Patient expectations in implant and aesthetic dentistry

Andrew Dawood[1]

Key points

Social media and digital culture have heightened patient expectations, often disconnecting them from the realities of treatment outcomes.

Clear communication and informed consent are essential to align patient expectations with achievable outcomes, reducing dissatisfaction.

Patients often misunderstand the complexity and limitations of implant treatments, requiring clinicians to clarify and correct false assumptions.

Unrealistic expectations and past treatment failures create stress for both patients and clinicians, emphasising the need for emotional resilience and tailored care.

Abstract

Implant dentistry has evolved significantly over the past decades, transitioning from pioneering procedures to a routine offering in modern dental practices. This evolution, coupled with the pervasive influence of digital media, has transformed patient expectations, often creating a disconnect between perceived outcomes and biological reality. This article explores the dynamics of managing expectations in implant dentistry, emphasising the critical role of informed consent and patient education. It delves into the psychological complexities patients bring to consultations, including influences from social media and celebrity culture. Various psychological concepts are examined in the context of implant dentistry, highlighting their impact on patient satisfaction and treatment outcomes. Transparent communication, ethical decision-making and empathetic care will foster trust and reduce patient dissatisfaction. Addressing the emotional and psychological challenges of patients, particularly those with complex histories or repeated treatment failures, is presented as a vital component of successful practice. Strategies to manage these challenges, protect clinician wellbeing and maintain team cohesion are also explored. In acknowledging the intricate interplay of technical, psychological and relational factors, this article provides a comprehensive framework for clinicians to navigate the ever-increasing expectations of implant dentistry patients while safeguarding their professional and personal resilience.

Introduction

I consider myself fortunate to have seen my work continuously evolve through four decades, from general practice in the 80s through to perio/prosthodontic practice in the 90s, adapting to and eagerly embracing the new digital technologies of the 00s, and over the last decade or so, an ever-deepening immersion in implant dentistry, exploring and pushing boundaries. We treat a broad spectrum of implant patients, including those who have experienced life-changing issues, such as orofacial trauma, cancer, or quite commonly now, the massive failure of a previous implant reconstruction. Some of our patients find their way to our practice through marketing activities, but most of the patients we treat are referred to us, and it is these patients who tend to be more challenging.

Throughout this time, the scope of a career in dentistry has grown, with the far-reaching power of the internet giving us access to information beyond our workplace, access to the astonishing technology that we use every day, and the extraordinary materials that we work with. In the early days of implant dentistry, the dentist and patient alike were pleased, relieved and satisfied to find that dental implants were stable and had osseointegrated. Precise positioning seemed less of a concern, with a focus on the success of the surgical and functional outcome rather than the cosmetic aspect of the treatment. Patients generally had lower expectations, perhaps seeing themselves as collaborators in a new and exciting journey. Patients tended to be older, more long-suffering, or more in need. There is no doubt that implant treatments can have a dramatic social and psychological impact upon our patients and their quality of life.[1,2]

Implant treatments have become more commonplace, available on most high streets and instantly found online. There is a focus on immediacy and expedited treatment protocols. Digital workflows make for faster treatments, with ready access to low-cost, digitally designed prostheses, milled from zirconia or hybrid materials, or 3D-printed resin-based systems.[3]

Access to information has also had a tremendous effect on our patients; they have changed, with aspirations and expectations moulded by social media and a celebrity culture.[4] Many patients see ‘befores’ and ‘afters’ with no appreciation of the irreversible and aggressive treatment that may have taken place or the digital filters that may have been applied. Patients may have carefully ‘researched’ their dental surgeon online and set them upon a pedestal before meeting them in person.

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Elsewhere in dentistry, scan, print, mill, align and bond, has become common currency, feeding a focus on cosmetic perfectionism, with little appreciation of longevity, or the distinctions between one minimally invasive cosmetic treatment or another more aggressive intervention.

Perhaps it is not surprising then, that patients seem to have become harder to satisfy, with expectations that appear to have grown exponentially. In the General Dental Council's (GDC's) Standards for the dental team,[5] the importance of obtaining valid consent and the management of patient expectations through clear communication is emphasised. Dentists must ensure that patients fully understand their treatment options, risks and costs before starting any procedure. This process should be ongoing throughout treatment, ensuring that consent remains valid and expectations remain realistic. The GDC highlights that shared decision-making is key to patient satisfaction, and aligning expectations early on helps prevent complaints related to dissatisfaction with outcomes.[6,7]

This article will explore these changing dynamics in patient care, examining the misconceptions that can arise in implant dentistry, how expectations may go unmet, and the subsequent impact on both the patient and dental team.

