Research Article

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End-of-life Care by Nurses in the Emergency Department in Japan: Application of Swanson's Middle Range Theory of Caring

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Abstract

Background: Few studies have focused on the meaning of the relationship among dying patients, their families in deep distress, and the emergency department nurses who support them from a caring perspective. **Aim:** The study aimed to describe the end-of-life care practiced by nurses in the emergency departments using Swanson's middle range theory of caring (SCT) as a theoretical framework and to identify the caring process. Methods: This research used a qualitative descriptive study design. Semistructured interviews using an interview guide were conducted with nine nurses who had worked in emergency nursing for over three years. Data were analyzed qualitatively. **Results:** The end-of-life care process provided by the nurses in the emergency department consisted of five categories: 1) believing that the families can overcome grief, 2) attending to and trying to understand patients and their families, 3) caring for patients and their families, 4) protecting patients and families from threats to their dignity, and 5) encouraging families to recover from grief. These caring processes were facilitated by 1) sharing information and emotions on a daily basis and 2) equipping teams to deliver better care. The caring process led to a change in the family members, who began to rise out of despair and gain the drive to continue emergency nursing care. **Conclusion:** Caring can be established in the emergency department, where relationships between patients and healthcare professionals are considered difficult to establish. End-of-life care in the emergency department provides spiritual healing for both family members and nurses through a five-step caring process.

Introduction

In Japan, 1.5% of patients transported to the emergency room are confirmed dead on arrival, and critically ill patients, who account for 10%, include those who die during treatment [1]. In many cases, emergency departments aim to save lives but fail to do so, and patients are immediately transferred to end-of-life care. End-of-life care in the emergency department is defined as care provided beginning at the time of presentation or at the end of active treatment in the emergency department and continuing until the patient's death in the same setting. Moreover, end-of-life care is provided in the same way as active treatment in interprofessional collaborative practice, with the aim of improving comfort and maintaining dignity [2,3]. The role of nurses in emergency care includes practices such as holistic distress relief, grief care and decision support [4]. Organizations are also expected to promote team medicine and organizational structures to ensure that high-quality care is delivered [4].

The aim of end-of-life care is to improve the comfort and maintain the dignity of patients and their families; patients and their families require support to relieve them of avoidable suffering [5,6]. However, emergency department nurses experience many conflicts and practice difficulties in family support and decision support [7-10]. Based on these experiences, it has been reported that some nurses believe that the emergency department is unable to provide the optimal care needed to achieve these aims and goals [8,11]. This has been attributed to the fact that in the emergency department, there is less time than in wards to build relationships among patients, families and healthcare professionals. This is because treatment is the first priority to save lives and reduce complications [5,6], making it more difficult to build trust [12,13]. Furthermore, in Japan, the lack of widespread use of advance care planning (ACP) [14,15] throughout society contributes to the difficulties and conflicts that nurses in the emergency department face in practice. Traditional Japanese values of death [15], which is considered anathema, are said to impede "the process by which patients discuss and clarify their goals and preferences for future medical treatment and care with their families and healthcare professionals" [14]. Therefore, having family members who are not fully aware of the patient's wishes is considered to be a factor that hinders the provision of quality end-of-life care, as the less trusting the family-patient relationship is, the more difficult end-of-life care becomes.

Thus, it is clear that emergency department nurses practice end-of-life care in an interactive relationship with patients and their families while facing various difficulties. However, the meaning they bring through their interactions with patients, families and professionals has not been explored, not only in Japan but also globally. In other words, end-of-life care in the emergency department has not yet been examined in terms of 'caring' [16], a central concept in nursing. In contrast, it remains ambiguous whether caring can be established in the emergency department. We therefore focused on Swanson's middle range theory of caring (SCT) [17,18] among the many theories of caring that have been published. Swanson [17,18] defined caring as "a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility." The five caring processes outlined in SCT [17,18] are maintaining belief, knowing, being with, doing for, and enabling. Swanson [17,18] suggested that healing is brought about when this process is followed. We could not find previous studies that applied SCT to the practice of end-of-life care in the emergency department. However, considering the theoretical basis of SCT [17,18], which was developed based on family members who have experienced loss, it is highly likely that the end-of-life care practiced by emergency nurses can be analyzed using SCT to appropriately identify the caring process. As a result, we hope to provide new insights into caring as practiced by emergency nurses.

