where necessary. Using semi-structured interviews allows the researcher to provide an opportunity for the participant to freely express their opinions, experiences and emotions whilst capturing an in-depth account. The interviews were guided by a script specifically designed for the study. The questions covered socioeconomic characteristics, the importance of R/S in people's lives, including the lives of health professionals, training issues, professional performance and their daily R/S experiences.

Consent for interviews was taken from the head of nursing for each of the nurse′s sectors with recruitment taking place from both day and night shifts. Although the participants were approached during work time, the interviews were carried out at a convenient time when the nurses were not busy. As a component of the consent, nurses were given the freedom to withdraw at any time. The interviews were conducted in a quiet and private area of the hospital, away from patients. All agreeing participants were only interviewed once they had read and agreed to the Free and Informed Consent Term, which were audio-recorded and transcribed in full. The average time of the interviews was 23 minutes.

2.4. Ethical Considerations

The research followed the ethical guidelines involving human beings, proposed by the National Health Council of Brazil, Resolution No. 466, of December 12, 2012. The aims of the study, confidentiality and anonymity, as well as the risks and benefits were explained to the participants. Consent was obtained from participants in writing prior to recording of the interview. The research was submitted and approved by the Research Ethics Committee (CEP) of the University of São Paulo at Ribeirão Preto College of Nursing under protocol number 3.026.622, as well as by the CEP of the co-participant institution, the Hospital in question (protocol number 3,027,861).

2.5. Data analysis

The individual interviews were allocated codes and the codes were clustered into categories. Content analysis was used which is a form of qualitative analysis that seeks to emphasise the differences and similarities between the codes that make up the categories (Graneheim & Lundman, 2004; Bardin, 2011). Three phases were employed: pre-analysis, material exploration and treatment, and interpretation of results.

The first step involved transcribing and organising the material from which ideas were organised into codes. The next step involved recording points of similarity and differences between the participants' statements, allowing the development of the shared and non-shared views. After this step, the categories which addressed the goals of the research were identified and presented. Interpretation of the data was based on literature that covers R/S′s interface with health within nursing studies. To ensure confidentiality and anonymity, the participants were identified using the letter (P), followed by numbers from 1 to 34. The answers were organised into three thematic categories and produced *a posteriori* from the respondents′ statements: 1. R/S as an Important Dimension in Life; 2. Notions of Religiosity and Spirituality; 3. Formal Knowledge of the Concept of Religion, Religiosity, and Spirituality.

2.6. Rigor and Trustworthiness

Certain criteria were followed to ensure the credibility and reliability of the data. First, data collection was performed by a researcher who was familiar with the research area and qualitative research, as well as experienced in interviewing health professionals. Second, special care was taken to approach the participants at a time when they felt comfortable and available to reflect and respond to the research interview. Third, the interviews were audio-recorded with the consent of the participants

and transcribed into Brazilian Portuguese and then the article was translated into English. Two British academics proofread the translation and then the article was reassessed by all researchers involved. Fourth, the research team was composed of professionals from Psychology, Nursing and Medicine, guaranteeing a multi-professional perspective. Having professionals from different backgrounds was advantageous in the content analysis and the subsequent discussion, reflecting the complexity of R/S in healthcare. Such processes demonstrate credibility and dependability and thus the trustworthiness in qualitative studies (Graneheim & Lundman, 2004).

3. RESULTS

Table 1 presents the characteristics of gender, religion or belief and areas of clinical practice.

[Insert Table 1]

3. 1. R/S as an important dimension in life

The categories generated by the analysis highlight that R/S is manifested as an important dimension both in the lives of patients and in the lives of nurses themselves. For a better representation of the data, the categories were subdivided into two subcategories: R/S as an important dimension in the lives of patients and R/S as an important dimension for nurses.

3.1.1. R/S as an important dimension in the lives of patients

For all 34 interviewed nurses, the R/S was manifested and considered as an important dimension in the lives of people (including the nurses' patients). It can be understood as an essential component to life, a basic condition that guides life, which has been present since birth. Illustrated by:

> […] I believe that no matter how much that person says "Oh, I'm an atheist, I don't have a religion.", there has to be something that guides it, that believes, a greater force, something to believe to be guided, otherwise life becomes too empty. I think that one complements the other, the person who has no religiosity, who has no religion, but she has her spirituality, something she has to believe so that she can walk her way. (P5)

> [...] I think that religiosity, spirituality is always present, since we were born, through the examples we have at home, through virtues, [...] religion brings a lot of experiences of virtues in a religious way, I think this is very present in society. I think that way it is very present and very intense in people's lives. (P21)

R/S can also be understood as an important resource in the face of difficulty, a means of faith, motivation, and support that leads to positive ways of looking at life, even in adverse conditions, such as illness. A point illustrated by:

