ORIGINAL RESEARCH

Why Some Dentists Still Smoke ? A Qualitative Study

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ABSTRACT

Aims: This study aimed to assess dentists who were smokers in terms of their reasons to initiate smoking, barriers to quit, perception as a smoker, attitudes towards tobacco cessation counseling, nicotine replacement therapy and tobacco control policies. **Methods:** Current Smokers were recruited from the dental community comprising of 10 in each, undergraduate and postgraduate categories respectively. In-depth interviews and four focus group discussions were held. These were recorded and various themes were generated depending on the responses. Manual method was used for transcribing the data, and recurrent themes were identified. **Results:** The initiation of the habit was between 16-18 years for all the participants. The main reasons to continue smoking were due to peer influence, and smoking was perceived as a stress buster. The undergraduates were in moderate dependence and low motivation state, while the postgraduates in low dependence and high motivation. The knowledge regarding the ill effects, tobacco cessation counseling and methods to use nicotine replacement therapy also seemed to be inadequate. Participants also felt they did not require any professional help to quit smoking. Enforcement of tobacco control laws in the institutions and information regarding the various laws was also lacking. **Conclusion:** Dental professionals play a significant role in identifying smokers, earlier than other healthcare professionals. Initiation of the habit from school level needs attention. The negligible attitude towards the habit requires emphasis of the hazards, at health and economical level during the dental course period. The personal behavior change along with tobacco cessation counseling is required to help dentists to play as role models for the community.

KEYWORDS: Dental Professionals, Dentists, Smoking, Qualitative Study

INTRODUCTION

Tobacco control is a multi-sectoral issue which needs the active collaboration of various professions, departments/ ministries of the government, civil societies and nongovernmental organizations. Health professionals play a pivotal role in tobacco cessation and motivating people not to initiate or withdraw the consumption of tobacco.[1] The impact of smoking on oral health are well established. It is also estimated that more than 50% of all smokers visit a dentist every year; which provides an opportunity to inform them about the risks of smoking and what benefits smoking cessation has on health. Thus, it becomes an integral part of dental profession to provide a structured approach to initiate smoking cessation, manage withdrawal symptoms, and provide long-term support. [2]

Although the literature has emphasized the role of dental professionals in tobacco cessation,[3] nevertheless tobacco consumption amongst this population has also been reported. The Global Health Professions Student Survey-India,2005 among dentists data showed that 21.7% use cigarettes (males -33.4% and females – 5.7%) and 8.6% use any other form of tobacco products (males 12.3% and females 3.6%).[4] In this regard, it is difficult for doctors to advise patients not use or quit tobacco if they themselves are tobacco users.

There has been much research concerned with quantitative assessments of knowledge, attitudes, and prevalence of tobacco- related habits among dental professionals; little attention has been given to their actual beliefs and perceptions regarding the habit which brings in the need for qualitative assessment among dental professionals.[5]

With this background, this study was contemplated to explore the evaluative beliefs and perceptions about smoking, barriers towards quitting, attitudes towards nicotine replacement therapy and tobacco control policies among dental professionals

METHODOLOGY

Study design: In-depth interviews and focus group discussions were conducted with smokers among dental professionals.

***Study participants and recruitment*:** This study was conducted among undergraduate (UG) and postgraduate (PG) dental professionals in Chennai city. A purposive

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approach was used to recruit the sample of smokers aged over 17 years who were not currently engaged in quit attempts. The candidates had varying levels of motivation to quit in the future. The snowballing sampling method was used, and the interested participants were interviewed about their opinions regarding smoking behavior. This was carried out until new responses or new ideas were generated. This theoretical data saturation was reached after assessing 20 participants. Therefore a total of 20 participants were recruited by this process which included 10 undergraduate and 10 postgraduate students. This study was carried out between January to march, 2016. Informed consent was obtained from the participants, and anonymity and confidentiality were assured. Ethical approval was obtained by the Institutional Review board of Ragas Dental College and Hospital, Chennai.