Aim

The aim of this study was to describe the end-of-life care practiced by nurses in the emergency department using SCT as a theoretical framework and to identify the caring process.

Definition of terms

Based on the definitions in the SCT [17,18], the five concepts included in the caring process are defined as follows:

Maintaining belief: Maintaining belief is the ability to sustain faith in the other, recognizing that the other has it in them to come through an event or transition and face a future with meaning.

Knowing: Knowing is striving to understand the meaning of an event in the life of the other, avoiding assumptions, focusing on the person cared for, seeking cues, assessing meticulously, and engaging both the one caring and the one cared for in the process of knowing.

Being with: Being with means being emotionally present to the other. It includes being there in person, conveying availability, and sharing feelings without burdening the one cared for.

Doing for: Doing for means to do for others what one would do for self if at all possible, including anticipating needs, comforting, performing skillfully and competently, and protecting the one cared for while preserving his or her dignity.

Enabling: Providing the information, support, and validation necessary to facilitate the other's capacity to get through an event or transition.

Materials and Methods

Research design

Qualitative descriptive research design.

Selection of participants

The survey request was made to nursing directors of two tertiary emergency care facilities that provide emergency care to critically ill patients such as those with myocardial infarction, stroke and head trauma. The participants comprised nurses who had been involved in emergency nursing for at least three years and who had experience in end-of-life nursing. Permission to conduct the study was received from one facility. Nine candidates who met the criteria to be potential study participants were recommended by the director of nursing at that facility.

Data collection methods

The study was conducted between September and December of 2022. The cooperation request form written about objectives and ethical considerations was distributed to the candidates in advance, and a date and time convenient for the candidates was

arranged. The research objectives and ethical considerations were reiterated to the candidates by the researcher on the day of the interview, and written voluntary consent to participate in the study was obtained from all nine candidates. No candidate withdrew from participation during or after the interview.

Semistructured interviews were conducted face-to-face in a private room in the healthcare facility where the participants worked. The interviews were conducted by one researcher with a Ph.D. and clinical experience, including in operating nursing, and experience in conducting qualitative research. The researcher had no conflicts of interest with the research participants and conducted the interviews in a neutral capacity.

The interview guide was placed first, with 'What are the attractions in emergency nursing?' as an introduction. Then, based on the narrative flow, the following questions were asked: 'Are there any situations (including patients and their families) that have left an impression on you about end-of-life care in emergency nursing? ', 'Please tell us what the situation (the person) was like', 'How did you act at that time', 'How did you feel at that time', 'What did you feel at that time?', 'What did the staff who were with the family member do?'. The questions were designed to elicit the facts and actions that occurred during care and the mental movements, awareness and thoughts, including emotions, that arose during the process. The interview guide was used in preliminary interviews with nurses with experience in emergency nursing practice, and a modified version was used as the final version.

When the interviews were conducted, no literature exploring the theoretical basis of SCT regarding end-of-life care provided by nurses in the emergency department was available. As new concepts other than the five processes described by Swanson [17,18] may be extracted from the interviews, it was decided to focus on the nurses' experiences in the interviews and to elicit aspects of the whole experience.

In principle, one interview per person was conducted. However, in cases where the researchers did not agree on the interpretation of the results, additional interviews were conducted to increase the validity of the analysis. The content was recorded using a voice recorder with the consent of the participants.

Data analysis methods

All interviews were transcribed verbatim and read and reread carefully to extract meaningful units. We formulated codes from meaning units, including carefully reflecting on the transcripts. The codes were classified into the five concepts of SCT [17,18]: maintaining belief, knowing being with, doing for, enabling and other groups.

