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Emerging Issues in Medical Ethics

CAROL C. NADELSON

Ethical principles are influenced by personal values and beliefs, and by societal context. They are not immutable. In medicine, as new technologies have developed and changes in health-care delivery have resulted, historically held views about the responsibilities, obligations and relationships between health-care providers and patients have been challenged.

The increasing complexity and cost of new technology, coupled with limited resources to provide care for all those who need or want it, creates new ethical dilemmas. These are related to the need for decision-making based on competing priorities, without established policies regarding who should make decisions and what the guiding principles should be. Current codes of medical ethics appear to be inadequate to address today's emerging questions because values and ethical systems vary widely and often conflict. Choices that enable one to preserve personal moral accountability in a pluralistic society are difficult to make.

Further, the process of medical decision making, as well as the delivery of medical care, is increasingly directed by those whose ethical frameworks do not originate from health-care training or practice. This affects decisions and their implementation. For example, a businessman running a private hospital does not expect to deliver care in the same way as a charitable institution. He is bound by the interests of his investors and not primarily by a concept of public good. The computerisation of medical records and requirements for disclosure of diagnostic and treatment data in order to provide reimbursement makes the transfer of confidential information routine. The concept of consent is altered by the financial pressure on individual patients to permit disclosure.

Medical ethics encompass an enormous range of issues. In this paper, I focus on aspects of current and emerging concerns, particularly some that relate specifically to women. Recognising that overt as well as subtle cultural differences exist, my major reference is to the United States.

Changing codes of medical ethics

Codes of medical ethics have existed since ancient times and have varied with culture and era. The Hippocratic Oath was unique in emphasising the cure of the patient as the single over-riding responsibility of the doctor. Subsequently, medical ethics has also been concerned with the dignity, honour and reputation of the profession. Currently, as guiding principles, most Western countries emphasise the autonomy or self-determination of patients, a concept of beneficence which implies doing 'good' rather than merely doing no harm, a concept of justice related to access to resources, and the doctor's responsibility to his/her individual patient.

Different priorities are placed on these principles in different societies. Patient autonomy may be limited by decreasing the availability of procedures like cardiac bypass surgery. Denial of access may be based on socio-economic, age or prognostic factors; family and societal needs may outweigh the desires of the individual in certain situations, like forbidding the performance of abortion despite the wishes of a woman (Newman & Brody, 1988). Engelhardt (1986) stated "at the very roots of ethics there is a tension. It springs from the difference between respecting the freedom and securing the best interests of persons."

This raises one of the fundamental problems of medical ethics, the definition and scope of paternalism. Generally, in the ethical literature, it refers to "practices that restrict the liberty of individuals, without their consent, with a justification for such actions as either the prevention of some harm they will do to themselves or the production of some benefit for them that they would not otherwise secure" (Beauchamp, 1979). Thus the debate centres upon whether paternalistic justifications can be morally acceptable and where the limits and boundaries might be.

Other principles of medical ethics that are further elucidated in Western countries include considerations of confidentiality and the boundaries of therapeutic relationships. These areas encompass issues like valid consent and refusal on the part of the patient; the responsibilities of the doctor, including failure to appropriately inform a patient; deception in practice and research; and sexual interaction between doctors and patients.

Decisions about access to care, and rationing, are often dealt with by omission rather than by clearly-

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stated policies. For example, patients may not have access to certain types of care because the resources are not available in their community or because they cannot pay for them. In other situations, ambiguities around conflicting ethical principles make it difficult to be definitive about policy. For example, considerations of patient confidentiality preclude disclosure of the diagnosis of AIDS, yet not to disclose endangers the health of family members and others in the community. The policy that patients' HIV tests should be confidential has recently been vigorously debated in the US because reports of doctors transmitting AIDS to patients has resulted in public pressure to test health-care workers and disclose results (Altman, 1990).

Pellegrino & Thomasma (1988) imply that shifting ethical paradigms and conflicting moral principles may be related to some of today's health-care dilemmas. They discuss the conflicting ethical principles of health care on business, contractual, preventive, covenantal and beneficent models. From the business perspective, they suggest that medicine has been considered a commodity and the ethical obligation of doctor to patient has become that of businessman to consumer. The contractual model is an extension of this model whereby a contract formalises the relationship, protecting the patient from excessive paternalism or economic self-interest from the doctor. The preventive, or public health, model obligates the health-care provider to protect many 'healths' and does not place as high a priority on the individual doctor–patient relationship.