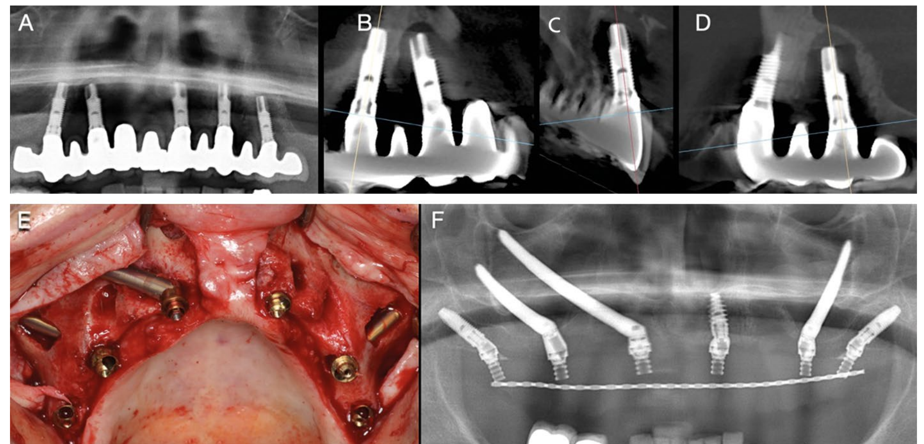

Fig. 1 Panoramic radiograph (a) and cross sections (b, c, d) through each implant site show extensive peri-implant disease and multiple implant failures. Subsequent treatment is inevitably more complex, in this case necessitating reconstruction with a combination of dental and zygomatic implants as seen at the time of surgery (e) and in a subsequent panoramic radiograph (f). Patients need to be made aware of the requirement for ongoing maintenance and repair, with an appreciation of the longevity of a reconstruction, and the possible need for eventual replacement

Expectations and consent

There is an important distinction between a failure to meet expectations and a lack of consent in dental or medical treatments, which generally lies in the patient's perception versus a legal obligation.

Failure to meet expectations occurs when the outcome of treatment does not align with what the patient anticipated, even if the treatment met professional standards. This often stems from poor communication or from unrealistic expectations. If informed consent was given and the standard of care was met, it is generally not legally problematic. In the United Kingdom, the Bolam test (Bolam versus Friern Hospital Management Committee)[8] determines whether a healthcare provider met the standard of care by comparing their actions to what a responsible body of professionals would consider acceptable. However, the Bolitho versus City and Hackney Health Authority (1997) case refined this principle, stating that the professional opinion relied upon under the Bolam test must also withstand logical scrutiny. This ensures that the standard of care is not only professionally acceptable but also reasonable and rational.

In contrast, lack of consent is a legal and ethical issue. Dentists must obtain informed consent by fully explaining the risks, benefits and alternatives before treatment. Montgomery versus Lanarkshire Health Board (2015) set the precedent that patients must be informed of all material risks that might influence their decision, emphasising the patient's right to autonomy.[9]

While failure to meet expectations involves dissatisfaction with the outcome, lack of consent addresses the absence of proper communication and agreement, with significant legal implications. Both emphasise the need for transparent communication to ensure patient understanding and satisfaction.

Many – perhaps most – complaints are a result of unmet expectations or often simple misunderstandings, which, if addressed in advance of treatment, require simple explanation, but if presented after treatment, are perceived by the patient to be elaborate excuses and a failure to consent. A well-informed patient is more likely to have realistic expectations and this can contribute to a greater level of satisfaction.[10] However, if these expectations are not carefully managed, even a successful procedure may lead to a complaint if the outcome falls short of what the patient anticipated.

Misconceptions and expectations

It is important for the patient to take full possession of their own problems, which they can only do if they are given the means to understand how they have come to be in their situation. Many patients will start a consultation by blaming others for their issues, which is definitely not a good foundation upon which to build – the next person to provide care may well become the next recipient of blame.