The data within each grouping were analyzed inductively and subcategorized according to the similarities and differences identified. We then categorized these data. The extracted categories were structured based on Swanson's theory of caring and healing [18].

Throughout the data analysis process, another research member reviewed and discussed the emerging content to verify that it was congruent with the expressed transcripts of the participant according to the research questions to ensure trustworthiness [19]. The validity of the qualitative data was enhanced through triangulation by checking relevant previous articles, disconfirming evidence, and peer review [20]. and then organizing the codes into categories. Data saturation was assessed by reviewing the coding applied to participant interviews until no new analytical points were found [21] and consensus was reached among the research team [22]. The Consolidated Criteria for Reporting Qualitative Research [23] reporting guidelines were used in both the framing and reporting of this study to guarantee that sufficient details regarding the methods of data collection, analysis and interpretation were provided.

Ethical considerations

This study was conducted after obtaining approval from the Ethical Review Committee of the university to which the researcher belongs (approval number 2022-74, approval date 22. June.2022). The purpose of the study, research methods, the voluntary nature of participation, confidentiality issues, and plans for the publication findings were explained to the participants in writing and verbally before obtaining their written consent to participate in the interview survey.

Results

Summary of study participants

The study participants were nine nurses from one facility, with an average of 13.4 years of clinical experience (range years 10-18) and 8.4 years of emergency nursing experience (range years 3-18). Of these, one was a nurse in a managerial position and two were certified nurses who had passed the Japan Nursing Association review and were recognized as having skilled nursing skills and knowledge.

Generally, one interview was conducted per person. However, a second interview was conducted with consent for the three participants for whom the validity of the interpretation of the results was deemed to require confirmation by the research participant. The interviewers were 54 minutes in length on average.

End-of-life care process by emergency nurses

After organizing and analyzing the narratives of the emergency nurses, five categories were identified that form the end-of-life care processes in the emergency department (Table 1). In addition,

two categories were extracted as facilitating the caring processes (Table 2), and two categories as outcomes brought about by caring (Table 3). The categories are outlined below, with the categories indicated by [ ], the narratives in "*italics,*" and the participants and codes in parentheses ( ).

Theme: Maintaining belief

[Believing that families can overcome grief]

The nurses believed that even families who were intensely upset by the unexpected and sudden death of a loved one had the potential to overcome their suffering during the rest of their lives. The nurses also saw the passage of time as necessary to overcome grief.

"I try to get involved with people who are distraught or angry, believing that there will be a time in the future when they will be able to look back." (ID 5)

"In the future, as time goes on, there will be a clearing of the mind and a resolution. Even if it is not possible in the emergency room, the family can always recover with the help of time." (ID 8)

Theme: Knowing

[Attending to and trying to understand patients and their families].

When the nurses first met patients and their families in the emergency department, they observed them carefully and tried to understand their lives and the anguish of their families. In this process, the nurses identified the personhood of the patient without being judgmental and used all five senses to gather information about the subject and to relate and interpret it.

"Some family members are on the floor and can't get up. Painful, sad, words surely cannot express it." (ID 2)

"My eyes are on the patient and my ears are listening to what the doctor is saying at the same time. Don't miss the patient. I also see the expression on the family member's face when they come in. All necessary information." (ID 5)

"If the patient had nails, did she like them? we ask the family. If we don't ask, we don't know anything about the patient. We talk about as many things as possible, and from the information we gather; we get closer to the real and inner life of the patient" (ID 5).

Theme: Being with

[Caring for patients and their families].

Patients and families are important to nurses. As such, the nurses were always concerned about the presence of patients and their families, not only when they were in contact with them but also when caring for other patients and their families, and they sought to provide care that was tailored to each individual.

"The deceased patient is one of the most important patients." (ID 9)

"There are other patients there, so I can't just stay with that patient. But even when I am away, I care about the patient and their families who are there." (ID9)

"Should I speak to them or not? If I do, what kind of words should I say? It's probably different for everyone, so I'm very worried every time. But we must not run away from it" (ID 8)

"Rubbing your back, even if there are no words." (ID 9)

Theme: Doing for

[Protecting patients and families from threats to their dignity].

