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Research Article

# Managing a Suicidal or Gravely Disabled Patient on an Involuntary Psychiatric Hold and Who Has End-of- Life Orders: Key Factors to Consider in an Emergency Room Setting

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## Abstract

Management of patients who have end-of-life orders may be complicated by the presence of an involuntary psychiatric hold for suicidality or grave disability. Decision-making factors that have been previously described include principles of medical ethics, laws and legal precedent, and examination of the motivations for end-of-life orders. However, management remains difficult, especially in time-limited settings such as the emergency room due to the wide-ranging existence of patient factors, individual ethics, and policies at governmental and hospital levels. We examined existing literature on the topic and created a structured conceptual model of key considerations for end-of-life issues during involuntary psychiatric holds in an emergency room setting, grouped into patient, involuntary psychiatric hold, system, and provider factors. These encompass the range of factors most likely to guide decision making on individual cases that emergency clinicians will face.

## Introduction

A 25-year-old female patient overdoses on two bottles of acetaminophen in a suicide attempt and is brought into a rural hospital emergency room at 1 am by paramedics and law enforcement. Law enforcement has already placed her on an involuntary psychiatric hold for being a danger to herself. A DNR/DNI/DNO (do not resuscitate, do not intubate, do not operate) flag is in her electronic medical record. Does the emergency medicine physician save this patient's life at this time of the night? A 68-year-old male patient with schizophrenia, hypertension, diabetes mellitus, and hyperlipidemia has stopped all of his psychiatric and non-psychiatric medications and is brought into an urban university medical center emergency room at 3 am by paramedics for a myocardial infarction. Upon arrival at the emergency room, the consultant psychiatrist places this patient on an involuntary psychiatric hold for being gravely disabled. A DNT/DNH (do not treat, do not hospitalize) flag is in his electronic medical record. Does the emergency medicine physician hospitalize this patient to treat the myocardial infarction at this time of the night? These clinical scenarios are not simple and interface many clinical, legal, ethical, and social factors [1] when deciding how to handle such patients in a time-sensitive emergency room setting. While DNR/DNI orders have existed for years, the recent COVID-19 pandemic has appeared to renew an interest in one's code status [2-6].

Many types of code status for end-of-life issues exist in modern medicine: DNR, DNI, DNO, DNT, DNH, full code, limited code, comfort care, AND (Allow Natural Death) [7-9], etc. Following a code status order is complicated enough in patients without acute psychiatric illness. This issue becomes more complicated in the context of suicidality or grave disability. An additional layer of complexity arises if such patients are placed on an involuntary psychiatric hold. A final layer of complexity arises when decisions need to be made rapidly in an emergency room setting (often in the middle of the night) where time is of the essence. In this paper, we first briefly discuss suicidality and grave disability in the context of end-of-life issues. Then, we provide a conceptual model of key factors to consider in the complex decision-making process involved in end-of-life issues during involuntary psychiatric holds in an emergency room setting. For each factor, we give examples of questions to ask. Our goal of this paper is to provide practicing emergency clinicians a thoughtful list of factors to consider when being involved in such complicated decisions in a time-sensitive emergency room setting.

## Suicidality and End-of-Life Issues

An examination of existing literature on suicidality and end-of-life issues reveals a wide range of suggested approaches to evaluation and management of patients presenting after a suicide attempt who have pre-existing advance care orders, which is complicated by inconsistency in legal, health system, and hospital-level policies [10]. Given the variability in individual providers' ethical approaches, treatment priorities, and medico-legal environments, it is likely that any rigid and uniform policy would be controversial. The debate over rational suicide can inform decision-making during end-of-life care in the setting of suicidality. The concept of rational suicide is controversial and has been described in the literature with various criteria. An example of criteria that have been put forth for defining rational suicide [11] are: (a) Realistic assessment of the situation on behalf of a person whose mental processes are not impaired by either psychological illness or severe emotional distress. The motivational basis for the decision could be understandable on behalf of uninformed observers. (b) The person understood the terminal nature of her/his condition. (c) The person consciously disengaged from treatment. (d) The person communicated the desire or made preparations to end her/his life. (e) A triggering event heightened a hopeless situation. A systematic review of the literature on this topic found viewpoints on this topic to be contrasting and inconsistent [12].