> Because I understand that when you are closer to God, to religion, your goals seem to be achieved. When you have your faith, your goals seem to have a meaning and that meaning gives value to life, which seems to be working out. When you are further away from God, it seems that things are going wrong. (P9)

I think that faith motivates. When you lose faith, you don't believe much, [...] And I think that having faith helps in overcoming. (P26)

I think we get attached to that, having faith, we have hope, especially in health care, with the sick one, he can lead a life, he has something to believe in. (P34)

3.1.2. R/S as an important dimension for nurses

Similarly, for all 34 nurses, R/S was an important dimension in their own lives, a dimension recognised for giving strength, bringing meaning to life, helping them to evolve and deal with difficulties, omnipresent as part of life. This subcategory is not drastically different from those above and is illustrated by quotes such as:

As a person, I evolved a lot because of religion, of religiosity, believing in a High Power, because I think this High Power helped me a lot. (P3)

[...] it is something that has not much to explain, but it is what I told you, it is the meaning of our life, we need this to move on, right? We are not just made of what is palpable. (P6)

[...] when we have faith, we can stand up, because everyone has difficulties, goes through a struggle and has to have faith that it will get better. I believe in that. (P26)

3. 2. Notions of religiosity and spirituality

The participants presented two differing notions of religiosity and spirituality. The first differentiates the phenomena and understands religiosity and spirituality as distinct (differentiated notion of the concepts of religiosity and spirituality). The other answer did not differentiate the phenomena, believing that religiosity and spirituality to

be the same thing (undifferentiated notion of the concepts of religiosity and spirituality). Only one participant was unable to say what religion and/or spirituality were for them. The subthemes are presented below and illustrated with quotes from the interviews.

3. 2. 1. Differentiated notion of religiosity and spirituality

For eight participants, religiosity and spirituality were different phenomena, but they can be related. However, religiosity is linked to religion and its practice and conduct, whilst spirituality is the essentiality of being, which can exist independently of religion and religiosity. A point illustrated by:

> Religiosity has to do with religion and I think that religion is nothing more than a brake on the human being, that you believe in something, that something is good and that makes you reflect on what is right and what is wrong. Spirituality is the evolution that you have about it, in being a better person, right? (P3)
>
> I think that spirituality every human being has must have to feel complete, to be able to be helping other people too. I think spirituality is a full concept that everyone must have, no matter what kind of religiosity they have. Religiosity would be the same as religions, which would be separate. I think like this. (P27)

3. 2. 2. Undifferentiated notion of religiosity and spirituality

The other 25 participants did not seem to have a distinction between religiosity and spirituality. They often linked R/S to religion, both referring to a connection with something greater, a deity, with having faith and believing in something positive. For these participants, the differentiation between these concepts is not relevant to their lives or professional practice. Instead, they prioritised the connection they can establish

with a dimension they consider superior, regardless of the plan that this superior being may have. A point illustrated by:

> Today I see that religion, spirituality, the person who seeks God, they live happier. I started to observe the patients who seek God, they face health problems differently. (P4)
>
> I think that religiosity and spirituality are what you believe in, what moves you. I see that it´s a way for you to see life, death, birth, illness, right? So, I see it this way, I understand religiosity and spirituality like the way you see what happens in life, both good and bad. (P20)

3. 3. Formal knowledge of religion, religiosity, and spirituality

The majority of participants did not have any formal or scientific knowledge to differentiate the terms religion, religiosity and spirituality. We were able to identify this when six participants reported that they did not know if there was a difference between the terms, for example, "*No, theoretically I can't tell you*." (S31). Three participants reported that they never thought about it, "*I never stopped to think about it*." (S8). Three participants believed that they were the same or complemented each other, "*Look, at me, it's all the same*" (S17). Nine participants imagined there are different concepts, but they do not know the difference, "*I know there is a difference, but I will not be able to explain to you what each one is*." (S23). The other participants (n=13), although they were not always sure, sought to differentiate conceptualisations from their points of view and is illustrated by:

> I don´t know the theoretical difference, in my view, the religion we have Catholic, Protestant, Umbanda, right? And spirituality is something more

internalized within you, sometimes you have no religion, but you have something in the soul, the spirituality. Now religiosity, I don't know how to tell you. (P5)

I believe there is a difference. Religiosity is this belief that a higher thing exists. Spirituality, I think, is even more like religiosity. But religion itself is the rule, the methodical thing of following what each religion asks. For me, there is this difference, but I never saw the concepts. (P24)

I think that religion is the choice of a religion in itself. Religiosity is you... wow, that is difficult! Perhaps I believe that there is a greater being, but this is more spiritual... I do not know how to define religiosity. I think that, maybe, the religion you choose, religiosity you follow the commandment and spirituality is a greater being that fills our soul. I don't know, I may be wrong. (P30)

4. Discussion

All participants considered R/S to be an important dimension in the lives of patients and their own lives, which, according to the literature, can be influenced by the characteristics of the professionals themselves. In this case, all nurses expressed some religious/spiritual beliefs. Most of the participants described themselves as belonging to a specific religion; others had faith but did not follow a particular religion, considering their spirituality. The literature suggests that professionals who have R/S may find it easier to consider it important in the lives of others and be more willing to approach it (Longuiniere, Yarid, & Silva, 2017; Cunha & Scorsolini-Comin, 2019).