The nurses consistently provided care that protected the dignity of patients and their families. For deceased patients, the nurses restored the person they had been before their death through meticulous care, such as reducing exposure during care so that they were not visible to others, while also covering wounds and cleaning up bodily fluids.

"If there was a lot of blood in the hair, we would wash it out and prepare it. Cleaning even the parts you can't see is the last care a nurse can give to a patient" (ID 3).

"To help them regain a little bit of their personality, like wearing lipstick in the color they liked" (ID 3).

Families facing sudden death are also under great stress and are at risk of accidents such as shaking and falling.

Therefore, the nurses did not fail to take care to protect the safety of the family. At the same time, the nurses created a time and space where the family and the deceased could be together without having to worry about the eyes of other patients, family members or medical staff.

"If a family member gets upset and falls or falls and bumps his head or falls on his buttocks, neither the patient nor the family can go home. We have to be careful about that kind of thing." (ID 4)

"I take care to keep them out of other people's sight, so that the family can touch and talk to the patient." (ID 4)

Theme: Enabling

[Encouraging families to recover from grief].

To help families take steps to overcome their grief, the nurses in the emergency department put the family first and worked with families and professionals in the limited time available.

"When I can tell that the family member has worked hard to take care of the patient, I say something to the family to thank them for all their hard work so far. This is the last time the patient's family member will be involved with a nurse. If they go home and there's

no one to acknowledge how hard they've worked, or how much they've done, they might not be able to get back on their feet. I try to get involved with that in mind." (ID 5)

"Sometimes doctors and I have different opinions and values. The role of the nurse is to facilitate the sharing of these, to put the patient and family first and to make sure that the opinions are put together properly" (ID 8).

"I tell the funeral director to be careful when turning the body around, such as changing the patient's clothes, as there is a fair chance of blood coming out." (ID 8)

Theme: Category   Subcategory

Maintaining belief: Believing that families can overcome grief
     1.   Believing that each family member has potential power.
     2.   Believing that time heals families.

Knowing: **Attending to and trying to understand patients and their families**
     1.   Understanding and accepting the distress of the family
     2.   Capturing the patient's life by connecting the information obtained

Being with: Caring for the patients and their families
     1.   Recognizing patients and their families as important.
     2.   Spending time with families facing distress without running away from them.

Doing for: Protecting patients and families from threats to their dignity
     1.   Restoring the patient's sense of self.
     2.   Creating a place where the family can be together with the patient without putting them at risk.

Enabling: Encouraging families to recover from grief
     1.   Sending a message that we care about the patients and their families.
     2.   Adjusting care based on the future life of the family.

Table 1: Categories of end-of-life care processes by emergency nurses.

Factors facilitating the caring processes (Table 2)

[Sharing information and emotions on a daily basis].

The nurses in the emergency department actively spoke to other staff and took care to maintain a positive atmosphere in the workplace. The nurses also shared not only information but also the events of the day and feelings they had with other staff members in an environment of mutual empathy. This mutual consideration and trust led to the emotional stability of individual staff members and created a care team.

"It's like all the nurses share everything. It's a small group, so we all talk about the patient or the family member or whatever they said this or that, and we share the information. We talk to each other. Not at conferences or formal occasions, but all the time." (ID 4)

"If I talk to them myself, the doctors talk to me. If we have a bad attitude, they will have a bad attitude too. So you have to talk to them, even if it's just a small thing. If you don't have a good relationship with them, it will affect patient care. So the working environment is very important." (ID 4)

"Even if the problem itself doesn't go away, nurses can empathize with each other, so when we say it, it makes it feel better." (ID 1)

[Equipping teams to deliver better care].

The nurses were not satisfied with the status quo and continued to develop as individuals and as an organization to provide the best possible care to patients and their families. This category was a prominent statement made by nurses with certified nursing qualifications (ID 4, 5) and those in managerial positions (ID 8), where the nursing profession's initiative and daily commitment led to the team providing the best possible care to patients and their families.

