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Original Article

Card game intervention to train healthcare professionals in advanced care planning for older adults: A holistic case study from Italy

Eleonora Taberna[1], Giovanna Artioli[2], Carlo Peruselli[3], Marta Perin[4], Silvia Tanzi[5]

[1]Fondazione FARO ETS, Tourin, Italy; [2]Department of Medicine and Surgery, University of Parma, Parma, Italy; [3]Former President of Italian Society Palliative Care (SICP), Italy; [4]Legal Medicine and Bioethics, Azienda USL-IRCCS di Reggio Emilia, Reggio Emilia, Italy; [5]Palliative Care Unit, Azienda USL-IRCCS di Reggio Emilia, Reggio Emilia, Italy.

Abstract. *Background and aim:* Advance care planning (ACP) promotes patient-centered care by aligning future healthcare choices with patients' values and preferences. Gamification may be a promising method to introduce ACP. This article describes a multi-component and experiential training program based on the use of a Card-Game inspired by the Go Wish Game, targeting HPs working with older adults living with frailty. *Methods:* We adopted a single, holistic case study with data triangulation. Data were collected by focus groups (FGs), field notes, and card-game form before and after the training. Data were thematically analyzed and triangulated. Data collected before and after the training were compared to identify the difference in meaning that professionals attribute to the use of the game and the activation of conversations on ACP. *Results:* At the end of the gaming session, clinicians wrote field notes and completed 9 card-games forms; 2 FG were performed (one before and one after the gaming session). Data analysis highlighted three main themes: 1) performing the card-game in clinical practice, 2) barriers to the card-game application, and 3) the card-game and ACP implementation. The ACP course based on gamification eases the use of card-game in clinical practice to start conversations on values and preferences with older persons and caregivers. *Conclusions*: Our results might offer grounds for further studies aiming to evaluate the training's effectiveness in terms of the increment of the participants' competencies towards ACP, using card-game. (www.actabiomedica.it)

Key words: advance care planning, older adults, training evaluation, card game intervention, healthcare training, cognitive decline, healthcare professionals, italy case study, geriatric care innovation

Introduction

Advance Care Planning (ACP) is a continuous communicative process that allows patients to discuss and share their values and preferences on healthcare treatments and often End of Life (EOL) decisions, define their goals with relatives and physicians, and record and review these preferences if appropriate (1,2). It is essential to understand in advance what older people expect from their approaching EoL care and attention (3). ACP for persons with cognitive impairment can promote patient-centered care by aligning future healthcare with older persons' values, goals, and preferences with a high degree of accuracy and reliability, which is essential for older persons living with frailty (4,5). Despite many older adults wishing to remain in charge of the decisions about their care, and many efforts have been implemented to improve it, the number of older adults who have ACPs remains low (6,7). Various factors hinder ACP implementation, especially with older people with cognitive impairment and their family carers (8-10). These factors concern

the rare documentation of frailty (11), difficulties of the person to understand what ACP is and why it may be relevant to them (12,13), the progressive reduction of decision-making capacity along with the risk of developing a form of dementia (14,15). Struggles of the HPs to implement shared decision-making have been associated with a lower likelihood of providing ACP (12). Consequently, compared to other populations, frail older people are exposed to a higher risk of receiving poor EoL (16). In 2023, an international consensus defined ACP in older people with Cognitive Impairment or dementia as a communication process adapted to the person's capacity, which includes, and is continued with, family if available (17). There is emerging evidence that older people living with early-stage and mild dementia can effectively participate in identifying and expressing their values and wishes for future care, and an important role is entrusted to their families (5,18). In Italy, ACP was regulated in 2017 by the law n.219 on informed consent and Advance Directives (19). Few studies in Italy have addressed the ACP and have done so in specific pathological conditions, such as psychiatric disorders and dementia (20), multiple sclerosis (21), and heart failure persons (22). Since the enactment of the law, geriatricians and nurses have emphasized the need for specific training focused on communication and ethical skills needed to start and carry on the complexities of EoL and ease the implementation of ACP with their patients (23,24). According to the literature, effective ACP training programs require a combination of decision aids, instructional sessions with role play, and training content focused on ACP communication skills (25). The incorporation of dialog skills in shared decision-making to develop care that focuses on patient values has also been required (26). A recent systematic review showed that gamification may be a promising method to introduce ACP, as it creates a safe environment to discuss sensitive topics via gaming elements, such as card games. Moreover, gamification in ACP can increase self-efficacy, readiness, and knowledge of ACP behaviors and facilitate frank discussions regarding EoL issues (27,28). However, to our knowledge, there are few experiences with the use of gamification in ACP training programs (25,26, 29), and no one has been conducted specifically with geriatricians dealing with frail older people living with cognitive impairment. To this end, the Palliative Care Unit of the Local Health Authority (LHA) of Reggio Emilia, promoted an experiential training program on ACP dedicated to all the HPs working with frail older people at the six Memory Clinics of the same LHA. The program incorporates a 'gamification session' that consists of the use of a card game by HPs as a tool to start conversations on care preferences and values with their patients and, eventually, their families.