Ross et al. (2016) highlighted that nursing students who report a high level of R/S feel more competent in exercising religious/spiritual care. What is not clear is

whether the particular religious/spiritual orientation itself is an attribute that guarantees this or if the impact of teaching R/S can promote an increment in this perceived competence and broaden the perception of students who are less, or not, religious/spiritual. It is not possible to confirm if there is a direct relationship, although this was not an objective of the qualitative study. However, the participants expressed religious/spiritual beliefs and consider R/S important in people's lives and their lives; indicating that potentially further research needs to be done investigating whether or not personal experience about R/S needs to be present in nursing practice.

That the participants perceived R/S as important in their lives, and in their patients', reflects the positive dimensions of R/S; where it is manifested as a foundation, guiding and beneficial, and giving meaning to life. Literature confirms that R/S can influence the way an individual experiences life, not only shaped by practices dictated by religions but because it confers existential meanings that permeate these practices. Furthermore, a religious/spiritual attitude constitutes a powerful element to deal with life′s adversities, including illness (Oliveira & Menezes, 2018). Other studies are in agreement with this and indicate that the presence of R/S has a positive impact on health outcomes (Koenig, 2012; Mishra et al., 2017), which was also recognized by the participants.

Furthermore, the religious/spiritual beliefs of the participants conform to the characteristics of the colonisation of Brazil, predominantly Catholic, Evangelical, and Spiritualist religions (IBGE, 2010). Simultaneously, participants who identify themselves as Catholic with an affinity for Spiritualism, or Eclectics, do not have a religious denomination. However, they do manifest spirituality through faith signalling the effects of globalisation on developing new trends in religion and spirituality.

According to Jungblut (2014), globalisation has produced a deinstitutionalised religion/religiosity, with individuals becoming more focused on their own experience and responsible for managing and elaborating their preferences. Although this movement is becoming more common, it is important to consider how R/S cuts across Brazilian culture and how professional training can contribute to reflection upon the personal characteristics, ethical issues and quality of healthcare.

Paloutzian (2017) claimed that this movement also contributed to a notion of spirituality, unrelated to religion/religiosity, becoming of interest to the individual and researchers. According to the author, this is a recent movement compared to the phenomenon of religion/religiosity in humanity and is one of the reasons why the concept of spirituality is the most difficult to agree upon amongst researchers. Nevertheless, spirituality is also most common because it encompasses a condition present in everyone, religious or not. Some respondents in our study seemed to follow this notion, separate from the concepts of spirituality in religiosity.

According to Curcio and Moreira-Almeida (2019), the same differentiated and undifferentiated notions concerning religiosity and spirituality were found in a sample of Brazilian patients who underwent hospitalisation. For the authors, the participants also tended to understand religiosity and spirituality as the same thing, without differentiation. This points to the importance that the combined term (R/S) can fill a gap, signaling the possibility of including the overlap and complexity between the phenomena (Mishra et al., 2017).

Although spirituality is relatively a new way of understanding human existence, the criticism in literature is about the extent to which both religion/religiosity and spirituality are complex and multidimensional phenomena. These phenomena are

related to cognitive, affective and emotional aspects that are present in the course of life and inherent to socio-psychological issues that influence health outcomes (Hill et al., 2000; Précoma et al., 2019). In Brazilian nurses' training, the participants reported that they had no knowledge which would help in making a distinction between the phenomena. Some participants had never thought about it.

Those participants who offered a definition were confused; it was clear from their interviews that there was difficulty in making the distinction, showing the complexity that exists between the concepts. Curcio and Moreira-Almeida (2019) also reported similar findings. The authors interviewed patients who also expressed doubt, confusion and insecurity when defining these phenomena. Nascimento et al. (2013) also report the same difficulty; highlighting that there are no certainties about the definitions and there are similarities and approximations between the concepts. For McSherry and Jamieson (2013) only the definition of spirituality would be diverse, complex and multifaceted by itself.

From a clinical point of view, undifferentiation between the phenomena is possible and perhaps, even welcome (Koenig et al., 2012). The participants who were aware of the potential benefits of R/S were also keen to investigate how their patients make positive and/or negative use of R/S. A point demonstrated by patients having better clinical outcomes when offered opportunities to express R/S preferences (Précoma et al., 2019). Both the differentiation and the undifferentiation of the phenomena have implications. However, the emphasis is on their application in healthcare. These concepts should not be interpreted as one-dimensional, because in practice, as evidenced by the participants, there are different ways to understand or think about these phenomena.