"If we don't do it, nobody can help. So I do my best to update my knowledge and skills so that I can help and give good care. Also, it's no good if I can only do it myself, so how to create an environment that enhances our strength as a team is also an issue." (ID 5)

"I broaden my horizons by talking to different people to see if there is such a way of thinking. This can sometimes clear up doubts and make sense." (ID 4)

"Nurses are not just people who work under the direction of a doctor. There is a doctor's diagnosis, and beyond that, what can we do as nurses for patients and their families? Other people can do the work, but I want to think about what only nurses can do and care for, and put that into practice." (ID 4)

Category
Subcategory
Sharing information and emotions on a daily basis
1. Talking to each other and sharing information
2. Sharing events and feelings with other nurses during the day.
Equipping teams to deliver better care
1. Updating on the knowledge and skills in the whole team.
2. Learning through exposure to different opinions and values.
3. Reflecting on what we can do as a nurse in the emergency department.

Table 2: Categories of factors facilitating the caring processes.

Outcomes of caring (Table 3)

[Families beginning to rise out of despair].

The nurses observed the change in the family members, who were confused and deeply distressed by the sudden death of the patient, as they understood the reality of the situation and their speech, behavior and facial expressions became calmer during the few hours they spent in the emergency department.

"The more unexpected the death is, the more the family is thrown down to the bottom of the pit and just stunned or breaks down in tears. But then, as time goes by, with the doctors and nurses explaining things to them, their expressions and the words that come out clearly change. It's only for a couple of hours. That's the power of the family." (ID 8)

"Even if everyone is distraught, one such person will say, 'I have to send my family to heaven properly; I have to be strong myself'" (ID 5)." (ID 5)

[Nurses gaining the drive to stay involved in emergency nursing]

The team was intended to save the patient, so the nurses felt disappointed when they could not. However, the nurses did not let it end there, and by reflecting on their involvement, they gained lessons and rewards that they could apply to future care. These were reiterated as the significance of the nurses' inclusion in the professional team in the emergency department.

"I'm sorry I couldn't help you. I'm sorry I couldn't do anything. I apologize in my heart to the patient. And I promise I'll make the most of it next time." (ID 8)

"Sometimes I think I could have done something more. I look back on these things in my mind every time. I try to sort out how to respond to the situation, and if I feel the same way next time, I think, 'I'll do this' or 'I'll have it in order.' Then I study and update it in my own way." (ID 5)

"There is a role in the emergency department that doctors cannot do, only nurses can do." (ID 5)

Category
Subcategory
Families beginning to rise out of despair
1. Understanding the patient's death and regaining composure with time.
2. Developing a sense of responsibility as a family member.
Nurses gaining the drive to stay involved in emergency nursing
1. Promising patients that we will make efforts to save lives.
2. Reflecting on one's involvement and learning lessons as a nurse.
3. Realizing what it means for nurses to be present in the emergency department.

Table 3: Categories of outcomes of caring.

The processes of caring and healing structures in the emergency department (Figure 1)