***Study instruments*:** A baseline data on tobacco consumption, details on previous quit attempts and their dependence level were assessed using Global Adult Tobacco Survey,2011 questionnaire, which has been validated by numerous earlier studies.[6] questionnaire. Further participants were screened using the validated Readiness to Quit Ladder[7]; a scale of items 1-10. The study participants were classified as having low motivation to quit with a score of below 6, and as high motivation to quit with a score of 6 and above. Cigarette dependence was assessed using the Fagerstrom Test for Nicotine Dependence scale[8] (FTNDS) and the participants were classified into three categories as having low, moderate and high level of dependence. With the initial analysis of in-depth interviews, a focus group discussion guide was prepared.

***Procedure*:** The study included an initial in-depth interview of each of the participants followed by focus group discussions. An interview guide was formulated so that we could probe into various aspects of smoking behavior. Both the focus group discussion and in-depth interview were conducted by a moderator along with an assistant. The recordings were done using an audio and video tape recorder. In depth- interviews were conducted for all the 20 participants which lasted for about 30 – 45 minutes each. In this study about four focus group discussions were held, two for each category which lasted for about 1 hour.

The areas of discussion included reasons to start smoking and to continue, their perception as smokers, attitude towards non-smokers and their knowledge regarding health effects of smoking. Further probing was done to obtain details regarding their quit attempts and their perception regarding the anti- health warnings on TV, newspaper, or the cigarettes packets. The last part of the discussion included their knowledge and attitude towards Nicotine replacement therapy (NRT) and tobacco control policies in the country.

Data Analysis: Data analysis was done in accordance with thematic framework analysis to allow themes to be generated from the data collected. The audio recordings were transcribed to their verbatim format. The recordings were read and familiarised multiple times to generate themes. The focus group guide helped to sort the emerging keys points and the new themes to be segregated according to the responses. Initial analysis was undertaken manually, and the responses from each participant were identified and charted under the respective key points. Finally, interpretative analysis was done to group together similar points and to identify recurrent themes which enabled the various aspects of smoking behavior among the participants of the two groups.

RESULTS

Among the 10 undergraduate students 7 were classified as low motivation and 3 as high motivation. The postgraduate students were classified under 4 low and 6 high motivation levels. According to the dependence level among the undergraduates, 4 fell in the low category and 6 in the moderate category and among the postgraduates 10 in low category during initial screening (Table 1, Table 2).

S.No	Total	Low dependence	Moderate dependence	High dependence
Undergraduate students	10	4	6	-
Post graduate students	10	10	-	-

Table 1: Dependence level status of the study participants

S.No	Total	Low motivation	High motivation
Undergraduate students	10	7	3
Post graduate students	10	4	6

Table 2: Motivation level status of the study participants

The responses generated after the focus group discussion were segregated and in accordance with them, the following themes were produced.

Reasons for start of smoking: The age of initiation was reported to be around 16- 17 years. The main reasons to have started smoking were due to the influence of peer groups and friends, while a few felt it created a high esteem among their juniors. One of the participants reported that he just wanted to know how it felt while smoking which made him initiate smoking:

"I just wanted to know the pleasure of smoking as I used to see my friends smoke a packet or 2-5 cigarettes a day. So I wanted to know what made them do so."(PG)

"During my school days most of my friends perceived smoking as a high image, seeing which I felt like smoking which made me feel like a hero too in front my juniors." (PG)

The other main reasons to have initiated smoking were because of staying away from home such as at hostel or along with friends who smoked and when parents themselves were a smoker. One candidate from the undergraduate level explained that he initiated smoking as he was asked to buy cigarettes for his father. This gave

him an urge to start smoking and as the availability was easy it become a habit.

"My dad was a smoker and he used to send me to the shop to buy cigarette which developed a curiosity in my mind to try smoking, so I picked up the habit because it was easily available for me and it also made me feel good to have a smoke whenever my dad used to shout at me." (UG)

"When I was at home I never smoked, while my parents were out of town for a month, I stayed with my friends. It was during this stay I started smoking which continued as I stayed at my college hostel for my higher studies."(UG)

Reasons to continue smoking: All the participants considered smoking as a stress reliever and as a major pass time with friends. They also stated that they could divert their mind from what was troubling them which provided them some relief for some time.