Materials and methods

This study aimed to describe the experience of using a card-game as a tool to facilitate discussion on ACP for HPs working with frail older persons, before and after the training program. The research question was: How did geriatricians perceive the use of training based on a gamification tool in introducing the conversation about ACP in older patients with frailty and how to use Card-game?

Study design

We adopted a single, holistic case study (30) using triangulation of data collected by (i) focus group (FG) before and after the gamification session, (ii) field notes collected during the Card-game application in clinical practice, and (iii) a gaming report form provided by HPs at the end of the gaming session. A single, holistic case study is used in situations where there is interdependency between the intervention and its context (31), a methodology that is strongly recommended for complex interventions in healthcare and palliative care (32,33). The advantages of case study research include its ability to investigate complex social phenomena and to handle dense data (34). The interplay between intervention (gamification training,) its context (applying gamification in geriatric practice,) and the complexity of intervention led us to choose the case study methodology as the most appropriate. This single holistic case study was reported according to the University of York Centre for Reviews and Dissemination's reporting standards for organizational case studies (35,36).

Case definition

The case was defined as the intensive ACP training program, which includes different educational methodologies according to previous educational experiences conducted with the Palliative care Unit team (37-39), addressed to a group of healthcare professionals working with frail older populations, living with cognitive impairment. The training was preceded by a Focus Group (FG) at T0 with HPs to collect the trainees' needs regarding ACP and its application and to develop the educational intervention accordingly. The final program was developed into 3 components (two theoretical lessons, an experiential learning session by role-play, and a final gamification session,) subdivided into a total of 5 months, as described in Table 1.

Along with the training, we conducted two FGs among the course's participants, before and after the gaming session, to get the opinion and perception of HPs about the use of the card-game to facilitate conversation about ACP with their patients and highlight the eventual meaning-shift before-after the application of the Card-game in clinical practice. The overall program is depicted in Figure 1.

The card game

The card-game was inspired by the Go Wish Game (GWG), an interactive English card game, which comprises 35 cards and a free 'wild card', reporting a simple and short statement of issues that may be relevant to people affected by life-threatening illness (such as symptom management, personal autonomy, communication with family members, and practical needs of daily life). (40,41) According to the GWG instructions, players are invited to rank their priorities as they sort through the cards, to identify the most relevant wishes or main desires, and to discuss them with relevant others, family members, or HPs (40,41). The emerging wishes and values can, subsequently, be incorporated into an individual therapeutic plan offering the patient the possibility to make ACP.

Setting

The ACP training was dedicated to HPs working in Memory clinics with older adults with frailty and cognitive impairment within the LHA of Reggio Emilia (Italy).