A different perspective derives from the traditionally held covenantal model. It is grounded in the trust and obligation between the doctor and the patient. Pellegrino & Thomasma, in re-emphasising the importance of the principle of beneficence suggest that the doctor and patient are joined because of the needs of the patient. Both partners recognise the patient's dependence upon the doctor, and the doctor's responsibility for making good and moral judgements on behalf of the patient. This model acknowledges that the patient who is ill may not be capable of totally free and informed consent or autonomy, by virtue of anxiety, fear or lack of knowledge. It is around this issue that psychiatrists have become most involved. They are often asked to assess patient competence to consent, especially when there is a question of impairment of judgement or decision-making capacity. Thus, psychiatrists may be said to act in a paternalistic fashion when they are asked to render opinions that potentially limit patient autonomy.

The nature of the covenantal relationship and the principle of beneficence call into question many current medical practices which involve the doctor in activities that may not do 'good' for the patient. These practices include the role of the doctor in the rationing of health care, as a gatekeeper or guardian of society's resources. (Nadelson, 1986; Pellegrino & Thomasma, 1988). While it is attractive from an economic point of view, serious ethical questions are raised if the doctor cannot be trusted by the patient to act in his/her best interests. If the doctor becomes a double or triple agent, acting for a government, an insurance company and/or an employer and presumably for the patient as well, the covenantal relationship is compromised.

Conflict between roles: the doctor, the individual patient and society

The doctor in today's society finds it increasingly difficult to differentiate his/her role and responsibilities as the agent of the patient from that as an agent of society. The conflict between these roles occurs in many aspects of practice. It is particularly evident in laws requiring that confidentiality be breached by reporting child abuse, threats of harm to another individual, or certain illnesses, such as sexually transmitted diseases, to appropriate authorities. Protecting the confidentiality of doctor–patient relationships runs counter to social concern about the public good in these situations, and confidentiality may not be upheld as an overriding ethical principle (Freudenheim, 1991).

There are many potential repercussions of compromising confidentiality, including the possibility that patients will no longer trust their doctors with certain types of information or seek appropriate or necessary care. These issues have been raised most often around the requirement to report HIV positive individuals in order to trace contacts and advise them about risks, or in reporting patients who have made threats of violence, or who have committed child abuse or crimes of violence.

Another aspect of these conflicting roles, with important ethical considerations, includes pressure on doctors to make decisions based on non-clinical indications. For example, for economic reasons such as increasing the reimbursement to a hospital, a doctor may be pressured to recommend a certain treatment or to admit or discharge a patient when, in his/her clinical judgement, this is not the best approach. Doctors may also be asked to take responsibility for treatments they have not personally recommended or administered because other personnel, who may not be legally qualified, have been the direct caretaker of the patient. This request places the doctor in an ethical (and legal)

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dilemma and potentially harms the patient, often without his/her knowledge or consent (Nadelson, 1986). In the US these practices affect women patients more than men because women use health-care facilities more often, and are more likely to be poor, and treated by a number of different kinds of health-care providers (US National Institutes of Health, 1990).

Paternalism and informed consent

Historically, the organisation of health-care delivery was hierarchically based, with the doctor dominating the system. The expectation that the doctor, who in the past was usually male, was informed, authoritative and protective conformed with traditional social roles of women and men (Notman & Nadelson, 1978). Although the numbers of women doctors have increased, their relative absence from policy-making positions essentially preserves this traditional type of paternalistic perspective.