"After I had my first smoke I felt a vague pleasure and thought this is why people tend to smoke. It gave me a hallucinating effect, and I tasted the pleasure which is why I continued to smoke."(PG)

Most of the participants quoted that they liked to smoke when in groups and they cannot avoid when called for smoke. As they stayed most of the time either at the college or at hostels their tendency to continue smoking increased.

"I smoke with my group of friends, hardly have I smoked alone. I always make it a point that I join my friends whenever they call for a smoke." (PG)

The participants also stated that they liked to smoke and mentioned that they smoked for the enjoyment, due to the force of habit, and association with alcohol.

"In my third year undergraduate level I started smoking, initially I smoked 2-3 per day which had increased to 20 per day as I felt calm and relaxed after smoke, in fact, I am happy smoking, I like smoking" (UG)

"Smoking along with alcohol gave increased pleasure, and during those times my number of cigarettes smoked also increased. It gives a euphoric state during which everything around me appeared to be beautiful, and I forget all my problems and troubles."(UG)

Perceptions of being a smoker: Smoker's particularly low motivational group favoured smoking behavior, stating it was their personal habit and no one can influence it. They felt that there were benefits of smoking like increased social behavior, interaction among people, stress relaxation and enjoyment too.

"I feel smokers socialize more than non-smokers, non-smokers are more reserved and don't interact much and are bit boring too."(PG)

"I don't bother about others. It is like a day to day activity, and it's my personal wish, I won't listen to anyone's advice."(UG)

Most of the participants also stated that others opinion regarding them did not affect them nor made them help to reduce smoking. Two undergraduate students illustrated their dislike of people looking down at them as smokers, like in one case; a participant said;

"When I smoke among people who do not smoke, they make it a big issue that we smoke in public space and they look down on us as if we are a terrorist"(UG)

Knowledge regarding health effect of smoking: Participants knew about the health consequences of smoking and its addictive nature. In response to the questions regarding health effect of smoking they had reported various health effects as health professionals their knowledge seemed to be inadequate. The postgraduates most commonly stated health effects such as oral and lung cancer, breathing difficulties, chest pain, some alterations in blood components and xerostomia. Only two among the undergraduates reported a few of the above ill effects, the others couldn't think of anything.

"I know that smoking causes lung and oral cancer, It will also change the composition of the blood. Mostly it causes oral problems like dryness of the mouth."(PG)

"As far as I know Smoking causes cancer, affects the lungs" and also causes loss of memory."(UG)

The postgraduates stated that the main reason why they would quit would be if they had begun to face any major health issues and a few others quoted that they have reduced the count of cigarettes due to some ill effects faced by them.

"I couldn't completely quit the habit due to addiction and exposure to smoking along with my friends in the hostel. As I started to develop allergy I reduced my number of cigarettes for a day because" (PG)

"I faced breathing difficulties especially while climbing stairs and my stamina reduced, and I feel tired too these days, so I thought to reduce the count of cigarettes and brought it to one per day." (PG)

Aspects related to quitting attempts: In the undergraduate group 6 participants never attempted to quit and among them 4 were in the low motivation group. Among the postgraduate group all of them had tried to quit at least once and 6 were in the high motivation group. The period of quitting did not last for more than 10 days to a month. Postgraduates stated concerns regarding their deteriorating health that they perceived because of smoking like lack of concentration, reducing stamina, allergies and more commitments towards family and career. The other main reason to quit would be the expenditure done on the habit.

"I reduced smoking because of financial burden faced due to it, earlier my parents used to give me pocket money, but as I am earning now, I am not comfortable to spend the money on cigarettes"(PG)

Although health and financial burden have made thoughts in the participant's mind to quit or motivated them, they

being health professional the course toward quitting has not been easy. They faced similar challenges like other tobacco users such as the force of habit, addiction to nicotine and tendency to fall back. The major barriers to quit were due to peer influence, friends and staff members and easy availability of alcohol and tobacco products at various parties and banquets held during academic conferences.

"I tried to quit; it lasted for a week. But when few of my friends smoked in front of me it triggered me to smoke again."(PG)

"It is obviously not good to smoke, and I tried to quit because my friends explained the health effects. The attempt did not last for more than one week, so I decided to reduce the count of cigarettes before I completely quit."(PG)

The undergraduate students felt that smoking was their personal habit which they would think to quit when they felt the need such as health effects or financial burden. They also thought that they are too young to think of it and had enough time to attempt quitting.