Presenting the cause of the original tooth or implant failure or loss – perhaps a consequence of inadequate maintenance or hygiene, medical problems, smoking, excessive loading, ageing restorations, or periodontal issues – may help to ground the patient and establish a sensible baseline from which treatment can begin. For example, a patient who suffered periodontal problems or who persistently fractured teeth or restorations needs to understand that treatment may well present them with the opportunity to face similar issues once again, with the prospect of worn, loosening or fractured implant prostheses,[11] or peri-implant disease (Fig. 1).[12]

Perhaps because implants are now perceived to be so readily available, there is little appreciation of the complexity which may be associated with individual treatments. Simpler alternative solutions must be presented, including the use of bridgework or dentures – many patients will specifically discount this option and this should be documented. Information on longevity and the need for repair and ongoing maintenance is important.

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Prolonged or complicated implant treatments are prolonged and complex precisely because the patient's problems require sophisticated and time-consuming management, which may involve multiple visits, extended healing periods and multiple adjustments. Some patients will complain about the lengthy process and may experience 'treatment fatigue' from repeated visits. A full appreciation of the anticipated timeline is important so that they can understand that you, the dentist, are accompanying them on what may be a long and sometimes frustrating journey to address their problems. If treatments are challenging or carry increased risk, then clearly this must be explained and discussed at the outset. It may be appropriate to recommend a second opinion or referral.

The cumulative cost of treatment may contribute to feelings of exhaustion or frustration, particularly if the patient is financially challenged or does not feel they are seeing the eagerly anticipated result. A full appreciation of the projected financial timeline is therefore important.

Discomfort during surgery can harm the dentist-patient relationship and reduce trust – prolonged discomfort afterwards may be an indication of a complication and must be taken seriously. However, some discomfort, as well as swelling or bruising during and after implant surgery, should be anticipated, and this is an important discussion to be had in advance. Expectation mismatch can cause dissatisfaction, as the patient's perceived pain tolerance fails to align with their actual experience – all the more so where there is anxiety or stress.[13] Cognitive dissonance may result when a patient with a self-image of being 'strong' and 'resilient' with a 'high pain threshold' experiences more pain than anticipated, complaining as a way of reconciling their expectations with their actual experience. It is thus important for clinicians to carefully assess each patients' pain management needs, regardless of their self-reported tolerance, and to consider and discuss the need for additional measures, such as conscious sedation. Even with conscious sedation, patients need to understand that they may remember what they become aware of in the course of treatment, and the intention is not to render them unconscious throughout the procedure.

Implant failure soon after surgery is disappointing for patient and dentist alike. It is ironic that where complications occur, the dentist may be involved in costly and frustrating remedial treatments, and also have to manage a difficult and unappreciative patient, offering little understanding or sympathy. It is important to acknowledge that there is always a risk of failure and this should always be discussed in advance, along with the manner that the failure may present, how failure will impact upon the overall treatment plan, and how it will be addressed, practically and economically.

While most patients are keen to reduce time in treatment, some expedited procedures may carry, or later be perceived to carry, an increased risk of failure, such as immediate implant placement, immediate loading of implants, combinations of procedures, or implant placement where periodontally involved teeth are present.[14,15,16] Documenting a discussion of the heightened risk associated with such procedures in advance of treatment will help to defend against a claim that treatment was 'rushed' and that the patient would have opted for staged treatment if they had understood the associated risk.

The duty of candour is a key ethical and legal obligation, demanding that healthcare providers are open and honest when things go wrong. It requires that complications, failures, unexpected outcomes and mistakes are disclosed. Candid communication will help reduce the likelihood of complaints by maintaining patient trust and preventing misunderstandings. Openly acknowledging complications or unexpected outcomes demonstrates transparency and fosters respect, defusing potential conflict. Patients are less likely to feel misled or frustrated when they are informed promptly.[17]

A common perception among many patients appears to be that implant treatments will provide a perfect substitute for a tooth, perhaps even something better than a tooth. The perception is that the tooth will be fully replaced, with little concept of the fact that with the loss of a tooth or teeth, tissues will remodel, and a composite hard/soft tissue defect may result. Lost bone or gingival tissues, particularly interdental papillae,[18] may be challenging or impossible to replace, and attempting to do so may require multiple surgeries with diminishing returns. Even in situations where the appearance of the natural or restored dentition is poor, the patient may have expectations for the final cosmetic result of the restored implant that are entirely unrealistic in terms of size, shape and colour, and this is better understood at the outset.[19] It is wise to also explain how the implant prosthesis will be retained, particularly the presence of screw channels or the use of a soft, potentially unreliable provisional adhesive.

