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Advance directives: perspective of the multidisciplinary health team

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Abstract

Patients with terminal illnesses often have reduced or no autonomy regarding their end-of-life wishes. This study aimed to identify the meanings attributed to advance directives and living wills among health professionals working in a highly complex general hospital. 21 professionals from multidisciplinary teams were interviewed. In total, four categories emerged from the qualitative analysis of the responses: understanding patient autonomy; professionals' experiences with terminally ill patients and family involvement; the implementation of advance directives in Brazil; and knowledge about living wills. Conflicts were observed among the wishes of patients, families, and the healthcare team, as well as a need for advance care planning and further guidance for professionals.

Keywords: Advance Directives. Autonomy. Health Personnel.

Resumo

Diretivas antecipadas de vontade: perspectiva da equipe multidisciplinar de saúde

Pacientes com doenças terminais têm reduzida ou nenhuma autonomia sobre suas últimas vontades. Este estudo buscou compreender os sentidos e significados atribuídos às diretivas antecipadas de vontade e ao testamento vital entre profissionais de saúde atuantes em um hospital geral de alta complexidade. Foram entrevistados 21 profissionais de equipes multidisciplinares. Da análise qualitativa das respostas emergiram quatro categorias: compreensão da autonomia da vontade do paciente; experiência dos profissionais com pacientes com doenças terminais e envolvimento da família; inserção das diretivas antecipadas de vontade no contexto brasileiro; e conhecimento sobre testamento vital. Foram observados conflitos entre os desejos do paciente, da família e da equipe de saúde, bem como a necessidade de planejar antecipadamente os cuidados e maiores orientações aos profissionais envolvidos.

Palavras-chave: Diretivas antecipadas. Autonomia. Profissionais da saúde.

Resumen

Voluntades anticipadas: perspectiva del equipo multidisciplinario de salud

Los pacientes terminales casi no tienen autonomía sobre sus últimos deseos. Este estudio pretendió comprender los sentidos que atribuyen los profesionales de la salud que actúan en un hospital general de alta complejidad acerca de las voluntades anticipadas y del testamento vital. Las entrevistas contaron con la participación de 21 profesionales de un equipo multidisciplinario. El análisis cualitativo de los datos identificó cuatro categorías: comprensión de la autonomía de la voluntad del paciente; experiencia de los profesionales con pacientes terminales y la implicación de la familia; inserción de directivas anticipadas en Brasil; y conocimiento sobre el testamento vital. Se observaron conflictos entre la voluntad del paciente, la familia y el equipo de salud, así como la necesidad de planificación anticipada de los cuidados y mayor orientación de los profesionales.

Palabras clave: Directivas Anticipadas. Autonomía. Personal de salud.

Research

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Advance directives (AD) and living wills (LW) emerged as a response to technological advancement and the increasing availability of treatments offered to patients with poor prognoses [1]. Advance directives enable any capable person in full use of their mental faculties to determine the health practices to which they wish to be submitted if, in the future, they present an irreversible clinical condition that prevents them from expressing their will [2]. In turn, LW reinforce patient autonomy [3] by defining criteria that enable any lucid person of legal age to establish with their physicians the therapeutic limits in their final phase of life. These optional documents can be prepared at any time and modified or revoked at any time [1].

Health care for patients with end-stage illnesses should ideally be provided by a multidisciplinary health care team [4] composed of various professionals such as physicians, nurses, psychologists, social workers, physical therapists, occupational therapists, and administrative staff (reception, screening, security, and transportation) [5]. According to the Brazilian Hospital Services Company [6], the collaborative approach of a multidisciplinary team aims to improve the quality of life of patients and their families, promoting greater understanding of the disease and what experiences lie ahead.

Although life expectancy has increased significantly in recent years, death is inevitable. In its relentless quest to preserve life, medicine can often fail to offer humanistic practices that support terminally ill patients and their families [7]. Recognizing the limits of life and creating conditions to face them is essential, focusing on relieving the suffering of patients and their families, more than exclusively on preserving life. The dignity of the human person is the basis for sustaining the focus on patient care, especially palliative care [7].

Palliative care promotes the acceptance of the finiteness of life, offering the necessary means to understand and experience this process with the best possible quality. Based on this perspective, death is seen as the natural conclusion of the life cycle. Care practices should prioritize a patients' best interest, respecting their feelings and those of their family by adequate communication between all the involved [8].