"I like smoking. I will try to quit when I feel the necessity for people who are intimate to me and if they encourage me to quit" (UG)

"Yes definitely there a financial burden at times, but at those times I buy smokes for lesser price because they are there at the market and I also receive pocket money from home "(UG)

When discussed about the influence of health warnings to initiate quit attempts, all the participants except two postgraduates felt the display never helped to initiate a thought as they bought the packet so frequently and it had the same old display picture which they never looked at.

Need for tobacco cessation counseling: Although no participant had obtained any form of help or cessation counseling to quit they felt that as they are health professionals they did not require any form of help. The postgraduates stated that as they understand the issues with smoking behavior they have reduced the count of cigarettes. A few candidates felt they would require some help either a counselor or some other doctor to continue the quit process and to motivate them towards cessation.

"We might need someone else's advice to help quit, but it is his own thing to care about his health. Yet I need to feel and realize the hazards of smoking rather than anyone else advising me."(PG) Two postgraduates felt the need for cessation counseling, yet said there needs to be the will to stop the habit, Otherwise it would not help.

"It will boost up my will to quit if I was given tobacco cessation counseling, and if someone gives counseling regarding tobacco quit attempts I think it will make people more aware of the ill effects and help to quit, but it is the person's own will to decide to whether to quit or not"(PG)

In terms to provide tobacco cessation counseling training, all the participants reported that they had not obtained any professional tobacco cessation training program.

Attitude towards Nicotine Replacement therapy: A few of the participants had tried various methods such as e-cigarettes, nicotine gums and usage of dry grapes to help them quit or to stay up the quitting phase. The participant's opinions regarding nicotine replacement therapy were varied. All the postgraduate candidates reported the nicotine gum did not help at all. One participant felt that the pleasure obtained while leaving the smoke out during smoking cannot be matched with the nicotine gums. While one of the undergraduates quoted that nicotine patches or gums could help in maintaining the quitting phase. When asked about the way the gum was used no one gave any specific method of usage.

Attitudes towards tobacco policies and law: Being health professionals there are major lacunae in the knowledge among both the groups regarding the various policies on tobacco control in the country. Most of the participants stated that major laws where not to smoke in public places and the ban on sale to minors. The familiarity of the Cigarettes and other Tobacco Products Act and the WHO- FCTC was not found among the undergraduate students while only two post graduates had some information regarding them.

Most of the participants stated flaws in the enforcement of the law. They stated that although smoking is banned at public places, yet it is continued because no severe action is implemented on violation of the law. Strict enforcement of the laws has to be made mandatory. One of the participants stated that although the laws are not strict, we should avoid smoking at public places.

"Of-course it's not right to smoke at public places. As we are aware of the consequences of second-hand smoking we should also instruct smokers not to practice the same" (PG)

One of the undergraduate students quoted that there should be smoking areas provided at public places to avoid any harm and inconvenience to other people.

Where are we suppose to smoke if we are should not smoke at public places??? There should be smoking areas available" (UG)

"I avoid smoking at public places as I don't want to disturb the other people. I usually smoke alone "(UG)

On further discussion, a few participants also stated that the health warnings on the packets would not bring in any change of attitude. There is a need to bring in a change in the pictorial warnings and the size of the warnings should be larger.

"The warnings are never noticed much, as we use the pack very frequently and the same picture is depicted, and it does not make us look at it. I feel that would not help people quit or to avoid smoking."(UG)

When discussed about methods to avoid initiation of smoking or to curb the habit the candidates stated that there could be some inclusion in the syllabus regarding the habit and its addiction at school level, so that the initiation can be hindered rather than struggling at a later stage to quit. Further one of the participants stated smoking is one's personal choice, only if one intends to quit any change can be done. One participant quoted about the increase in the price not being a viable option because there are always cheaper options to use which are more harmful. There should be a uniform increase in the price to avoid the usage and bring in a quit attempt.