Participants

Eligible participants of this case study were HPs working at the Memory clinics with frail older patients with Cognitive Impairment. A convenience sample of physicians and nurses was selected

Table 1. Description of the components of the training program

Components	Contents's description	Time
Teoretica session	ACP, the local Italian law about ACP, the theory and practice of Go Wish Game	Two sessions, lasting 3 hours each, for a total of 6 hours, in two weeks
Experiential learning session with role play	Peers developed the learning skills on the card-game. Each participant played the role of both the doctor, the patient, and the family member	Lasting 3 hours each, in small groups, and repeated after 15 days to allow all the participants to participate
Gamification session	The application of the card-game in clinical practice: during the subsequent four months since the role-playing session, participants were invited to apply the card-game with their patients. The training participants were free to choose to use the cards with patients they considered most appropriate, based on the type of patient and/or caregivers, the daily work schedule, and their personal preferences. A report form has been provided to HPs to describe the participants' characteristics of patients playing the card-game and the frequency of the chosen cards.	Four months since the end of the experiential learning session.

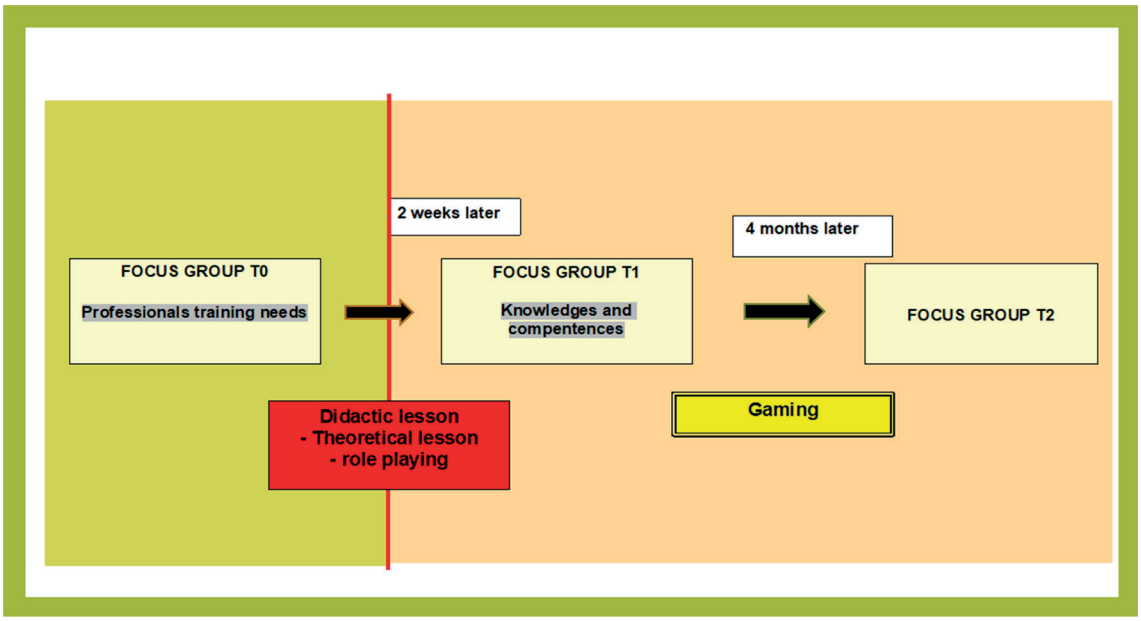

Figure 1. The overall program along the time.

Table 2. The Focus Groups' topic guides.

FG at T1 topic guide	FG at T2 topic guide
Knowledge and experiences on ACP conversations	Competencies and experiences on ACP conversations
Difficulties in starting ACP conversations	Difficulties in starting ACP conversations
Achievement of the training's expectations	Change in the training's expectations
Opinions on the Card Game	Opinion on the card Game
Opinion on the possible use of the Card Game in clinical practice	Opinion on the use of the Card Game in clinical practice

Data collection

Data were collected from:

Focus groups: two FGs involving geriatricians and nurses working with the frail older people population. The participants were the same between FG at T1 (after the role-play session), and FG at T2 (at the end of the training.). The FGs were conducted by a facilitator (ET) and an observer (GA), with expertise in qualitative research. (42,43). The interaction was simulated using two topic guides (Table 2).

Field notes (FN)

During the gamification session, researchers collected fields notes that the geriatricians wrote when they applied card-game to the patients.