Listening and acceptance by professionals are ways of respecting bioethical principles such as beneficence (doing good), non-maleficence (not harming the patient/not causing harm), autonomy (respecting patient desires), and justice (treating patients with dignity and respect), considering the sick individual as the protagonist of their own care [9]. The Federal Constitution of 1988 [10] supports and substantiates bioethical principles by concretizing the principle of the dignity of the human person (title I, art. 1, item III). Moreover, title II, chapter I, art. 5, item III highlights that no one should be subjected to inhuman or undignified treatment [10].

Thus, it is important that healthcare providers are aligned with the purpose of guiding and supporting patients in the final phase of life so that they can experience the process of dying with dignity. This idea is related to the right to a dignified death: to receive care, to have physical and spiritual suffering relieved, and to experience this moment of anguish and sadness surrounded by understanding and respect.

Currently, cultural changes have taken death from the home environment to hospitals, in which patients often die alone, away from their family and friends [11]. With this understanding, the Brazilian Federal Council of Medicine (CFM) published Resolution 1,995/2012 [3], which deals with advance directives as a way to reduce interventions that could prolong suffering. This resolution highlights the importance of advanced health care planning so that individuals' wishes prevail over the interests of family members [3]. Thus, this study aimed to understand the senses and meanings attributed to advance directives and LW by healthcare providers who work in a high-complexity hospital.

Method

This is a descriptive study with a qualitative approach and a convenience sample. The inclusion criteria were being a healthcare provider (nurse, physician, or psychologist) working in a high-complexity teaching hospital with at least one year of experience in the care of terminally ill patients.

The exclusion criteria were being a technician, a professional in training, or a resident physician.

The professionals were invited to participate in their own workplace, in the sectors of palliative care, hemodialysis, oncology, and intensive care unit, with the authorization of their superiors and according to their availability. After receiving explanations about the study, those who agreed to participate were interviewed based on guiding questions:

- What do you understand by autonomy of the patient's will?
- Can you share your experience with terminally ill patients and the involvement of the family in these cases?
- How do you understand the insertion of advance directives in Brazil by CFM Resolution 1,995/2012 [3]?
- Have you ever heard of a living will? If so, would you be able to explain what it is with your words?

Participants' answers were recorded and later transcribed in full by the researcher. After reading the data familiarization, the content coding stage began, grouping it into four categories based on its meaning for a following thematic and comprehensive analysis. Each category included the "statements" or "units of meanings" most representative of participants [12].

The study was approved by the Research Ethics Committee on December 11, 2023. The participants were represented by the letter "P" (Participant), followed by symbolic numbers, unrelated to the order of their "responses" or their professional category, ensuring complete anonymization of the data.

Results and discussion

A total of 21 interviews were conducted at the professionals' workplaces. Data collection took place from February 28, 2024 to June 10, 2024. Participants' data are shown in Table 1.

Most professionals were women with 37.7 years (±8.5) mean age, who were distributed between nurses, physicians, and psychologists. Most reported having a religion. The length of experience in the profession ranged from one to more than 21 years.

Table 1. Characterization of the participants (n=21)

Characteristics	n	Frequency (%)
Sex		
Female	17	80.95
Male	4	19.05
Experience		
From 1 to 5 years	6	28.57
From 6 to 10 years	7	33.33
From 11 to 20 years	5	23.81
Over 21 years	3	14.29
Education		
Master's degree	3	14.29
PhD	2	9.52
Complete higher education	1	4.76
Lato sensu graduate studies	15	71.43
Age		37.7 (±8.5)*
Profession		
Nurse	7	33.33
Physician	7	33.33
Psychologist	7	33.33
Religion		
Yes	20	95.24
No	1	4.76

**mean and standard deviation*

Qualitative data analysis made it possible to group the answers into four categories: 1) professionals' understanding of the autonomy of patients' will according to CFM Resolution 1,995/2012 [3]; 2) experience with terminally ill patients and family involvement; 3) insertion of advance directives in the Brazilian context; and 4) knowledge of healthcare providers about living wills.

Category 1

The data indicated an understanding of the autonomy of patients' will. However, the professionals pointed out the need for

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patients to understand their diagnosis and the available treatments so that autonomy can be effectively exercised.

"I understand that they have the power to decide what kind of treatment they want to be subjected to" (P1).