In many instances, decisions about an individual patient's care, or policy about resource use and priorities have been based on this perspective, so that the best interests of the patient may be determined by others, often with little input (Nadelson & Notman, 1979, 1990). In the US this is best exemplified in policies related to reproduction, including availability of sterilisation or abortion, and allocation of resources for new technologies, like *in-vitro* fertilisation. A recent decision in the US to prohibit the use of RU 486, an abortifacient that appears to have other possible medical uses, is a specific example. Among the potential uses are treatment of some types of breast cancer, brain tumours, Cushing's Syndrome and endometriosis (Wickenden, 1990). The decision was based on the values and beliefs of those with decision-making authority, not those who would be most affected. The potential benefit of the other uses was not seriously weighed. Another example was the recent judicial ruling that ordered a woman convicted of child abuse to have an implanted birth-control device as a condition for her probation (Lewin, 1991). These decisions have raised serious ethical and legal debate, which has not yet been resolved.

Recent discussion about medical and surgical care including the performances of transplants and bypass surgery suggests that bias exists regarding criteria for the choice of suitable patients. Women and minority-group patients are less frequently offered these options in the US (US National Institutes of Health, 1990; Abraham, 1991). The documentation of gender bias in medical care and in research has led to the creation of an Office of Research on Women's Health by the United States government and to proposed legislation to address the "inadequacies in the treatment of women's health in three critical areas: research on women's health, access to services, and prevention activities . . ." (US National Institutes of Health, 1990; Markey 1990; Palca, 1990).

The negative aspects of paternalism are also seen in research policy, exemplified by banning the use of foetal tissue for research. This was done because it was felt that more women would seek abortions if they felt there was a justification, or that 'good' use could be made of the products of conception. Not only is this supposition unsupported by data, but it reflects a patronising and paternalistic view of women. The decision was made by government officials, based more on political pressure than ethical principles (Boston Globe, 1991; Hilts, 1991).

Failure to include those affected by decisions in the decision-making process, is an aspect of paternalism. At the same time, while there has been an increase in paternalism in the US health-care system (exemplified by the encroachment by government and insurance companies on policies involving medical care) there has been a decrease in paternalism in the individual doctor–patient relationship. Patient expectations that they be informed and participate in decision-making regarding their own health care have affected this relationship and the locus of decision making has shifted towards the patient and family, at least when it is not in the hands of the government or insurance companies. A recent article stated that in the past, doctors "were empowered to make health care decisions for the benefit of the patient because they understood that patient's condition better than any layperson. Now . . . the physician's role primarily is to explain the various options of treament – the pros and cons. The physician is the adviser, not the decision-maker" (Scheier, 1991).

Paternalism, then, has shifted away from the doctor into the hands of bureaucracies. This confuses the picture for patients who do not know who to turn to or blame, and intensifies discontent with the lack of responsiveness of the system. This is particularly important because of what we know about an individual's illness and his/her expectations of those who are caretakers and healers.

Illness engenders responses that may be at variance with an individual's usual behaviour, especially since those who are ill become more dependent on others. The patient who perceives him/herself as needing to be cared for by a strong, parental figure can become too compliant. At times of crisis and in gratitude for being helped, the patient may also surrender aspects

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of his/her autonomy (Notman & Nadelson, 1978). Ethical questions can be raised when the patient is encouraged or required to be passive and thus may not make an informed decision (Kahana & Bibring, 1964). These patient responses may further encourage the physician or the bureaucracy to maintain greater authority than may be in the best interest of the patient. This can prevent communication and the development of mutual respect between doctor and patient, and can lead to disappointment, antagonism, and mistrust of the system and those providing care in it (Notman & Nadelson, 1978).

One way of dealing with these reactions in patients has been to compel the doctor or the health-providing agency to detail, in advance, the dangers and risks of a particular procedure or medication. Despite these efforts, however, we know that barriers to communication arise from the nature of the relationship itself. An official recommendation, whether explicit or implicit, can overshadow a cautionary statement. The language may not be understood and the implications not heard, or they may be so frightening to the patient that in order to agree, he/she must ignore potential problems or complications. Thus, the authority of a doctor or institution may prevent a patient from objectively assessing dangers, benefits, or alternatives, even if they are clearly stated. On the other hand, a patient may also compromise his/her care by developing a negative response to a paternalistic posture and being mistrustful and unwilling to accept advice or recommendations, or by over-reacting to a statement about risks and side-effects (Notman & Nadelson, 1978). These responses raise questions about how we understand and obtain informed consent from patients.