Gaming session report form

At the end of the entire training period, the participants were given a form to report the use of the game with people with cognitive impairment during the application in clinical practice in terms of a) the patients' demographic and clinical characteristics, b) the main cards' themes chosen by patients, and c) the time spent playing it.

Data analysis

We used thematic analysis methodology according to Braun and Clarke (44,45), both for FGs and field notes. This study should be considered in a, broadly speaking, interpretivist paradigm, where we searched our dataset to have a better understanding of the perception of HPs on the use of the card game as a tool for their professional activity. We therefore adopted a mainly inductive model of thematic analysis.

The researchers analyzed FG separately at T1 and T2, then comparing the data showed any difference in significance between T1 and T2. These findings and field notes were concurrently triangulated (46). Our thematic analysis involved two researchers (ET and ST) independently analyzing the transcripts by repeatedly reading the text, gradually extrapolating the units of meaning, and grouping them into sub-themes and main themes. Extrapolating the themes, researchers highlighted the possible change of meaning (meaning shift) concerning what professionals expressed at T1 and T2 (47).

Rigor

The methodological rigor of the analysis process has been further ensured through the supervision of a third researcher (GA) from outside the study. The third researcher facilitated the achieving of consensus among coders to improve the reliability of the data (48). Triangulation in qualitative research is a strategy to ensure credibility, reliability, and greater scientific accuracy. This method enables information confrontation and minimizes bias from a single analytical perspective.

Ethics statement

The Ethics Committee (EC) of Area Vasta Emilia Nord approved the study's research protocol at its meeting in January 2019. The researchers explained the study's aims and objectives in detail. They were then asked to sign a specific informed consent form for the study and the processing of personal data, which was filed with the study documentation. The interviewer also requested and collected appropriate documentation for the operators who participated in the focus groups before they were conducted. Professionals were given the information note and specific consent to be signed by the patient to whom the game was administered.

Results

The training was led by the palliative care unit team, who had experience in the training and activation of communications about ACP. The course took place from April to September 2019. It was proposed to a total of 29 HPs and was attended voluntarily by 10 HPs. Of them, five were geriatricians and 5 were nurses.

The gaming session

All HPs who attended the course applied the card game in their clinical practice and the game was proposed to a total of 9 older people, previously selected by HPs using the Clinical Dementia Rating Scale (CDR) and Mini-Mental State Examination (MMSE) The average age of persons enrolled in the study was 74 (the youngest was 62 while the oldest was 84). The average value of MMSE was 24/30 (min 13/30-max 30/30.). Accordingly, from the HPs' perspectives, the MMSE value was not correlated to the older people's ability to perform the game. Five geriatricians belonging to five Memory Clinics provided a total of 9 schedules reporting the use and application of the card game between HPs and older persons. "To be free from pain" was the most frequently chosen card among patients, followed by "To be able to say goodbye to the important people in my life", "To be treated how I want", and "To have my family close". No one chose themes such as "To know how my body will change", "To trust my doctor", "To have my funeral arranged", and "To be able to talk about what death means to me".

The FGs

Two FGs were performed: 5 HPs were involved in FG at T1 (3 geriatricians, 2 nurses), and 7 in FG at T2 (4 geriatricians, 3 nurses.)

Data triangulation

Data triangulation identified 3 main themes and related sub-themes, describing the meaning shift before and after the intervention. Field notes supplemented with post-training statements. The main themes were as follows:

Playing the card-game in clinical practice
The barriers to card-game application
Card-game and ACP implementation

Table 3. Emerging theme and sub-themes highlighting meaning-shift before-after the intervention