A consequent question raised is: If rational suicide exists, what role do healthcare providers have in intervention and treatment after a rational suicide attempt, from an ethical and legal standpoint? Karlinsky, et al. [13] approach this question by pointing out that patient autonomy is not an absolute determining factor, and that neither physicians nor patients can impose their wishes on the other, suggesting that physicians may not be obliged to withhold resuscitation of an unconscious

patient following a suicide attempt if this is a violation of their own ethical principles. Henman [14] outlined reasons to honor and reasons not to honor a DNR order after suicide attempt and discussed ways in which a suicide attempt might be considered a rational action. And others posit that even if a suicide attempt is considered by a provider to not be a rational or autonomous decision, severe injuries sustained during the attempt (e.g., severe burns, mutilating injury) may lead a patient or surrogate to make a rational decision to forego life support [15].

A different argument raised by Clarke [16] posits that rationality is limited in part by the impossibility of fully knowing the consequences of suicide, arguing that nobody can know what existence (or lack thereof) proceeds death. In this case, they define a rational decision as being realistic (having full knowledge of options and consequences) and having minimal ambivalence. While suicide cannot be considered a rational act, the concept of “understandability” (understanding the decision in the context of the person and their thoughts, desires, values, and relationships) may be used in place of rationality. They also suggest reframing the questions as not “to be or not to be”, but rather as “whether to die now or later”.

Moving beyond the rationality of suicide, various articles have suggested criteria in which it is appropriate to withdraw life support after attempted suicide. Brown et al. [17] published the following criteria: (1) Surrogates request withdrawal of care and the adequacy of surrogates is confirmed, (2) An external reasonability standard is met, (3) Passage of time, perhaps 72 hours, to allow certainty regarding the patient’s wishes, and (4) Psychiatric morbidity should be considered as grounds for withdrawal only in truly treatment-refractory cases. They raise an “external reasonability standard”, similar to the idea suggested by Teven & Angelos [15], which can be ascertained by asking, “If this were not an attempted suicide, would a request to withdraw care be reasonable?” These authors, as well as Cook et al. [10], both point out that most DNI/DNR laws did not take into account the situation of a person with mental illness framing a DNI/DNR order as preparation for suicide – for instance, in cases of individuals with mental illness and no terminal illness, or limiting life support in the setting of moderate or potentially survivable injury. The authors also suggest that advanced directives drafted “in the throes of mental illness” are invalid, and consequently, advance directives in the aftermath of attempted suicide should be held to a higher level of scrutiny. As such, the default response of health care providers to withdraw non futile life support after attempted suicide should be refusal to withdraw life support, pending further evaluation adherent to the aforementioned criteria.

### Grave Disability and End-of-Life-Issues

There is little existing literature on how grave disability should influence the interpretation of end-of-life orders. Various definitions of “grave disability” exist, though they tend to reference a person not being able to meet their own basic physical needs as a result of mental illness. For example, the California Welfare and Institutions Code § 5008(h)(1) [18] defines “gravely disabled” as, “A condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter.” The argument for following end-of-life orders in an individual who meets criteria for grave disability is predicated on autonomy and originates in the constitutional right of privacy guaranteed by the Fifth and Ninth Amendments [19]. Whether grave disability interferes with one’s capacity to make decisions surrounding end-of-life issues has not been examined in existing literature.

Providers may be tempted to argue that reversal of the gravely disabled condition – by treating the underlying disorder, or by providing for food, clothing, or shelter – might alter a patient’s decision to have life-saving measures withheld. In that vein, Clarke [16] argues that when a person wishes to die, there is usually ambivalence, in that the person would likely rather live if only they could change several things about their life, and that demoralization and a limited view of options limits autonomy. Yet when patients and providers alike have tried to ameliorate their gravely disabled condition, and the patient continues to be unable to provide for their own personal needs, a limited view of options may reflect the reality of our treatment options. Clarke’s concept of “understandability” may be useful in this context.