DISCUSSION

Among the health professionals, dentists hold a unique and an important position in the control of tobacco use. Prakash A, et al. in their study stated that dentists are well placed to identify smokers and other tobacco users; it may range from diagnosis of periodontal disease to potentially malignant diseases.[9]

The Global Youth Tobacco Survey, 2009 showed that a high number of school children between the age of 13-15 years were currently using or had tried tobacco indicating the initiation of the habit mostly before adulthood.[6] In the present study also the age of onset reported by the participants was around 16- 18 years. The reasons for this as reported in our study was to achieve a high esteemed image, easy availability of the cigarettes at the nearby shops and parents those who sent their kids to buy cigarettes.

The reasons to continue smoking in the present study were relief from stress and to feel relaxed after smoke. This was similar to the results of a study done by Nichter M et al. 2007.[10] Kobus K et al. 2003[11] in his review stated influence of peers on the habit. This finding was similar in our study wherein most of the participants continued to smoke due to the influence of friends and faculty in the institution.

Globally, 5.4 million deaths annually are caused by tobacco use, and it is expected that by the year 2030 about 80% of these deaths will be in developing countries.[12,13] The economic burden faced due to tobacco related deaths in India was reported in the year 2011 had amounted US$ 22.4 billion which was found to be 1.16 percent of the GDP.[14] All our study participants lacked in the knowledge regarding the health effects, economic burden and recent trends in tobacco mortality and morbidity in the country.

The next theme derived in our study was opinions regarding nicotine replacement therapy. The result obtained were in contrast with a Cochrane report, 2012 wherein it was concluded that the success of smoking cessation could further be increased by 50-70% by the addition of nicotine replacement therapy, when compared to brief intervention.[15] The participants reported that NRT would not help. This could be due to lack of information about the correct usage of the gums and patches and due to no professional help.

Participants in the present study realized the importance of abstaining from smoking in public places which were consistent with the results in Inandi T et al. 2013.[16] We also found that they carried out smoking activities in the campus after college hours and also at hostel premises. The major reason for this could be inappropriate enforcement of the COTPA law by their school/college authorities.

Tobacco cessation interventions are considered one of the ways to prevent and reduce tobacco use prevalence in the community. Austoker J in his analysis reported that a three-minute brief intervention by the patient's general practitioner would double the long term success rate to about 5 perent. It is also reported that a dental practitioner can achieve cessation rates of 5-12% by brief intervention.[17] To achieve this, there is a need for adequate knowledge and efficiency regarding tobacco cessation service. In our analysis it was found that dental professionals did not feel the need of any professional help and there is a lack of adequate knowledge regarding tobacco cessation.

Opinions about "National tobacco control policies" give us an idea that all the participants felt the need to enforce the laws more strictly. The opinions regarding effects of display of warnings on the packs and price increases were consistent with results of the qualitative study done by Uppal N, 2013.[18] The knowledge of various anti - tobacco laws such as COTPA and WHO-FCTC also seemed to be lacking among both our groups.

The strengths of this study are that it gives a detailed illustration of the attitudes and beliefs of dental professionals towards smoking habit using an in-depth interview and focus group discussion. The latter assumes significance as in-depth interviews provides individualized views and opinions which study participants might feel reluctant to express in a group. A focus group discussion would provide an opportunity for an individual either to endorse or oppose a view or idea expressed by the other members of the focus group, and thereby generates a discussion, whereby logical conclusions can be derived.

The limitations of this study would be the transferability of the data to a general population. This would require similar kind of analysis in different regions among various strata of populations, as the reasons for the smoking behaviour, could be unique for different populations. Further this study used a manual method for assessment of outcomes and no statistical software were used for the data transcribing or for sorting of data.

The study findings of this study throw light on the importance of early initiation of tobacco habit. Since most of the current smokers start smoking at early adolescence, adequate exposure towards the ill effects of smoking should be done at school level through trained teachers and include the same in their school curriculum. In medical training institutions, customized care should be made available for health professionals to motivate them to quit tobacco both through behavioral and

pharmacotherapy. This would not only make them ambassadors for a tobacco-free environment but also help them understand the success of tobacco cessation services, thus increasing their knowledge and advocate these to their future patients who are tobacco users. Since environmental factors also play a pivoted role in maintaining a tobacco free community, adequate legislative enforcement of banning the use of tobacco products within the vicinity of educational institutions should also be emphasised. These practices would advocate a tobacco-free community among health professionals thereby contributing to the overall improvement of health care services both at individual and community level.