Themes	Subthemes	Pre-intervention (FG1)	After the intervention (FG2) and Field Notes
Theme 1: Playing the *card-game* in clinical practice	1.1. Selecting the patient to whom to propose the card-game	*From the hypothesis of a 'right patient'*	*To apply preventive selection of the patients*
	1.2. Families and the card-game	*From feeling fear toward families' reactions*	*To consider families as an aid to playing the card-game*
Theme 2: The barriers to the card-game application	2.2. The geriatrician's point of view	*From personal difficulties*	*To difficulties related to patients' characteristics*
	2.2. Organizational difficulties	*From the problem of 'time'*	*To an 'unpredictable' amount of time*
Theme 3: Card-game and ACP implementation	3.1. Opinions about the use of *card-game*	*Some doubts and esitations*	*Strengthening the healthcare relationship with their patients*

We defined a summary of the themes and sub-themes with relative changes in meaning in Table 3. Data are identified by a specific code, composed as follows: numeric reference of the participants (C1.1, C2…), and data from Field Notes (F.N. 1, 2…).

Playing the card-game in clinical practice

This theme collects the perceptions of HPs regarding how they apply the card-game with their patients. It comprehends two sub-themes: (i) the problem of selecting the patient for the card-game; and (ii) the role of family members and the card-game.

Selecting the patient for the card-game

Before the experience, participants paused to understand what the right patient might be – i.e. a patient "already known" (C 2.22), presenting "mild cognitive impairment" (C 2,14) with a "good education" (C 2.32) – and how the presentation of the 'game' during the visit could be, as well as the preparation of the family for the *card-game* visit. After the experience, the participants all acknowledged that they had "together" (C 3.69) "made an upstream selection for the choice of the patient" (C 3.34; F.N. 3). Specifically, in choosing the sick people, the geriatricians, with some amazement, state that: 'We did a card-game with a patient with MMSE 22 [high level -n.d.r.] and he was able to pick out the cards... he took longer, he didn't do it quickly, but he did it... unlike another [with lower MMSE -n.d.r.] who had a harder time picking out the cards' (F.N. 2; 4).

The role of family members and the card-game

Before the intervention, family members were seen as "additional figures" (C 2,27) to be informed and prepared, and a potential obstacle. The clinicians say, "It is challenging for patients and families to be asked such questions" (C 2,43). After the experience, family members were considered as a "further resource" (C 3,42) for the greater effectiveness of the game and the geriatricians themselves. Geriatricians say: 'There were two family members; they were a facilitating presence' (C 3,57; F.N. 2).

The barriers to card-game application

The second theme collects the barriers perceived by participants to the implementation of the card-game in their clinical practice. Barriers emerged as (i) the geriatrician's point of view and (ii) the presence of organizational difficulties

The geriatrician's point of view

Before the experience, HPs perceived several personal difficulties, mainly hypothetical, described in

terms of their "lack of ability to propose and use the game" (C 2,37) with the patients. After the experience, HPs identify the barriers "mainly related to their patients' characteristics" in terms of the cognitive deficit" (C 3,121), the "difficulty of projecting oneself into the future"(C 3,110), and the "cultural level of older people" (C 3,97). For example, a geriatrician said: "I had to physically do the test for her in the sense that I showed her card by card...she would never have done the three bundles by herself!" (C 3.154; F.N. 1). In addition, geriatricians reported that 3 patients chose the wild card option, reporting themes already cited in the rest of the cards (To not be attached to a machine", "That there is always harmony and mutual help among family members", " That my family may be prepared for my death"): when asked if there were other topics they wanted to talk about, they recovered in their memories phrases read a few moments before on the cards and proposed to them again as additional issues.

Organizational difficulties

Before and after the intervention HPs identified the "amount of time required for using the game during the visit" (C 2,58), and the "time required to prepare themselves, patients, and family members for the game" (C 2,63). Time is difficult to quantify. Accordingly with HPs' experiences, "performing the card-game requires almost one hour" (C 3,78), and "it is difficult to concretely do it during the outpatient visit within the local context" (C 3, 85; F.N. 5). In addition, HPs highlighted also the perception of loneliness and a lack of sharing and collaboration with other professionals.

CG and ACP implementation

The third theme collects the participants' opinions regarding the use of a *card-game* as a method for strengthening the healthcare relationship with their patients. It is described by the following sub-theme.