### Key Factors to Consider in Decision-Making Process

Deciding what to do in these complicated cases in an emergency room setting will inevitably involve numerous perspectives, such as the patient (if possible), family members (if possible), hospital ethics committee, treating professionals (e.g., emergency medicine, psychiatry, nursing), etc. There is no easy solution, and the final decision is often made after a quick multidisciplinary team discussion in an emergency room setting. We provide a conceptual model of key factors to consider in the complex decision-making process involved in end-of-life issues during involuntary psychiatric holds in an emergency room setting (Figure 1).

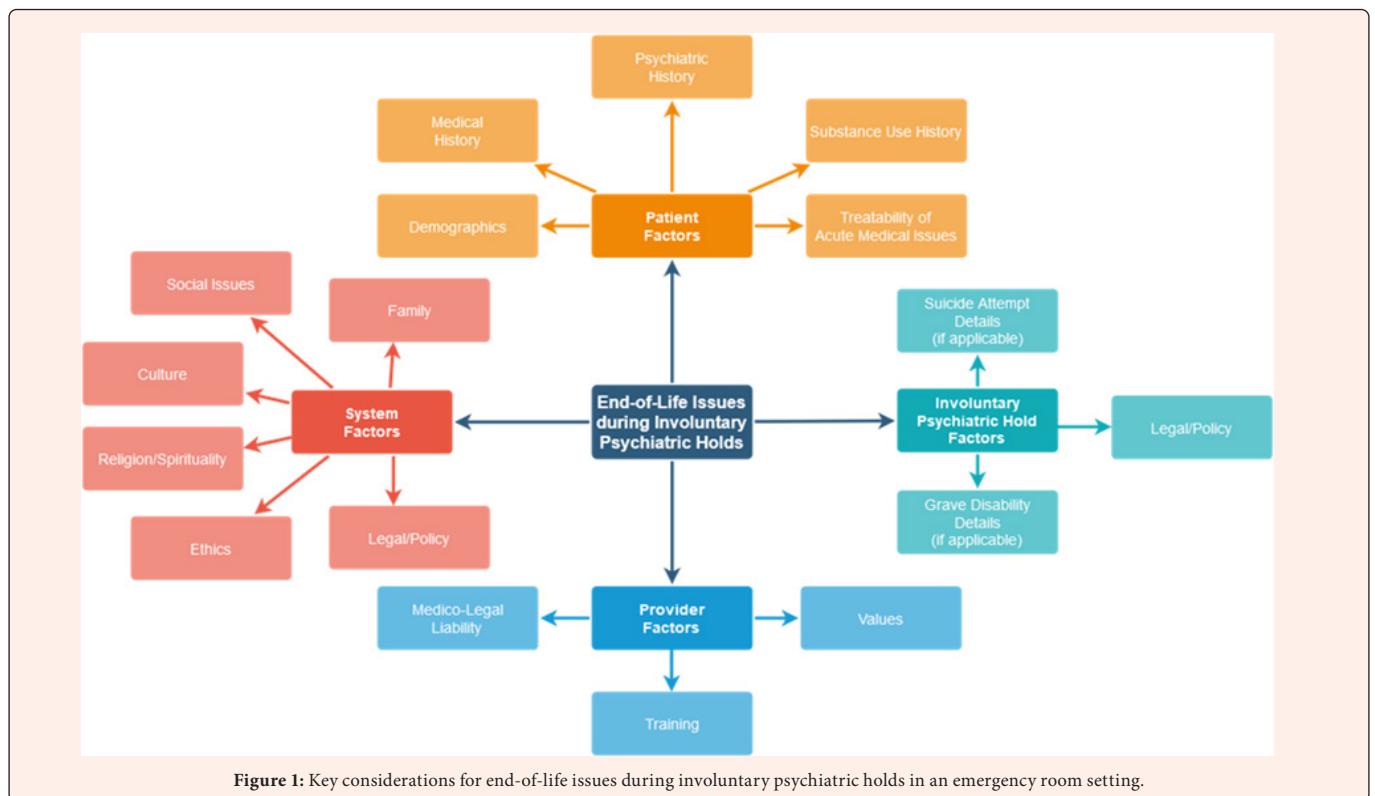


Figure 1: Key considerations for end-of-life issues during involuntary psychiatric holds in an emergency room setting.