Many patients do not understand the concept of bridgework and this can lead to misunderstandings; patients need to be able to distinguish between the implant itself as distinct from the prosthetic tooth. They need to understand that implant units may be splinted and that they will not be able to floss between teeth. Although it may seem perfectly obvious to the clinician, a patient may feel short-changed if they find that their full arch prosthesis is supported by just four implants, as has become commonplace with the popularisation of the 'all-on-four' concept.[20]

Remodelling of the jaw may increase restorative space such that prosthetic teeth appear elongated, and a high smile line may necessitate the use of prosthetic gingivae, or in the particular case of full-arch treatments, a need for reduction of the ridge in order to conceal the transition from the prosthesis to the tissues behind the lip. Patients need to understand, accept and consent to both these features of their treatment. A current trend towards 'FP1' type prostheses[21] (fixed prosthesis 1: a fixed prosthesis that replaces only the crowns of teeth, restoring the normal anatomy without requiring replacement of any missing soft tissue or bone) may mean that face height is reduced in order to create a normal-sized dentition; this needs to be carefully considered, along with other changes to facial form, such as the lip support offered by a prosthesis, which may cause the patient to struggle with adjusting to their new facial identity, which they may find difficult to explain or verbalise. Involving the patient in decision-making in the steps leading up to the design and production of provisional bridgework will help to ensure that they are satisfied with the outcome of definitive work later on. Demonstration models, photographs and digital plans and simulations can all help patients to understand what treatment they are to receive, but these must not be misleading.

Patients may experience difficulty adapting to implant prostheses, complaining of difficulty with speech,[22,23] air escape and lisping, including spitting when speaking, food impaction and cheek biting.[24] The author has noticed that patients who progress from wearing a denture to implant bridgework will respond and adapt more favourably to treatment than the patient

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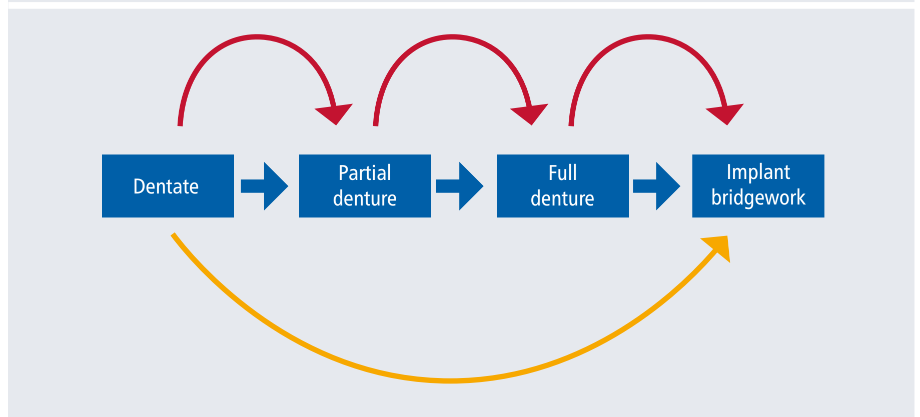
who progresses from a functional but failing dentition directly to implant bridgework (Fig. 2).

Nonetheless, given time and a reasonable clinical result, most patients will ultimately adapt. Some patients will exhibit adaptation impatience, which may reflect their frustration with the duration or complexity of the treatment process, resistance to change, and a fundamental lack of trust. Inevitably, some patients are intrinsically difficult to please and demand extra attention, and for these patients, clearly documenting the fact that comprehensive information has been provided in advance of treatment will help to avoid legal repercussions should a more formal complaint arise.