Opinions about the use of card-game

Health professionals move away from (i)" some doubts and hesitations" to (ii) "strengthening the healthcare relationship with their patients". Before the experience, HPs expressed several "doubts, hesitations, and fears" (C 2,73) concerning their preparedness to apply the card-game to their patients and to deal with "the difficult interactions with family members" (C 2,55). Differently from their expectations, HPs reported "positive feedback from their patients" (C 3,77), highlighting that "there were no negative reactions from them" (F.N. 5). At T2, HPs reported a "change in their feelings as a result of the experience" (F.N. 3,1), which they defined as a "good call to perform good medicine" (F.N. 2;4;5). Participants underlined that this changing attitude goes beyond the strict application of the card-game within the study, and they "appreciated starting to discuss such issues" (F.N. 3;4) with their patients. Before the experience, HPs considered the card-game as a hypothetical and potential aid to help them "deal with difficult conversation with patients and family members" (C 2,59), while after the experience, it was perceived as a tool to help the patient "to identify personal values" (C 3.124) and "express herself when he/she can still do it" (F.N. 2; 3). Participants identified the card-game as a supportive tool of care since "a better knowledge of the person can help them along the care pathway" (F.N. 1;3).

Discussion

This study aimed to describe the experience of using a *card-game* as a tool to facilitate discussion on ACP for HPs working with frail older persons population with cognitive impairment. The results of the study highlight some fundamental elements of change in the perspective and approach of geriatricians concerning the use of *card-game* with older people living with dementia. All geriatric participants in the training applied the card game with the older people.

Change in attitude of geriatricians

The most exciting elements of the study are the change in the attitude of geriatricians towards card playing and the type of cards chosen by patients. According to some studies, the change in geriatricians'

attitudes from before to after training makes clinician training an essential element in fostering ACP (7,48,49). In our study, we present a multidimensional training model that can also be repeated in other contexts. Concerning the type of cards chosen by the older people, our results provide specific information on which issues are most important to the illness persons living with dementia interviewed (e.g. "To be free from pain" or "To be able to say goodbye to the important people in my life", "To be treated how I want", "To have my family close",) in contrast to the literature where these data are not easily found as other factors prevail, such as the perceptions of the actors involved, facilitating or hindering factors (48).

Geriatricians engaged difficult conversations with patients

Geriatricians went from carefully selecting patients to understanding that *card-game* is only a tool to apply to some people, not completely related to their cognitive impairment (10). The game session motivated participants to engage in difficult conversations and an in-depth collection of patients' values and choices. Training in using a card-game facilitates open communication with older persons and caregivers them, as well as expressing and confirming the importance of conversation and relationships in the ACP approach. (50,51).

Engagement of family

Several studies have highlighted the role of family members in collaborating with clinicians to perform an ACP. In recent literature, we move from considering the engagement of the family member as very important for the ACP (18) to thinking of the family member as the one who intervenes when the person's cognitive abilities are no longer adequate (17), in a dyadic dimension of concordance between the person with dementia and the family member who cares for their relative (52). In our study, geriatricians understood how family members are not an obstacle but rather an ally in the game, and the doctor-caregiver collaboration becomes invaluable in activating complex communications with the person with dementia.

The application of the game

Geriatricians recognize that it should not be taken for granted that if the ill person is in an early stage, they will understand the game, and if in an advanced stage of illness, they will not be able to understand it. Above all, the information gathered from the field notes after the game confirms that older persons with mild cognitive impairment could also play the game. The decision-making ability is disjointed from cognitive impairment (5). The card game is widely used in the literature and very much enjoyed by the participants (53,54).