We first divide the key factors into 4 categories: patient factors, involuntary psychiatric hold factors, system factors, provider factors. Next, we provide several subcategories for each of the 4 categories. In each subcategory, we then provide examples of questions (Table 1) that emergency clinicians can quickly raise during a multidisciplinary team discussion in a time-sensitive emergency room setting. Finally, in each subcategory, we cite relevant literature to the questions being raised.

Table 1: Examples of questions to raise in a multidisciplinary team discussion in a time-sensitive emergency room setting.

Table with 2 columns: Factor Category and Question. Categories include Patient Factors (Demographics, Medical History, Psychiatric History, Substance Use History, Treatability of Acute Medical Issues), Involuntary Psychiatric Hold Factors (Legal/Policy, Suicide Attempt Details, Grave Disability Details), System Factors (Family, Social Issues, Culture, Religion/Spirituality, Ethics, Legal/Policy), and Provider Factors (Medico-Legal Liability, Training, Values).

Patient Factors

Demographics

What is the patient’s age, gender, and race/ethnicity?

Is the patient an adult (greater than age 18) or a minor (less than age 18)? The court system may need to be involved in cases involving an infant [20]. Depending on the context [21,22], a minor’s views towards end-of-life decisions have been considered by the court system. In an elderly patient [23], a concurrent diagnosis of dementia may complicate the clinical picture and question the patient’s capacity to make their own end-of-life decisions. Race/ethnicity may be another factor in end-of-life decisions. In a study of Advance Medical Directive (AMD) documentation, Caucasians had AMDs significantly documented more frequently than African Americans [24]. In a study of patients in an urban teaching hospital, non-white patients were more likely than white patients to have DNR orders, and patients who spoke fluent English were more likely to be involved in a DNR decision than those who did not [25].



## Medical history

### Does the patient have any underlying medical disorders?

A patient's baseline medical condition may complicate the picture [26-36]. One study found that despite similar prognoses, patients with certain diagnoses (e.g., AIDS, lung cancer) were much more likely to receive DNR orders than those with other diagnoses (e.g., cirrhosis, severe congestive heart failure) [37]. Another study of patients with advanced cancer found that those who were peacefully aware had a higher rate of advanced care planning (e.g., completing DNR orders) than those who were not peacefully aware [38].

## Psychiatric history

### Does the patient have any underlying psychiatric disorders?

Current psychological functioning, past psychiatric history, and past history of suicidal behavior have been found to contribute to DNR decisions [39,40]. Decision making is especially important for patients who are not competent to make their own decisions [41], and psychiatrists are often consulted to help determine a patient's capacity for decision making [42]. Psychiatric disorders, such as major depressive disorder [43-45], intellectual disability [46,47], dementia [48-51], eating disorder [52], and borderline personality disorder [53], can impact the capacity for decision making. Regarding end-of-life decisions, the determination of whether such psychiatric disorders are reversible can be difficult. For example, a qualitative study psychiatrists found that even establishing "irremediable psychiatric suffering" in the context of Medical Assistance in Dying (Maid) can be challenging [54].

## Substance use history

### Does the patient have any underlying alcohol or substance use disorders?

A patient's suicide attempt or grave disability may occur in the context of an alcohol or substance use disorder. For example, if a patient with a chronic alcohol use disorder has an intentional opioid overdose but also has a DNR order, whether naloxone should or should not be given is debatable. Chronic alcohol or substance use may be viewed as medical futility [55], and end-of-life decisions may still need to be made in such scenarios.

## Treatability of acute medical issues

### Is the acute medical issue treatable or reversible? How invasive are the acute interventions that are being proposed? What are all of the facets of acute care that are being proposed?

Is the acute medical issue treatable or reversible, such as an opioid overdose? Or is the acute medical issue irreversible, such as brain death [56,57] or rigor mortis [58]? In a study comparing elderly homebound patients with Congestive Heart Failure (CHF) versus dementia [59], a DNR order was given in 62% of patients with CHF versus 91% of patients with dementia. Also, CHF patients were more likely to have care plans directed at disease modification and treatment, whereas dementia patients were more likely to have care plans that focused on symptom relief and anticipation of dying. How invasive are the interventions that are being proposed? Minor/low-risk or major/high-risk? What are all of the facets of care that are being proposed? Resuscitate, intubate, hospitalize, operate, any treatment, etc.? Whether the decision is to stop all treatment or do maximal treatment (such as CPR), patients themselves may not understand the complexity of orders while they are dealing with the emotional component of a major decision [60] in those critical clinical moments. Thoroughly discussing the intensity of care and proposed interventions at the end-of-life are an important conversation to have with patients [61].