The categories identified in this study were sequential and could be organized as a series of processes. Central to the caring process was the nurses' belief that grief could be overcome by the family. To facilitate recovery from grief that had just begun, the nurses took the first step of paying attention to the subject and used the information obtained to be with and for others, providing a layer of support. This resulted in positive changes for both the family and the nurses.
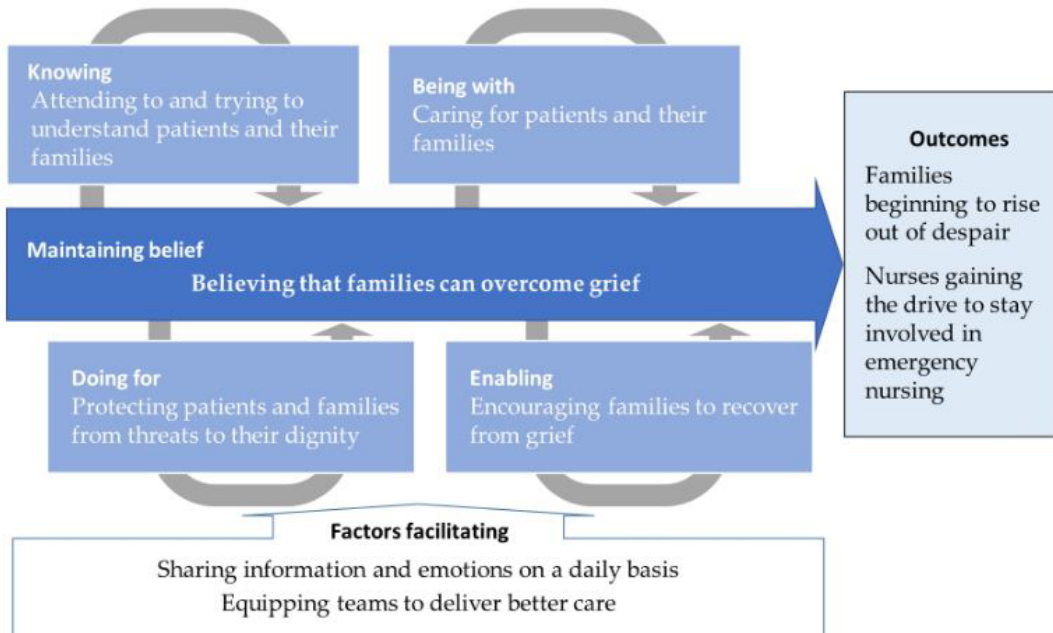
Figure based on Swanson Caring Theory[18]).

Figure 1: End of life care processes by nurses in the emergency department.

Discussion

This study used SCT [17,18] to describe the end-of-life care emergency that nurses provide and showed that caring can be established in the emergency department. Specifically, the results showed that the caring process provided psychological stability for both the family and the nurses. Describing the caring process also yielded two secondary outcomes. First holistic distress relief, decision support and grief care [4] were interrelated as roles of end-of-life nurses in emergency care. Second, factors facilitating the caring process were demonstrated.

The end-of-life care practices described by the participants included family-centered support for grieving, decision-making, etc [4], and nurses faced conflicts and difficulties [7,10] in the support process. These results are consistent with those of previous studies. Unlike wards, it is difficult to engage continuously with patients and their families in the emergency department, and with the added time constraints of an outpatient setting [12,13], it is difficult to obtain information about the life history, attitudes and values of the patient and family. It is also not easy to develop a mutual relationship during just a few hours of involvement [12,13]. These factors made family support in the emergency department difficult.

However, it was the nurses' beliefs and belief-based care that overcame the difficulties of end-of-life care in the emergency department. Families in turmoil and distress often have difficulty controlling their emotions, such as becoming aggressive toward others. Nurses have been reported to behave toward such families by hesitating to engage, avoiding dialog and distancing themselves [12]. In contrast, the participants were interested in the family members who exposed extreme emotions and were meeting them for the first time, trying to identify their different individual needs and support them according to their needs. These attitudes, which could be seen as symbolic of the nurse's ethics and tenacity, could be interpreted as stemming from the belief that all families have the capacity to overcome deep distress and that nursing's role is to draw out this capacity. Furthermore, the nurses kept the family safe and talked to the patient, providing care that restored the patient's peace of mind. The steps of nurses' involvement led to care that maintained the patient's dignity after death and at the same time had an aspect of emotional support and grief care [24] that involved listening to the family's grief, suffering and thoughts. The results showed that the family members were able to face the reality of death in the midst of their anguish and regain a degree of calmness that allowed them to say goodbye to the patient.

The caring process in the emergency department had a positive outcome for nurses in that it gave them the impetus to continue emergency nursing. In other words, caring was again shown to bring healing to both clients and care providers [16-18]. The changes in families in the emergency department described

earlier represent a step forward in moving beyond grief and can be seen as the result of emergency department nurses' success in drawing out the family's latent strengths needed to recover from grief. The nurses justifiably evaluated these processes and outcomes as achievements of nursing in the emergency department, which can be interpreted as having led to a sense of confidence and pride as nurses and a sense of the meaning of the nurses' presence in the emergency department. At the same time, the nurses' belief in the potential power of the family was considered to be unwavering and firm, leading to a virtuous cycle of providing consistent care based on belief. As the study participants had an average of over eight years of emergency nursing experience, the lessons learned and outcomes from the caring process could also have provided the basis for continued emergency room nursing.