The time for the patient

The issue of time emerged, both in terms of time used by the clinician to perform the ACP and 'time' as the best time for the patient for the effectiveness of the ACP. On the issue of 'time for the patient', the literature has expressed itself in varying terms, favoring the earliest ACP but also arguing that ACP can also be performed in more advanced dementia conditions (55,56). Several studies on geriatricians' perspectives on ACP for people with dementia have pointed to difficulties in performing ACP in the dynamic and subjective assessment of the patient's decision-making capacity and the need to balance patient and family involvement (7,57). Our results recognize that cognitive impairment is a long-standing condition and not easily predictable; however, it is acknowledged that we are not prepared to grasp 'the patient's opening windows' because we do not feel competent. The training proved to give geriatricians confidence to the extent that all trained participants activated the game and the ACP with their patients. Although the data are limited in number, the whole experience described shows how training can change geriatricians' initially skeptical and then positive perspectives. In agreement with recent literature (7,17), our results point out that

ACP in people with dementia is possible, indeed desirable, due to various tools facilitating the initiation of communication between clinicians and the sick person or family member. Then, our results suggest that training geriatricians on the use of card-game would help for the implementation of ACP and the so-called "Care Planning Umbrella", a recent broad care planning framework from the perspectives of patients, surrogates, caregivers, and the community, which conceptualizes ACP as part of the continuum of care planning, with quality of life and meanings as the fundamental cornerstones (7). It is in line with the ACP framework which considers ACP as part of our life journey, which requires not only measuring the impact of ACP but also extending the partnership network, building supportive systems, and engaging and educating stakeholders (58). In our study, we described, with effective results, the use of training and the card game as tools facilitating the initiation of communication in ACP.

Strenghts and limitation

The main strengths of this study are that it offered a structured training course with different educational methodologies and focused on using the card game to facilitate difficult conversations and ACP with older persons with dementia. The study is also a new element in the Italian context, where the regulations on ACP are recent and still little understood by clinicians, especially geriatricians working with frail older persons. The study's limitations were the small number of participants, whose recruitment was difficult. Only about 30% of the involved Memory Clinic HPs took part in the training. It was voluntary participation, and probably not all the professionals were ready to play the game and understand the importance of ACP. Furthermore, the data collected monitored the training but not the months following the training. No follow-up was carried out 3 or 6 months later to check whether and how geriatricians activate ACP. In addition, no information was collected on the satisfaction of the older people and their caregivers with this intervention.

Implication for clinical practice

Our findings confirm that gaming, compared to other tools (scales, questionnaires, etc.), may be an easier method for engaging in an ACP discussion, for discussing EoL topics, and for appointing a trustee (28,51,59, 60). As a practical implication of the study, the use of the card-game and its positive perception by HPs prompted the development of an Italian version of the GWG, culturally adapted to the local context, and which can be used by Italian HPs to improve ACP in clinical practice (61).

Conclusion

Our findings confirm that the card game would represent an easy way to talk to older patients when they can still say something about themselves: it offers a space for listening to them, their value system, and their family system (40,50,58). Our findings highlight that training based on using a card game with older adults with frailty is very useful for health professionals working with this population and their caregivers. There were results of changing geriatric attitudes towards ACP, and all geriatricians who attended the course applied the card game with older adults. Our results can offer grounds for further mixed-methods studies aimed at evaluating the training's effectiveness in terms of the increment of the participants' competencies towards the topic. Further strategies, both at institutional and organizational levels, are needed to facilitate the process.

Ethic Approval: The local ethics committee Area Vasta Emilia Nord (AVEN) approved the study Prot. no. 2019/0004232 del 11/01/2019. All participants provided signed informed consent to participate in the study.

Conflict of Interest: Each author declares that he or she has no commercial associations that might pose a conflict of interest in connection with the submitted article.

Authors Contribution: Conceptualization, E.T, and S.T.; methodology, G.A, and S.T..; validation, E.T., and S.T.; formal analysis,

G.A.; investigation, G.A, and E.T; data curation, G.A, and M.P; writing—original draft preparation, S.T and E.T.; writing—review and editing, M.P., C.P. and S.T.; supervision, E.T; project administration, S.T. and E.T. All authors have read and agreed to the published version of the manuscript.

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Correspondence:
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Marta Perin, PhD
Legal Medicine and Bioethics, Azienda USL-IRCCS of Reggio Emilia
Street Amendola 2, 42124, Reggio Emilia, Italy.
E-mail: marta.perin@ausl.re.it
ORCID: 0000-0003-4631-7380