## Involuntary Psychiatric Hold Factors

### Legal/Policy

#### Who initiated the psychiatric hold? Is the psychiatric hold period enough time to make end-of-life decisions?

Who initiated the psychiatric hold for this patient? Was it a psychiatrist, nurse, police officer, relative, friend, clergy, etc.? Mental health state laws significantly vary on who can initiate a psychiatric hold [62]. The validity of the psychiatric hold may be called into question depending on who initiated the psychiatric hold, as the training to initiate a psychiatric hold can vary depending on the individual. Typically, a psychiatric hold is for a 72-hour period. Is this time period enough to make end-of-life decisions? Or is this period too short or too long, depending on the circumstance [63]? For example, Spike [63] argues that a 72-hour waiting period may be too long when a suicide attempt

leads to a "grave condition with no chance of return to a meaningful life", or this waiting period may be too short if a specialist says that an organ system is improving but doesn't know until one waits longer. The time lapse between a suicide attempt and subsequent treatment refusal may be complicated and require involvement of the legal system [64].

## Suicide attempt details (if applicable)

### What are the details of the suicide attempt? Was the suicide attempt impulsive or planned?

What are the details of the suicide attempt, such as the method, level of planning involved in this attempt, number of previous attempts, etc.? Was the suicide attempt planned for a while, or was this an impulsive action? There is debate on the concept that patients who attempt suicide are lacking capacity due to an acute psychiatric illness [17,65,66]. Not every patient who attempts suicide automatically means that the patient can't make rational decisions about their healthcare [14,67].

## Grave disability details (if applicable)

### What are the details of grave disability? Is the decompensation acute or chronic?

What are the details of grave disability? Is the patient dehydrated or malnourished despite being given food, not utilizing clothes despite being given clothes, failing to stay housed despite being given shelter, etc.? Patients may be decompensating from a psychiatric disorder and/or a medical disorder [61,68-71]. A patient's decompensation may also be an acute process (e.g., hours, days, weeks) or a gradual chronic process (e.g., months, years) [16,19].

## System Factors

### Family

#### Does the patient have any family or other surrogate decision-maker?

Is there any family or other surrogate decision-maker for the patient? A patient's spouse, family, or caregiver may have influence over a patient's end-of-life decisions [72-79]. For example, patients with comorbid advanced dementia depend on family surrogates to make end-of-life decisions for them [80]. Family members typically need assistance from healthcare professionals with these types of decisions [81]. One study found that patients who had a family member present at death were more likely to have DNR orders written, to have treatments withdrawn, and to receive narcotics before death [82].

### Social issues

#### Does the patient have any social difficulties?

Does the patient have any social difficulties? Social determinants of mental health include factors such as housing, education, and income [83]. Homelessness [84-87], low education [88], and low socioeconomic status [89-93] can be barriers for adequately addressing end-of-life care issues in patients suffering from these social challenges.

### Culture

#### Does the patient have any cultural preferences?

Does the patient have any cultural preferences? Cultural norms may influence end-of-life decisions. For example, some cultures may view suicide as honorable, whereas other cultures may view suicide as a sin [94]. Asking about a patient's identified culture can help recognize how end-of-life decisions are approached in various cultures [95].