Fig. 2 A patient slowly transitioning from a dentate state to implant bridgework via a removable prosthesis may be better able to adapt, and expectations may be better met, than a patient who progresses immediately from a functioning natural dentition to an implant supported prosthesis



Unrealistic expectations

Patients who do not seem to comprehend or accept the realistic boundaries of a procedure, and who may dismiss professional advice about what is possible, are more likely to be disappointed with the outcome of treatment. If a patient dismisses professional advice and expects results beyond what is technically or biologically feasible, dissatisfaction is likely to follow. Where patients appear emotionally invested in the outcome of treatment, believing that the procedure will solve broader emotional or psychological issues, significant disappointment may result when the expected life changes do not materialise after treatment.

A history of multiple procedures is another indicator of unrealistic expectations. Patients who have undergone several treatments without satisfaction may be chasing unattainable goals, suggesting the issue is not the past treatment but their own unreachable standards. Similarly, patients who struggle to articulate their goals may have vague or unrealistic expectations, leading to dissatisfaction when these unclear desires are not met.

Comparison with celebrities or digitally altered images, or seeking a dramatic transformation based on unrealistic standards, will generally lead to disappointment when the actual result fails to align with these idealised images. A focus on others' reactions rather than personal satisfaction also signals unrealistic expectations, especially when patients expect a procedure to dramatically impact their social life.

Patients who dismiss or minimise risks that pertain to their own selves eg the impact of smoking or their medical state, or disrespect recovery or healing times, may lack a realistic understanding of the treatment, leading to frustration if the process is more challenging than expected or if complications occur. A refusal to accept professional advice is clearly a major warning sign. These patients often expect specific outcomes despite expert guidance, setting themselves up for inevitable dissatisfaction.

The hedonic treadmill

Some patients undergoing dental implant treatments may become increasingly difficult to satisfy as they near a 'definitive' result. Minor improvements feel less rewarding and the pursuit of perfection becomes more elusive. This behaviour aligns with the concept of the 'hedonic treadmill' (or hedonic adaptation), introduced by psychologists Brickman and Campbell in 1971.[25] It suggests that people quickly return to a baseline level of happiness or dissatisfaction after major life changes, adapting emotionally over time. In implant dentistry, the initial loss of teeth can feel catastrophic,[26] leaving a deep emotional impact. Replacing a denture with a fixed bridge may bring a surge of elation as function is restored, yet as patients adjust to this improvement, their sense of joy diminishes.

As they near 'normality', patients may begin comparing themselves to others, often influenced by social media, raising their expectations beyond their personal journey. After each intervention, the patient sets a new baseline, making subsequent treatments feel less impactful.[27] This cycle represents the hedonic treadmill in motion, constantly chasing the next improvement without appreciating progress.

This relentless pursuit of perfection can lead to dissatisfaction, stress and anxiety as the patient raises the bar higher with each step. In extreme cases, this behaviour may resemble body dysmorphic disorder (BDD), where minor or imagined flaws dominate the patient's focus, leading to compulsive desires for further improvements, often resulting in a diminished quality of life.

Body dysmorphic disorder

BDD is a mental health condition,[28,29] marked by an obsessive focus on perceived flaws in appearance. Individuals with BDD experience significant distress and may engage in repetitive behaviours, such as mirror checking, grooming, or comparing themselves to others. These obsessions can interfere with daily life, causing social avoidance, relationship difficulties and challenges in work or study.

The causes of BDD are multifactorial, involving genetic, neurobiological, psychological and environmental influences; it often runs in families. Childhood experiences like bullying or abuse, along with societal pressures, can also contribute. Body image concerns are often amplified through constant exposure to idealised images in media, particularly social media.[30] Major life transitions and high stress can trigger or worsen symptoms.

The face is a common area of focus, and these individuals may seek cosmetic dental or implant procedures[31] to fix perceived flaws but are often left unsatisfied. Patients with BDD will often have unrealistic expectations and may remain dissatisfied, even when treatment is clinically successful. This dissatisfaction can lead to ongoing frustration and demands for revisions or further procedures in pursuit of unattainable perfection. The patient may fixate on minor flaws or continuously shift their focus to new concerns, leading to repeated requests for adjustments.

Overtreatment or repeated interventions are a risk when trying to meet unrealistic

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demands and the patient may never be fully satisfied, which can strain communication and increase the likelihood of complaints or even legal action. Recognising these dynamics early in the process is crucial to managing patient expectations and preventing overtreatment.