To understand how the concepts of religiosity and spirituality permeate nurses' beliefs, will be better evidenced in an alternative academic discussion. For the term ‘spirituality’ there are several pieces of literature where spirituality is disconnected from religion/religiosity. We suggest that this principle should be evaluated in the Brazilian context as well as in other countrieswith high prevalence of religion/religiosity. Whilst we concur that spiritual care would be complex, nonetheless support from a spiritual point of view should be offered in healthcare. The patient’s definitions would be required possibly involving religion/religiosity. However, health professionals should consider that their own R/S beliefs can influence the impact on patients but can also facilitate the understanding of R/S especially if it is different from their own beliefs.

Although there is recognition of the importance of R/S as a dynamic dimension, it also has an important role in humanity. Literature claims that nurses continue to have difficulties in addressing issues related to R/S (Cone & Giske, 2016; Nascimento et al., 2016; Tavares et al., 2018). There are difficulties in understanding which concepts require discussing although we have addressed the layers of complexity which have been thematically presented here to highlight the problems about the presence and/or absence of religious/spiritual care in healthcare.

In Brazil, religious/spiritual aspects in healthcare are still strongly regarded as taboo; which in turn affects nursing practice because the role of nurses reveals that they can be an asset to promote religious/spiritual care. However, the difficulty lies in how to achieve this whether that be through fear of offending ethical positions, or being seen as unprofessional (Nascimento et al., 2016). Furthermore, there may be intolerances towards patients' decisions that are contrary to the biomedical or scientific model,

especially as it would be deemed non-conventional in the Brazilian context (Azambuja & Garrafa, 2010).

The discussion of the subject in undergraduate and continuous education in Brazilian nursing is important to ensure healthcare practice considers R/S views of the patients, promoting inclusivity. It would also guarantee support to understand that the religious/spiritual experience needs to be open to diversity. The attention and promotion of religious/spiritual care within the healthcare system should not be based on the healthcare professionals' knowledge of R/S. Nevertheless, it should provide comprehensive care with a respectful view to the various manifestations of R/S.

4.1. Limitations of the study

The region where the hospital is located reflects the characteristics of the population and local traditions. Brazil is a very extensive country with very different cultural regions, so that in other locations the influence of R/S may be more or less present. The fact that data collection took place in the workplace could be a source of bias, since the participants may have felt uncomfortable, which could have potentially inhibited their responses.

5. Conclusion and future recommendations

The present study contributes to the research on R/S and healthcare. It provides a voice to Brazilian nurses in practice allowing an understanding of the interaction between research and teaching. It provides evidence for nurses to improve the quality of healthcare. Additionally, it provides evidence and new opportunities for further

research, as well as highlighting the gaps in nurses' training, especially with a view to R/S.

We suggest and challenge that R/S should be considered as an aspect of Brazilian healthcare and to be offered as a component to nursing care. R/S should be included in nurse training as an element that supports the concept of multidimensional health, contributing to the greater engagement of nurses in this discussion. In doing so, it will further qualify their position and allow for the integration of R/S into healthcare. The care must go beyond the formal knowledge associated with the concepts but begin from the recognition, opening space to reflect on the subject. In countries with high levels of R/S, these actions may be more welcome, with greater use in healthcare. R/S can be seen as a resource and strategy, which may even show a reduction in hospital costs.

Further research is a requirement not just in nursing but with other health professionals; allowing for a multidisciplinary view on the subject. It is also suggested that among the participants in the present study, a more detailed analysis is required in areas of practice within Brazil's hospitals. Such a study would investigate the extent to which expressed notions of religion, religiosity and spirituality may be linked to greater or lesser daily exposure to different aspects of healthcare. Research is required which explores the relationships between the characteristics of health professionals and the frequency of religious/spiritual engagement. How personal religious/spiritual beliefs affect nurses' understanding and use of R/S in their practice, which in turn will benefit the understanding of how R/S impacts healthcare in Brazil.

For the participants, R/S was an important dimension in their lives and the lives of their patients, confirming the need for attention and the repercussion of knowledge

and professional practices. R/S should be encouraged in training, expanding the understanding of holistic health outcomes. The lack of knowledge and doubts about the distinctions of concepts show how much the subject of R/S needs to be discussed in professional training, whether in academic, research or clinical practice.

AUTHOR CONTRIBUTIONS

Study design: VFC, SCP, SZ, CW, FSC

Data collection: VFC

Data analysis: VFC, SCP, FSC

Manuscript writing: VFC, SCP, SZ, CW, FSC

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CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

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