## Religion/spirituality

#### Does the patient have any religious and/or spiritual preferences?

Does the patient have any religious and/or spiritual preferences that may influence end-of-life decisions? Previous literature has found that a patient's spiritual and/or religious beliefs can impact end-of-life decisions [96-98]. A study of young patients with severe developmental disabilities residing in a skilled nursing facility found that interpersonal relationships, such as those with family members, a religious leader, and a physician, were more influential for families who chose full resuscitation compared to those with a DNR preference [99]. A study of oncology inpatients found that the belief that DNR decisions are morally wrong was predicted by certain religious practices, such as near-daily meditation, near-daily thinking about God, and current practice of meditation, and endorsing the statement "My faith sometimes restricts my action." [100]. A study of veterans in their last 7 days of life found that those who received



pastoral care visits were more likely to have DNR orders than those that didn't receive such visits [101]. Another study of patients with advanced cancer found that positive religious coping was associated with a lower rate of having a living will and predicted a higher rate of intensive, life-prolonging care near death [102].

## Ethics

### What ethical principles or debates are at stake?

What ethical principles or debates are at stake? Considering the fundamentals of ethics (autonomy, beneficence, nonmaleficence, justice) and physician responsibility are essential in all of these cases [13,15]. Opinions on what should be done vary widely [103]. Even having advance directives can still involve ethical uncertainties [104-107]. There is debate on whether beneficence overrides patient autonomy in cases of suicide or grave disability [108,109]. There are ethical debates on suicide prevention and rational suicide [12,16,110]. For example, the Vision Zero for Suicide in Sweden [111] has been perceived to be nonconstructive or even counterproductive because of potential conflicts with values and interests of patients and the general public. Thus, consulting the ethics team in one's setting is a critical 1st step for these complex cases [112,113].

## Legal/Policy

### Does the patient have any legal difficulties?

*Does the patient have any legal difficulties?*

*Does the patient have any pre-existing legal documents (e.g., advance directives, conservatorships, POLST)? When were these legal documents certified, and are they still valid? What was the original rationale for these legal documents? Were there any updates since the original rationale?*

*Do any federal, state, county, city, or hospital guidelines give guidance?*

*Does one's professional association give any guidance?*

Does the patient have any legal difficulties? For example, did the patient attempt suicide in the context of being taken into legal custody and then request a DNR in the emergency room setting? Suicide is a significant concern in the custody population [114,115], and the timing of such end-of-life requests should be taken into consideration. Does the patient have any pre-existing legal documents (e.g., advance directives, conservatorships, Physician Orders for Life-Sustaining Treatment [POLST])? [116] When were these legal documents certified, and are they still valid? For example, did the timing of a DNR order occur in the last week, or was it made more than a year ago? What was the original rationale for these legal documents? Were there any updates since the original rationale? If a patient is incapacitated and is awaiting a court-appointed guardian, is there a surrogate decision-maker who can make end-of-life decisions [117]? Even having a DNR tattoo, as reported by Holt et al. [118], can cause initial confusion as to what action to take.

Do any federal, state, county, city, or hospital guidelines give guidance? Different countries may have different perspectives on end-of-life decisions [119-121]. One international study of hemodialysis patients found that the United States of America (USA) had a higher prevalence of DNR orders compared to other countries due to a greater legal and cultural emphasis on patient autonomy [122]. Another study found that Denmark has no national guidelines on DNR orders [123]. Different states may have different perspectives on end-of-life decisions [124-128]. One state-level issue is whether a resident or a non-resident can request physician-assisted suicide in that state. For example, in March 2022, the state of Oregon determined that terminally ill patients seeking physician-assisted death in Oregon are no longer required to be residents of Oregon [129].

Proactively having a policy in one's hospital setting regarding how to address these complicated cases would be highly beneficial [130,131], such as in the psychiatric hospital [132] and veterans hospital [133,134]. Such policies should include when such end-of-life decisions are starting to be discussed or being made [135]. The timing of such decisions includes the prehospital setting (outpatient, nursing home, palliative care, etc.) [136-147], at the time of arrival to the emergency room, upon hospital admission [148,149], during hospitalization [150-153], operating room [154-156], intensive care unit [157-160], or day of death [161]. One study of intentional ivermectin pesticide ingestion found that three patients developed respiratory failure but were not intubated because of a DNR order [162]. One's professional association can also be another source of guidance for these complicated cases [163].