BDD is not simply a concern over appearance; it causes intense distress and significantly impacts quality of life. When recognising signs of BDD, liaison with the general practitioner and a multidisciplinary approach that includes psychological care is often necessary to ensure the patient receives proper treatment for their underlying condition while avoiding unnecessary dental interventions. This balance helps protect both the patient's mental health and the dentist's practice.

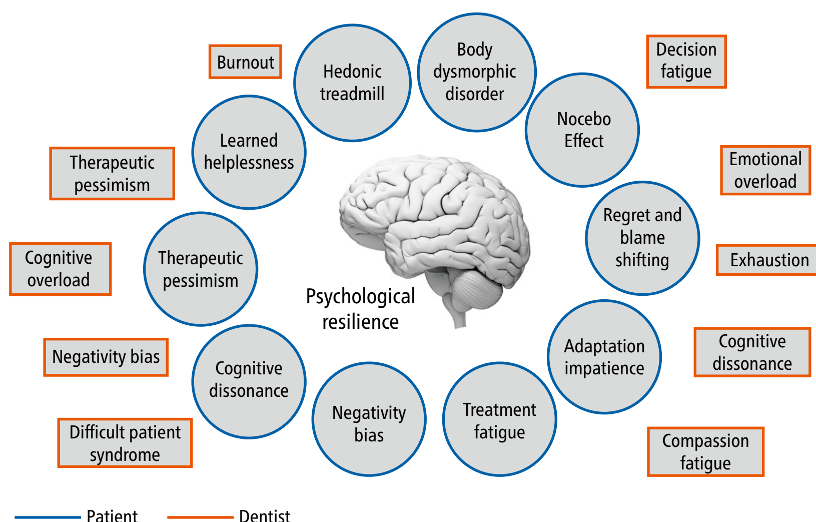

Fig. 3 Some of the psychological factors which may impact upon the patient and the dental team in the course of challenging treatments

Negative expectations

Where treatment is prolonged or repeated with minimal perceived benefit, patients may experience treatment fatigue and can become exhausted and disengaged. This can lead to further complications in managing their condition and adhering to an effective treatment plan. Patients who have undergone repeated treatment failures often experience profound psychological effects that can influence future treatment outcomes. One such effect is learned helplessness,[32] a condition where patients begin to believe they have no control over their situation, leading to passivity and reluctance to engage in further treatment, even when viable options for improvement exist.

Patients who have failed to respond to multiple treatments face significant psychological challenges. Their history of failure can lead to feelings of frustration and hopelessness, making them more difficult to treat. These individuals may also be more vulnerable to the nocebo effect,[33] where their negative expectations of treatment result in poor outcomes, further complicating treatment. Additionally, demoralisation syndrome[34] can develop in patients facing chronic issues or repeated failures, characterised by low self-esteem, hopelessness and a loss of motivation, particularly where there is reduced social support. This mental state can severely hinder their willingness to engage in future treatments and impact their overall wellbeing.

In implant dentistry, where both functional and cosmetic transformations play a crucial role, there is an inevitable psychotherapeutic aspect to care.[35] The bond between the clinician and patient can be strained due to repeated unsuccessful treatments, a phenomenon analogous to 'therapeutic alliance rupture' in psychotherapy.[36] This breakdown of trust and collaboration can make future treatments by the original clinician or by clinicians who may be providing remedial care further down the line more challenging to navigate.

Addressing these psychological factors is essential in managing patient expectations and improving treatment outcomes.

Discussion and conclusion

The complexities of modern implant dentistry now extend far beyond technical proficiency. With advances in materials, digital workflows and instant access to information, patient expectations have changed dramatically. Clinicians are increasingly tasked not only with managing the physical aspects of treatment but also with addressing the psychological and emotional responses of patients, many of whom have been influenced by social media with expectations that are detached from the biological realities of implant treatments.

One of the primary challenges lies in the growing disparity between patient expectations and clinical outcome. Patients often enter treatment with preconceived notions shaped by success stories and aesthetic ideals, which can clash with the complexity and risks inherent in implant procedures. This highlights the importance of comprehensive patient education and informed consent, where clinicians must go beyond standard explanations to ensure that patients fully understand the realistic goals and limitations of their treatment.

Psychological factors, such as learned helplessness and therapeutic pessimism, can further complicate treatment, especially for patients who have experienced multiple failures. These patients may emotionally disengage, making it more difficult for the clinician to achieve positive outcomes.