"Patients have the autonomy to choose which are their (...) wishes (...) We must meet their wishes" (P2).

"Autonomy is when patients are fully aware of the benefits and the risks of their decisions. So, autonomy is patients' will (P4).

"They have to fully understand their condition, the pros, the cons, if it is treatable, if it is not. Then, after the patient knows the whole picture together with the physician, respecting medical ethics, they will decide together with the professional the best treatment path" (P5).

Patients with chronic or terminal illnesses rarely have the opportunity to dialogue with their physicians about the end of life, and the lack of dialogue about death limits the ability to pre-plan advance directives and exercise their autonomy [13]. These data indicate that discussions about the finiteness of existence should occur at the beginning of the disease and involve cultural aspects, family participation, and the challenges to be faced.

Early referral of patients to palliative care can contribute to reducing the fear of abandonment and facilitating early treatment planning. However, the lack of advance directives and the difficulty of initiating dialogue about the end of life still remain frequent challenges. Healthcare providers reported that many patients avoid discussing death and, when the topic is addressed, they are not always able to clearly express their wishes [14].

Thus, if, on the one hand, autonomy brings more dignity and respect to people with terminal illnesses, in practice, the right to self-determination and to advance directives can raise deep controversies as ethical, legal, and religious issues are intertwined in this situation, generating complex dilemmas, especially in situations of extreme suffering and loss of quality of life. The possibility of patients anticipating their wishes for the end of life (including refusing certain treatments) questions the limits of medical intervention [15].

According to the experience of the professionals who participated in this study, there is a lack of knowledge and guidance about advance directives among health teams, patients, and their families, which increases the probability of disrespect for the principle of autonomy.

Category 2

Even when patients make their wishes clear, there may be a conflict between them, the family's ideas, and what the health team considers most appropriate in terms of care.

"There are patients who do not want to undergo treatment but the family determines that the patient will do the treatment" (P8).

"I had a patient who was very, very ill. Several times, she expressed that she didn't want to do the treatment. She was getting very weak. She even expressed it several times: 'I don't want to continue, I don't want to continue'. Even so, the medical team treated her to the end! She had a son who wanted us to do everything under the sun. The doctor always took what the son in greater consideration than what the patient said. So much so that the decision to 'palliate' her went like this. I think a week before she passed away. She was a very lucid patient. She expressed several times: 'I don't want to! I don't want to!'" (P3).

"In fact, patients' desire is often different from their family's or the patient's and the family's desire is different from what the health team desires" (P15).

"In Brazil, palliative care is very recent... I think that health teams are not prepared to address finitude. Then, this process becomes more painful. So, with palliative care we enter into the picture very late in the game. When we are called, very close to the process of dying, it is more difficult for us to act and be able to work" (P1).

The experience of the professionals indicates that the families' will can prevail to the detriment

of patients' wishes, generating conflicts between patients, their families, and health teams. When a life-threatening disease or condition is identified and treatments that can modify its course are implemented, patients should also be referred to palliative care, a measure that also enables a discussion about the future.

Patients are often referred to palliative care only when they are already in the process of dying, being unable to express their wishes about how they would like to be cared for. Thus, the data suggest the relevance of planning health care in advance and point out that the lack of guidance. Moreover, communication among those involved remains one of the biggest problems.

Worldwide, only 14% of patients in need of palliative care receive palliative care [16]. In Brazil, 625,000 people need palliative care, 33,894 children and 591,890 adults. In this context, it should be noted that, following the principles of the National Policy for Specialized Care, the National Palliative Care Policy is articulated with the More Access to Specialists Program, which and strengthens the National Policy for Cancer Prevention and Control.

The National Palliative Care Policy has the following pillars: to integrate this care into the Health Care Network, especially in primary care; promote the improvement of patients' quality of life, ensuring humanized and quality care; provide medications for the safe control of symptoms; promote training, continuing education, and appreciation of professionals who work with palliative care in the Unified Health System; and raise awareness and educate the population about palliative care [17].

Although population aging has led to changes in the incidence and prevalence of chronic non-communicable diseases, access to trained teams to meet the demands of this profile of patients and their families is still critical in Brazil [7,17]. Thus, so all those who need it have access to quality palliative care, education and professional training programs, policies for availability, and access to essential medicines (provided for in the National Policy, which incorporates this type of care into the health system) [4,17] are needed.