Since informed consent implies understanding and assent, a patient's inability to comprehend the language used by the doctor, the insurer, or other health-providing agencies due to educational level, mental illness, or other factors, can be seen as violating the principle of obtaining informed consent (Applebaum & Grisso, 1988). Thus, those in authority influence the patient's perception of his/her options and alternatives, and affect compliance and decision making (Nadelson & Notman, 1979).

As in treatment, the agreement to participate in research may be influenced by a subject's perception of the experimenter as possessing superior knowledge and authority. Agreement may be given by a person who appears to be willing, but may not be able to make an objective decision (Nadelson & Notman, 1979). Obviously, it is not possible to change the nature of the relationship entirely or perhaps even substantially, but every effort should be made to prevent distortion and promote mutual participation.

In the research area, an often-quoted example of ethically unacceptable research was a study on contraception in Mexican–American women (Katz, 1972). One group of women was given contraceptive pills and another was given placebo and a vaginal cream, known to be a less effective contraceptive. All of the women believed they were protected from pregnancy. The misuse of the trust of the subjects was deceitful; the subjects never gave informed consent and the women were unknowingly exposed to the risk of pregnancy. Just as it exists between a doctor and a patient, the importance of a partnership built on mutual trust exists between a researcher and a subject (Nadelson & Notman, 1979). The subject must understand the information given and make an informed choice to volunteer.

Autonomy and reproduction

The special characteristics of women's reproductive roles lead to specific ethical considerations. Since decisions about childbearing, contraception, abortion, sterilisation and surgery involving reproductive organs have profound social consequences, the autonomy of a woman in deciding these questions is often challenged. From a historical perspective, debate about contraception and abortion have escalated when there are desires for population expansion (Nadelson & Notman, 1979).

In most cultures, women have generally not been in a position to achieve their own goals if they are distinct from those of their family and society. Decisions about medical care or surgical procedures that have an impact on sexuality and childbearing are often made by others, including governments and families. For example, whether sterilisation or abortion is funded can determine if a woman can make that choice. Decisions may reflect the personal, cultural or religious values of the doctor, the family, or society. A father may insist that his pregnant teenage daughter cannot have an abortion because he does not believe in it, or a gynaecologist may assume that a woman past 40 would want a hysterectomy or sterilisation because she would not want to expose herself to the risk of having a defective child. In these cases, the actions taken or assumptions made can compromise the woman's autonomy.

A recent, troubling ethical dilemma has involved genetic testing in pregnancy. When used to diagnose genetic disorders, it may lead to a decision to have an abortion. Many believe that abortion should not

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be performed for any reason, but even those who do not share this view are troubled by the potential use of abortion for social reasons including family finances, unmarried status or even sex selection. From an ethical perspective any restriction can be said to limit a woman's autonomy, and to place the interests of the mother in opposition to those of the foetus. When can they be considered equal persons? The question of determining when 'personhood' can be said to exist is an important consideration in this ethical debate.

Since genetic testing using amniocentesis or sampling of chorionic villi can also reveal the sex of the child, an abortion could take place if the baby were not of the desired sex. In those families and cultures where boys are more valued than girls, this could result in major changes in population demographics. The argument has also been made that once these new technologies are available, control of their use is not possible. Thus, unethical or coercive practices could result, including forced abortion.

As society and medicine change, the doctor must become accustomed to a range of new realities. These include the extensive use of reproductive technologies, the possibility of sexually transmitted disease in a wide diversity of patients, and requests for artificial insemination for unmarried women and homosexual couples (Notman & Nadelson, 1978; Stotland, 1990). As I have suggested, the emergence of AIDS in all segments of our society has also raised ethical considerations regarding testing, the right to privacy and protection of others.

The use of *in-vitro* fertilisation, artificial insemination by donor and surrogate motherhood have also stimulated ethical debate and legal action. The new technologies "raise the specter of reproduction totally controlled by females whose uteri, despite methods of laboratory fertilization, remain essential for growing fertilized ova to human status. Patriarchal dominance and male lineage are suddenly at risk. Affiliative rights and knowledge of parenthood, particularly of fatherhood as an aspect of identity, become unsure. Even the social mother can no longer state with certainty that this is her biological offspring" (Brody, 1988).