The study also showed that factors facilitating the caring process included an organizational culture of sharing information and feelings and development as an organization, which may have acted to calm the negative emotions of nurses facing difficulties and conflicts. In addition, nurses with managerial and accreditation qualifications were notable for their behavior in terms of organizational development, as well as for their advanced nursing practice, which served as a model for other nurses, including the coordination of opinions with other professionals. Such advanced nursing practice is thought to have led to a deepening of partnership [25,26], in which nurses deal with difficulties not only individually but also as a team. From these findings, it can be seen that the facilitators of the caring process shown in this study are essential factors for the development of a team that provides the best possible healthcare for patients and their families.

In summary, this study has identified processes and facilitators of caring in end-of-life care in the emergency department. On the other hand, relying solely on the beliefs and practices of nurses in the emergency department may limit the quality of end-of-life care. The challenges Japan faces in disseminating ACP [26] are presumed to be factors that inhibit the caring process. Before emergency care is needed, it is necessary for patients, families and healthcare professionals to widely share their ideas and values. This would further facilitate the family's recovery from grief.

Limitations and strengths of this study

Caring is established between the nurse and the patient receiving care and between the nurse and the professionals working together. However, the focus of this study was limited to nurses in the emergency department and did not include family members or other professionals receiving care. Although there are significant ethical challenges in exploring caring in end-of-life settings in the emergency department, including patients and their families, the approach to bereaved families, and additional research with other professionals will allow us to test the validity of the findings of the present study from multiple perspectives. The study also has

the potential to identify new aspects of the caring process and the outcomes of caring.

This study included nine nurses from one institution. Although data saturation was determined by reviewing the coding until no new points of analysis could be found, and an agreement could be reached among the researchers, the effect of facility characteristics cannot be denied. Therefore, the scope of the study should be expanded to include nurses from other facilities, and the validity of the analysis should continue to be examined. In additional research, semi-structured interviews are required to expand on this study and take into account the categories that make up SCT. This would allow for a clearer picture of the caring process in the emergency department.

Despite these limitations, this study is unique in that it uses SCT as theoretical framework to verbalize the end-of-life caregiving process based on the direct narratives of emergency nurses. Furthermore, it demonstrates that caring can be established in the emergency department even when patients, families and nurses have never met, have a tenuous relationship or interact for only a short period of time, which is an encouraging finding for emergency department nurses.

Conclusions

The caring process in the end-of-life outpatient emergency department had five aspects: believing that families can overcome grief, attending to and trying to understand patients and their families, caring for patients and their families, protecting patients and families from threats to their dignity, and encouraging families to recover from grief. These five caring processes were shown to be facilitated by organizational developments, such as daily sharing of information and emotions among staff and preparing the team to provide better care. It was also found that the caring processes resulted in empowering families in their grief and encouraging nurses to continue emergency nursing.

Author Contributions

Conceptualization, J.S..; methodology, J.S.; investigation, J.S.; data curation, J.S.; writing-original draft preparation, J.S.; writing—review and editing, J.S., C.U, and Y.M.; visualization, J.S., C.U, and Y.M.; supervision, Y.M.; project administration, J.S. All authors have read and agreed to the published version of the manuscript.

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Institutional Review Board Statement

The study was conducted in accordance with the Declaration of Helsinki and approved by the Institutional Review Board of

Yamagata University (protocol code 2022-74, approval date 22. June.2022).

Informed Consent Statement

Informed consent was obtained from all subjects involved in the study.

Data Availability Statement

The data used in this study are not open to other researchers at this time.

Conflicts of Interest

The authors declare no conflict of interest.

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