Concern about the effectiveness of autonomy in practice exists since family interference compromises a patient's freedom of choice, making decisions about their health often in disagreement with their desires and values. In this sense, when persons have reduced decision-making capacity, their rights may be violated by family imposition, compromising their interests and well-being [18].

Moreover, the disagreement between the desire expressed by individuals and that expressed by their family creates an ethical impasse as the health team is faced with a situation of uncertainty. The difficulty in enforcing patients' real will makes decision-making complex and delicate, requiring a careful analysis of all involved aspects [19].

Ensuring patients' right to express their choices regarding the health care they want to undergo is not always easy. The absence of clear legislation in the Brazilian legal system, added to the possibility of conflicts with the wishes of family members, creates obstacles to the fulfillment of patients' last wishes. It is important to emphasize that the non-observance of the will manifested in life by patients constitutes an affront to their dignity since it can subject them to painful treatments, often incompatible with their values and beliefs and which, in most cases, cause suffering and are considered futile, as they do not offer a solution to the problem [17,20].

In addition to the difficulties related to patients and their families, medicine centered on healing at any cost does not prepare professionals to deal with the finitude of life, which may cause suffering and frustration to physicians. Thus, medical schools must be aligned with bioethical principles to guide and train professionals to deal with death without it representing defeat or disappointment [21].

The effectiveness of palliative care thus becomes fundamental. In contexts in which palliation is not prioritized and the teams do not have the necessary tools, the implementation of this care faces obstacles, such as the lack of knowledge about the guidelines, bioethical and palliative principles and their application, and the absence of institutional protocols and

policies and the scarcity of ethical debates on the subject [22]. In the face of such challenges, this study highlighted the importance of training professionals to deal with death and the dying process.

Communication proved to be a determining factor in the provision of palliative care for its success and for coping with difficulties. Communication skills can transform the experience of dealing with finitude, whereas its lack generates suffering and creates barriers in the relationship between professionals and patients [22].

In this context, there remains a dilemma that transcends the medical sphere and reaches bioethics, exemplified by the decision between starting or suspending hydration and nutrition in terminally ill patients. Understanding the principles that guide this area is essential to offer individualized care, with respect for the patient's autonomy. The consideration of bioethical aspects enables healthcare providers to make more conscious and humanized decisions, aligned with individual values and desires [23].

A recent study found that most healthcare providers do not consult their patients' advance directives in palliative care. Such omission directly affects the quality of care as it prevents individuals' will being respected. Lack of knowledge, inefficient communication, and the absence of clear protocols are some factors that contribute to this reality, putting patients' autonomy and dignity at risk [24].

In summary, medicine needs a profound transformation in its approach to the end of life. The routine of standardized protocols and procedures must be rethought, giving way to more humanized and individualized care. To this end, it is essential to establish an open and transparent dialogue with patients and their families, actively involving them in decisions about the care to be provided so that death, a natural part of life, is addressed with respect, dignity, and attention to individuals' needs [25].

In this sense, advance care planning contributes to improving the experience of patients, family members, and healthcare providers, although the results on the quality of care provided and the health status of sick people remain controversial, requiring more studies to evaluate the death process in cases of terminal illnesses [26].

Category 3

The view of professionals regarding the relevance of advance directives in their practice is also presented:

"Wow! I think it's very, very precarious. The treatment that is most concerned with directives is palliative care. Oncology also has a certain participation, but most other specialties (...) look at the medical side of curative treatment and not much at patients' autonomy. There is a lack of guidance. We are very massified in our medical training for cure. But what we should seek is to care and be cared for. And that it is not what we are taught" (P5).

"Terrible! Because sometimes not all professionals meet these guidelines. Not everyone knows about these guidelines and especially palliative care (...) It is very little talked about. You see? And families do not understand what the guidelines are. It's something that we still have to insist on a lot from academic staff in all health areas and professionals who are already in the area. However, it is still quite scarce. There is a lack of guidance" (P9).

"The lack of legal regulation ends up influencing the non-compliance with advance directives a lot" (P7).

"So, there is still a lot of an idea from doctors that it is just the healing process without looking at patients' quality of life. Patients often don't want to do the treatment, but then they have to do it or they'll die. That goes on a lot. I almost don't see the guidelines" (P8).