CONCLUSION

Within the limitations of this study, it can be concluded that the knowledge regarding the health implications and the economic burden faced due to tobacco-related diseases seemed to be inadequate amongst this study population. With regard to the need to quit tobacco-related habits, postgraduate dental students had a higher level of motivation than their undergraduate counterparts. Most of them also felt they did not require any professional help to quit smoking. The use of NRT was reported to be not helpful, and the information regarding legislative efforts advocated by governmental agencies for tobacco control was also inadequate.

REFERENCES

1. Surani NS, Pednekar MS, Sinha DN, Singh G, Warren CW, Asma S, et al,. tobacco use and cessation counseling in India-data from the Global Health Professional student Survey,2005-2009, Indian J Cancer 2012;49:425-30
2. Stassen LF, Hammarfjord O, Smoking cessation and the role of the dental practitioner. J Ir Dent Assoc. 2015; 61(2):90-2
3. Walsh MM, Ellison JA, Treatment of Tobacco Use and Dependence: The Role of the Dental Professional, J Dent Educ 2005;.69(5):521-537
4. Sinha DN, Singh G, Gupta PC, Pednekar M, Warrn CW, Asma S, Lee J. Linking India Global Health Professions Student Survey data to the World Health Organization Framework Convention on Tobacco Control, Indian J Cancer. 2010 ;47 Suppl 1:30-4.
5. Qualitative research for tobacco control, Research for International tobacco Control, Canada. Accessed from, http://www.idrc.ca/tobacco. Accessed on April 26,2016.
6. Global Adult Tobacco Survey collaborative Group. Tobacco Questions for Surveys: A subset of key Questions from the Global Adult tobacco Survey (GATS), 2nd edition, Atlanta, GA: Centres for Disease Control and Prevention, 2011.
7. Biener L, Abrams DB: Contemplation Ladder: validation of a measure of readiness to consider smoking cessation. Health Psychol 1991, 10:360–365.
8. Fagerström K: Determinants of tobacco use and renaming the FTND to the Fagerstrom Test for Cigarette Dependence. Nic Tob Res 2012, 14(1):75–8.
9. Parakh A, Megalamanegowdru J, Agrawal R, Hathiwala S, Chandrakar M, Tiwari R, etal,.Dental Practitioners Self Reported Performance of Tobacco Cessation Counseling Interventions, Asian Pacific Journal of Cancer Prevention,2013;14:6141-6145
10. Nichter M, Nichter M, Carkoglu A, Reconsidering stress and smoking: a qualitative study among college students, Tob Control. 2007; 16(3): 211–214.
11. Kobus K, Peers and adolescent smoking, Addiction. 2003:98 Suppl 1:37-55.
12. Global Adult Tobacco Survey; GATS - India 2009-2010. Ministry of Health and Family Welfare. Government of India.
13. Gauravi A. Mishra, Sharmila A. Pimple, and Surendra S. Shastri, An overview of the tobacco problem in India, Indian J Med Paediatr Oncol. 2012 Jul-Sep; 33(3): 139–145.
14. Economic burden of tobacco related diseases in India-executive summary. Ministry of Family Health Welfare, Government of India 2011.
15. Stead LF, Perera R, Bullen C, Mant D, Hartmann-Boyce J, Cahill K, Lancaster T Nicotine replacement therapy for smoking cessation. Cochrane Database Syst Rev. 2012 Nov 14;11:CD000146.
16. Inandi T , Caman OK, Aydın N , Onal AE , Kaypmaz A , Turhan E, et al,. Global health professions student survey–turkey: second-hand smoke exposure and opinions of medical students on anti-tobacco law, Cent Eur J Public Health 2013; 21 (3): 134–139
17. Austoker, J., Sanders, D., Fowler, G. Smoking and cancer: smoking cessation. BMJ 1994; 308: 1478-1482.
18. Uppal et al.: The forgotten smoker: a qualitative study of attitudes towards smoking, quitting, and tobacco control policies among continuing smokers. BMC Public Health 2013 13:432.

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