## Provider Factors

### Medico-legal liability

#### What are potential medico-legal concerns of the actions being discussed?

What are potential medico-legal concerns of the actions being discussed? Could one have a lawsuit for potentially saving someone's life [164], such as being sued for wrongful prolongation of life, failing to let a patient die, or providing unwanted treatment as battery? Medico-legal liability concerns include battery, infliction of emotional distress, breach of fiduciary duty, deprivation of constitutional rights, discrimination on the basis of handicap, and contract liability [165,166]. Physicians have been sued for saving a patient's life [19,167-169]. On the other hand, could not saving a patient's life be viewed as being complicit in a patient's suicide attempt [170]? Medico-legal concerns are a concern in these complex cases.

## Training

### What training on end-of-life issues has each team member received?

What training on end-of-life issues has each team member received? Has there been any training at all? Educational initiatives, such as the Objective Structured Clinical Examination (OSCE) at the physician resident level, can be a starting point to educate physicians about end-of-life issues [171,172]. Junior physicians (i.e., house officers) are often involved in the discussion of end-of-life issues and would need adequate training to handle such complicated discussions [173]. A study of practicing Certified Registered Nurse Anesthetists (CRNAs) found that education on proper procedures surrounding a DNR, such as required review of DNR orders, may be necessary [174]. One study found that provider type (e.g., behavioral health provider, medical provider, surgeon) may have different thresholds on questioning treatment decision-making capacity [175].

## Values

### What is each team member's own values towards end-of-life issues?

What are each treatment team member's own values, background, blind spots, and countertransference towards end-of-life issues [176,177]? One study found that a provider's personality characteristics such as self-directedness, cooperativeness, and self-transcendence, showed significant relationships with attitudes underlying end-of-life decisions [178]. Another study found that physicians were more likely to place a DNR order without consent for imminently dying patients [179]. Nurses may have differing opinions on aspects of a DNR than physicians [180-184]. Nurses can especially be helpful to patients in this difficult decision-making process [185,186], and having DNR orders can influence the aggressiveness of nursing care attitudes [187]. Regarding the COVID-19 pandemic, one study in Iran found that healthcare providers' attitude towards DNR implementation in patients with COVID-19 was positive despite a legal ban on DNR implementation in Iran [188].

## Discussion

Making decisions in cases involving patients on involuntary psychiatric holds who have end-of-life orders involves weighing a wide set of factors, including patient, system, and provider factors. This becomes even more challenging in the emergency setting when time is limited, often prohibiting seeking input from other entities that can help guide decision making. Existing literature offers a wide range of interpretations and guidance in these situations, and policies at the government, hospital, and professional association levels vary. As a result, clinicians are likely to find themselves in difficult conundrums with no clear correct or wrong answers. Nonetheless, an analysis of this topic suggests a number of factors to consider in these situations.

Clinicians should examine patient factors including the medical, psychiatric, and substance use history, and treatability of acute medical issues alongside the invasivity and risks of the proposed intervention. The patient's social, cultural, and spiritual context may also help to inform decision-making. The involuntary psychiatric hold should be considered, including the context in which it was initiated, such as the details and timeline of preceding suicide attempt, or the chronicity of grave disability. The end-of-life orders should be examined carefully, including the time and mental state in which they were initiated. Provider factors, such as training in end-of-life issues and personal values toward end-of-life issues will weigh into decision-making and should be recognized in multidisciplinary discussions. Individual providers may also face medico-legal liability for their actions. Clinicians should also identify and involve



other relevant parties that may assist in decision making, including patient's family or surrogate decision-makers, other members of the multidisciplinary team, ethics committees, and health systems legal teams. Clinicians should also look to federal, state, county, city, and hospital policies and professional association recommendations for guidance.

## Conclusion

Directions for future study include surveys of clinician attitudes towards managing patients with end-of-life orders on involuntary psychiatric holds, the prevalence and quality of training on this specific topic, and compilation and analysis of the wide range of policies that exist at various government and health systems levels. On initial examination, it appears that there are few existing policies or guidelines that pertain specifically to the intersection of end-of-life orders and involuntary psychiatric holds, and based on the wide range of views in existing ethics literature, it is likely that any rigid policies would be controversial.

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## Contributors

Dr. Dinh and Dr. Kalapatapu completed the background literature search. Dr. Dinh and Dr. Kalapatapu wrote the 1<sup>st</sup> draft of the article. All authors have approved the final article.

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