"It is extremely necessary (...) talking a little more about patients' rights since graduation. I think that even this legal part is a little lacking in the health area (...) I didn't study that in graduation" (P11).

"I have the feeling that professionals, families of palliative care patients, and sometimes even the patients themselves, still have difficulties

understanding what the directives are about, their importance, and even how therapeutic and careful they can be. It is a discussion that does not reach us. There is a lack of access, a lack of guidance" (P17).

"*The lack of regulation of a law causes a lot of insecurity in professionals. So, there is this 'yes-or-no' thing. So, for sure the lack of law has a great impact on these issues of insecurity of professionals*" (P19).

"*Most patients come to us in a process of death. We are unable to carry out the directives. So, in Brazil it is still... very difficult due to the lack of knowledge of professionals. And another thing, the lack of law that protects professionals causes a lot of insecurity!*" (P2).

"*In Brazil it is very little publicized. Patients are not given this option for patients to choose what will be done with them* (...) *so, the culture of Brazil, the medical culture is mainly to treat. And many times this is not what patients want, they do not feel happy about it. There is a lot of resistance from doctors regarding this*" (P10).

According to the experience of the professionals who participated in this study, there is a lack of knowledge and guidance about advance directives in health teams, patients, and their families, which increases the probability of disrespect for the principle of autonomy. The lack of legal regulation also generates insecurity in compliance with the directives, although some participants pointed to the CFM resolution as a guideline to be followed. In any case, there is difficulty in addressing end-of-life decisions and openly dealing with autonomy, especially in cases of diagnoses with no prospect of cure.

Scientific production on advance directives in Brazil is still scarce, and the lack of consensus in the available information makes it difficult to understand and disseminate them. Thus, it is necessary to carry out more research to further knowledge on the subject and promote debate on its implications. The National Palliative Care Policy helps in this regard as it brings among its innovations the incorporation of advance directives and respect for people's autonomy in decision-making, especially in the case of children or guardians [17,27].

Thus, advance directives and LWs are instruments of support in the face of complex ethical dilemmas [28]. LWs are legal documents that ensure any individual of legal age and in their full capacity the right to decide in advance about the treatments they wish or not to receive if they are unable to make decisions. It is a way to ensure respect for the last wills in situations of life-threatening illnesses [28].

Thus, advance care planning can strengthen and give more security to the performance of the health team, promoting transparent communication and respect for patients' choices. This practice contributes to improving the quality of life of patients and professionals [29].

From this perspective, the concept of a good death, which involves hope, pleasure, and respect for the individual, is directly linked to the advance planning of care. In this context, previously registering the desired end-of-life care provides patients with greater peace, dignity, and respect. Thus, encouraging the early preparation of LW can even improve the quality of the dying process of the involved person [30].

A Brazilian study carried out in 2018 on advance directives with physicians who worked in a hospital context indicated that 77% did not know about them, 13% had heard of them, and 10% recognized the CFM standard but knew that there was no legal regulation until that moment. Therefore, although CFM Resolution 1,995 [3] is from 2012, it is still little known and is not clear to a significant portion of these professionals [31].

Although legislation in several countries recognizes the importance of advance directives and research on the subject indicating its good social acceptance, the preparation of these documents still occurs with low frequency. The divergence between legislation, public opinion, and practice highlights barriers to its effective implementation [32].

Advance directives are valuable tools in palliative care but their use is still limited in many countries, including Brazil. Its effective implementation requires discussion, definition of essential aspects, guarantee of access,

and application. It is essential that society, healthcare providers, and patients are well informed about its importance and benefits [33].

Thus, although considered relevant by the surveyed professionals, the lack of knowledge and guidance about advance directives compromises their effective application and, consequently, the patient's autonomy in choosing a process of finitude based on dignity and respect for their last wishes.

Category 4

Participants' answers regarding LW show ignorance and lack of clarity about the term.

"I've never heard of this term" (P6).

"I don't think I have the technical training to be able to define it. I can't right now" (P7).

"No, I've never heard of it" (P12).

"No. I don't think so. Living will, no" (P17).

"No, I've never heard of it" (P19).

"I have heard of a living will, but I cannot explain what it is (...) *I don't remember what it is"* (P2).

Understanding LW is essential for their correct application in clinical practice, and it is essential that healthcare providers are trained to find the appropriate times to prepare this document and to follow the guidelines described therein. In this sense, continuing education in bioethics is an indispensable investment to ensure that health teams are prepared to deal with the complex issues related to the end of life, ensuring greater safety and dignity for patients [34].