These techniques and their use raise questions about the role of biological versus social parents, the rights of children born from these procedures, and the nature of informed consent by all parties. A woman making a surrogate contract, for example, may have been coerced, or she may not be able to make an informed decision because she cannot predict her feelings after gestation. The advent of surrogacy has also brought into focus questions about whether women can be used as incubators and whether foetuses have become commodities, raising the spectre of forced pregnancy presented by Atwood (1986) in *The Handmaid's Tale*. Certainly, contractual surrogacy places pressure on poor women to rent their bodies.

An aspect of the use of emerging technology that is especially salient for psychiatrists is the expectation that they can predict outcomes and psychological risks of surrogacy despite the absence of data on psychological impact. Not only is information lacking on how those involved in surrogacy will fare, but there are no data on the outcome for children born into these families. There are also no guidelines or criteria for selection of surrogate mothers and families. Currently, arrangements are made by entrepreneurs with minimal ethical or legal constraints.

Debate about this subject has been polarised and no clear principle or policies have been formulated. One recently articulated perspective that has attracted attention is that relationships, not genes, should determine parental rights and responsibilities (Rothman, 1989). Rothman believes that gestational mothers, with nine months of relationship before the birth of their babies, should have more rights than do fathers or adoptive parents. The priority she proposes would change as fathers or adoptive parents develop nurturing relationships with these babies.

Additional ethical questions involving the rights and status of children born through these new techniques remain unsettled. The right to know one's genetic, family and medical background has been controversial in cases of adoption; certainly it is in cases of surrogacy or artificial insemination. There is a potential conflict between the interests of the 'parents' in privacy and the right of the child to know.

Techniques which allow embryo freezing with potential for later use raise additional ethical dilemmas when couples divorce or die, or when they seek to terminate the 'life' of the embryo. A new kind of paternalism also arises when procedures and technologies are reserved for specific types of individuals or situations, for example, *in-vitro* fertilisation only where there is an organic impediment to conception, or when the women are married heterosexuals (Van Hall, 1988).

Substance abuse during pregnancy has been another subject of recent ethical and legal controversy. In the past, the foetus was viewed as a potential threat to the mother's life and health, since pregnancy and childbirth had substantial morbidity and mortality rates. In recent years this view has shifted so that mothers are seen as potential threats to their

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offspring, and not necessarily acting in their best interests. This change in perspective has led to legal action and even prison sentences for pregnant alcoholics and addicts. This pits the autonomy of the mother against the interests of the foetus. In addition, it has changed the nature of the obstetrician–patient relationship. In this situation, when the obstetrician is treating both the mother and foetus as 'the patient', the mother's autonomy can be compromised. The foetus is accorded both rights and 'personhood', as is the mother. They obviously cannot be entirely equal, bringing into question, as suggested above, when and whether the 'personhood' of the foetus can be differentiated from that of the mother (Bowes & Selgestad, 1981; Lenow, 1983; Blank, 1986; Johnsen, 1987; Landwirth, 1987; Murray, 1987; Rhoden, 1987; McNulty, 1987–88; Cole 1990; Harrison, 1990).

Another controversy involving pregnant women concerns consent for *in-utero* treatment of their foetuses, and whether failure to consent constitutes foetal abuse. Here a distinction between moral and legal responsibilities of the mother has been made. It is generally held that a pregnant woman cannot be coerced to accept treatment to benefit her foetus. The doctor's ethical duty according to the American Medical Association (1990) is to be non-coercive and accept the informed consent of the patient.

Doctor–patient sexual interaction

An issue of increasing concern in the US today is sexual interaction between doctor and patient (American Medical Association, 1990). Because of the intimate nature of the doctor–patient relationship, a wide range of emotions, including sexual feelings, are evoked and there is a potential for overt sexualisation of the interaction (Gabbard, 1989). The incidence of sexual contact between doctors and patients is difficult to document, but those studies that have been done, coupled with recurring ethics complaints and lawsuits, suggest that it is not an infrequent occurrence (McCartney, 1966; Shepard, 1971; Kardener, 1974; Perry, 1976; Holroyd & Brodsky, 1977; Romeo, 1978; Gartrell *et al*, 1986; Derosis *et al*, 1987; Rapp, 1987).