In more extreme cases, patients with BDD may seek unrealistic transformations. Early recognition and a multi-disciplinary approach, including mental health support, are key to managing these patients, protecting both their wellbeing and the integrity of the treatment process.

Maintaining trust between clinician and patient, particularly in complex cases or where patients are perceived to be 'difficult',[37] requires transparent and empathetic communication, especially when complications arise. Open discussions about potential risks and realistic outcomes are essential in fostering cooperation and reducing the likelihood of complaints.[38] Treating patients with high and unrealistic expectations, or those who have been through multiple treatments, failures and complications, can be exceptionally stressful for the dentist and their team. These patients often come with emotional baggage from previous treatments, leading to heightened anxiety, scepticism and sometimes even hostility. For the dental team, the pressure to deliver results that not only address complex clinical issues but also meet exaggerated or unattainable patient expectations can be overwhelming.[39] The dentist must balance the need for clear, empathetic communication

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with the technical demands of the treatment, all the while managing a patient's potential emotional volatility (Fig. 3).

One of the key challenges in treating these patients is the emotional burden placed on the clinician who may feel trapped, carrying out treatment with a diminishing return and a patient with higher and higher expectations. Knowing that a patient has been disappointed by past treatments can create a constant sense of unease – dentists may worry that, despite their best efforts, the patient will be dissatisfied again, leading to complaints, further emotional distress, or even litigation. This can result in significant mental fatigue for the dental team, who are constantly working under the threat of unmet expectations and can even lead to diagnostic errors.[40] The stress of having to justify every decision, explain every step, and manage the patient's ongoing emotional responses adds another layer of complexity to the already demanding clinical work. Patients often require extra time and attention, which can disrupt the normal flow of a dental practice. Appointments may run longer due to the need for extended consultations, reassurance and detailed explanations. The team must be prepared to handle repeated calls, questions, or concerns that may arise between appointments, further taxing the clinic's resources; this may not have been factored into an original quotation for treatment, leaving the practice out of pocket and not wishing to provoke a complaint by charging more. All this can lead to burnout,[41,42] not just for the dentist, but also for other members of the team, as the emotional needs of these patients can become all-consuming.

From a psychological perspective, the clinician must maintain a delicate balance between validating the patient's concerns and managing their unrealistic expectations. Patients with a history of multiple treatments and failures are often stuck in a cycle of disappointment, and breaking that cycle requires both technical skill and a deep understanding of the patient's emotional landscape. Dentists may feel the weight of this responsibility, knowing that their work goes beyond just providing a clinical solution – it involves healing both physical and psychological scars. The fear of not meeting the patient's lofty expectations can lead to a sense of self-doubt in the practitioner, even when they know they have done everything correctly.

Additionally, these high-stakes situations can place a strain on the team dynamic. Stress levels can rise within the team, particularly if members feel that the demands of a difficult patient are taking away from their ability to deliver quality care to other patients. Dentists and their teams must be mindful of maintaining open communication and supporting each other, particularly when dealing with emotionally draining individuals – dentists working alone are more vulnerable to burnout.[43]

Regular team meetings to debrief on difficult cases, support from mental health professionals, and fostering a culture of self-care and mutual support within the practice are all essential in preventing burnout. Additionally, seeking second opinions or referrals for complex cases may help alleviate some of the pressure on the primary clinician while also giving patients a broader perspective on their treatment options.

Ultimately, treating patients with high or unrealistic expectations requires not only clinical expertise but also emotional resilience. Dentists must be equipped with both the technical skills and psychological tools to navigate these complex cases successfully. Providing comprehensive care for these patients can be immensely rewarding but also carries significant challenges that, if not managed properly, can affect the wellbeing of the entire dental team.

Apprehension driven by concerns about potential complaints, litigation and the intrinsic demands of treating such patients may result in dentists becoming reluctant to take on patients who are perceived to have psychological complexities. This may lead to patients being bounced between practitioners and hospitals, where they may struggle to receive appropriate care, heightening their sense of rejection and distrust in the dental system. The consequence of this cycle is that a patient with legitimate needs might not receive treatment, leading to a worsening of their condition and increased frustration, compounding the emotional and psychological burden on both the patient and the dental profession.

Ethics declaration

The author declares no conflicts of interest.

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