The concept of living wills was born in the United States of America in the 1960s [35]. A milestone was the case of the young American Nancy Cruzan, aged 25 years, who highlighted the debate on the right to a dignified death and the autonomy of patients in their phase of finitude [34]. After a serious car accident, Nancy was left in a vegetative state, unable of any interaction [36]. Faced with the impossibility of her recovery, her family requested the interruption of the feeding and artificial hydration that kept her alive. The hospital refused to grant this request without judicial authorization. Her parents went to court, arguing that their daughter had expressed that she would not want to prolong her life if she was ever in a persistent vegetative state. After a long legal battle, the court authorized the interruption of treatments based on medical evidence and Nancy's previous statements about her wishes regarding the end of life [36].

This case led to a deep reflection on patients' right to refuse useless treatments. Thus, Nancy's story reinforces the importance of preparing a legally valid written document that expresses persons' last wishes regarding their health as a way to guarantee their right to a dignified death.

The increase in longevity of the Brazilian population highlights the need for more discussions about health and death. In this context, it is essential that professionals are trained to address such topics in an ethical and humanized way, ensuring that patients have access to clear and complete information that enables them to make informed decisions about their care [37].

However, some professionals showed some knowledge about LW.

"It is a document that has to be registered in a notary's office. And then we advise the patient to give it to someone in the family or someone close who will ensure that their wishes are considered" (P8).

"I've heard of it. A living will is what the patient chooses for the end of life. So, if they want to stay at home, if they want to stay in a hospital environment, if they want their family, if they want to be alone... whatever they want" (P11).

"I've heard of it. It is a living will about (...) *what makes sense to patients regarding their health, their treatment"* (P14).

"I understand it as a record of an advance directive so it is not just in words but registered while the patients are still live and is (...) *capable of answering question about when they are no longer with us"* (P15).

In this scenario of the finiteness of life, complex ethical challenges in the care of patients are evident. Bioethics can offer support to guide medical decisions and ensure that care respects the dignity, autonomy, and individual values of each person. It is essential to balance prolonging life at any cost and ensuring good quality in the dying process. By integrating bioethical principles into medical practice, healthcare providers can address the ethical challenges inherent in end-of-life care in a more humanized way, prioritizing well-being and respect for patients' choices. An ethical approach ensures more humanized and patient-centered care, reflecting values such as autonomy, beneficence, and dignity [38].

Thus, it is essential to intensify the training of the entire multidisciplinary health team on bioethical principles, making them able to deal with situations related to the end of life. Education in all areas of health should include more in-depth and standardized training in palliative care and the dying process [39].

The data of this study highlight the importance of promoting discussions and developing skills in healthcare providers to deal with the finitude of life since their training. Professionals with the competence to adequately deal with the finiteness of life in their practice can help patients and family members to experience this final phase of the life cycle with a better quality of life.

Final considerations

An adequate dialogue between patients, family members, and healthcare providers about death and patients' right to autonomy requires adequate training of professionals and dissemination of information in society. This topic raises controversies related to the involved ethical, legal, and religious issues, configuring a complex challenge, especially in situations of extreme suffering and loss of quality of life. The data from this study indicate that, in the experience of healthcare providers with patients in severe or terminal stages, the will of family members often prevails. Moreover, there are conflicts between the wishes of families, patients, and professionals. Thus, the discussion about end-of-life care should be started as early as possible, enabling decisions to be made in an aligned way among all. In summary, it is concluded that health education demands a profound transformation in its approach to the end of life. The routine of standardized protocols and procedures should be reviewed, giving way to a more humanized and individualized care, supported by bioethical principles.

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Participation of the authors
Janaína Aparecida de Sales Floriano, Giuliano Citrini Stipkovic, Eudes Quintino de Oliveira Júnior, and Maria Cristina de Oliveira Santos Miyazaki participated in the conception of the study, data collection, analysis and interpretation, and discussion of the results. Neide Aparecida Micelli Domingos, Maria Jaqueline Coelho Pinto, and Homaile Mascarin do Vale participated in the analysis and interpretation of the results, and interpretation of the data. All authors participated in the writing of the manuscript, critical review of the content, approval of the final version, and are responsible for the integrity of the content.

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