Between 5 and 10% of psychiatrists and psychologists have reported sexual contact with patients. Although there have been recent reports suggesting that the incidence of sexual contact is decreasing, it is not clear whether this reflects an actual decrease or a change in reporting patterns. There are no specific data available on sexual interaction between patients and non-psychiatric doctors, but one study suggested that the figures may be comparable (Kardener *et al*, 1976). For psychiatrists in the US, it has been estimated that about 88% of reported incidents of sexual misconduct involve male psychiatrists and female patients; 7.6% involve male psychiatrists and male patients; and 3.5% involve female psychiatrists and female patients (Gartrell *et al*, 1989; Simon, 1989).

Desires for secrecy and the patient's dependency on the doctor to protect their confidentiality complicate our ability to learn of this problem or to intervene (Marmor, 1976; Dahlberg, 1970). Many women fear being publicly exposed, especially if they have participated in a long-term sexual liaison, or they feel betrayed or demeaned and do not want public acknowledgement of their activities (Nadelson, 1989).

Doctors become sexually involved with their patients for a variety of reasons. Women may appear to be seductive to the doctor who, due to depression, loneliness, disappointment, or stress, may be particularly vulnerable to being needed or sexually desired. These problems may lead him to respond sexually to a patient who enhances his feelings of importance and effectiveness, or who is physically appealing. Some doctors who become involved in this behaviour are sociopathic or compromised by alcoholism or substance abuse. Although a patient may misinterpret 'warmth' and physical contact, such as hugging, by a doctor as sexual, when it is not so intended, it remains the doctor's responsibility to be clear about the boundaries of the relationship (Nadelson, 1989).

Given the nature of the transference in the doctor–patient relationship, the patient's ability to give informed consent has been questioned (Kardener, 1974; Herman *et al*, 1987; Kluft, 1989). The analogy to rape and incest has been made by many clinicians (Gabbard, 1989). This is especially related to the transference aspects of the therapeutic interaction (Barnhouse, 1978). In some states in the US there are specific laws based on these special characteristics. Since 1985, sex with patients has been made a felony in seven states, and others are moving in this direction (Goleman, 1990).

Although some doctors have claimed that the sexual interaction is 'therapeutic' despite evidence to the contrary, it has been explicitly stated to be unethical and exploitative by the American Psychiatric Association (1989) and the American Medical Association (1990). The ability of the doctor to be objective and to give necessary care is compromised by breaching the therapeutic boundary. There are times when the nature of the therapeutic relationship is not clear, for example, the doctor who has

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consulted briefly on a patient, or has provided care that does not involve intense interpersonal relationship. Likewise, questions have been raised about when a patient ceases to be a patient and how long one can assume that the transference would be operative.

A number of clinical studies have stated that sexual relationships between carers and patients are harmful to patients and may have acute as well as long-term consequences (Burgess, 1981; Bohoutsos *et al*, 1983; Feldman-Summers & Jones, 1984; Pope & Bohoutsos, 1986; Herman *et al*, 1987; Kluft, 1989). In addition to the shame, guilt and mistrust they experience, these patients have been reported to suffer from post-traumatic stress disorder, anxiety and depressive disorders, sexual symptoms, sleep disorders, and are at higher risk for substance abuse. There have also been reports of increased suicide risk and psychiatric hospital admission.

Conclusion

This paper has briefly touched on some contemporary and emerging ethical issues, including those that especially affect women. For the doctor, the complex dynamics of his/her relationship with the patient demand constant vigilance in order to be clear about his/her role as the patient's advocate as opposed to the agent of society, and the special nature of the boundary of professional and personal relationships. For society, the changing role of women and the emergence of new technologies, especially those involving reproduction, have raised questions with profound ethical implications. It is also clear that culturally determined values and ethical values may clash. It appears at the moment that there is no consistency to medical decision-making or a process for resolution. Perhaps the way forward lies in continued discussion, education and mutual understanding.

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Carol C. Nadelson, MD, *Dept of Psychiatry, (Box 1007) Tufts-New England Medical Center Hospitals, 750 Washington Street, Boston, MA 02111 USA*

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