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Understanding and Combatting Ageism in Healthcare

Dane Wanniarachige

Trinity College Dublin

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What is Ageism?

As I waited for the tram on a windy day in Dublin, I noticed an older man wearing a flat cap shuffling unhurriedly towards the busy platform with a noticeable parkinsonian gait. The tram slowed to a halt and as soon as the doors opened, a gust of wind blew the gentleman's hat upward and behind him into a parking lot enclosed by a tall iron fence.

"My hat, my hat!" he softly cried out. I noticed that a couple of passengers looked over their shoulders as they boarded, but most didn't give it a second thought as the doors closed behind them and the man was left in a new crowd of bustling people eager to reach their next destination.

While ageism in the broad sense isn't exclusive to older adults – young people may also be discriminated against due to their age – it is still predominantly defined as negative attitudes toward older adults (Bratt *et al*., 2018). In Robert Butler's (1969) paper where he initially established the term ageism, he says that the attitude "reflects a deep seated uneasiness on the part of the young and middle aged – a personal revulsion to and distaste for growing old, disease, disability; and fear of powerlessness, uselessness, and death." The way this underlying predisposition manifests is not unlike other forms of discrimination where a group is considered as different or 'other'. As a result, older persons are "categorized as senile, rigid, and old fashioned in morality and skills… we subtly cease to identify them as human beings, which enables us to feel more comfortable about our neglect and dislike of them." (Butler, 1975)

In an opinion article about ageism in healthcare, Dr. Kenneth Rockwood, a Canadian geriatrician recalls this discussion with a trainee doctor:

Healthcare is overstretched, she argued. "We can't do everything for everyone, so why spend money on old people, who have little chance of benefit?" For her, ageism is not all that bad — in fact, it's a practical response to limited resources. (Rockwood, 2018)

The student doctor's attitude is embedded in the philosophy of utilitarianism – patients who can contribute to society more should be given greater priority. In a study by Wiseman (2007), utilitarian attitudes were exhibited by university students who were asked to triage healthcare situations –as opposed to a more egalitarian approach that supposes all people are of equal worth. In a response to a survey asking introductory psychology students to rank the priority for treatment of a hypothetical patient with kidney disease, participants favoured patients who were young, had children and were mentally healthy.

The irony of this attitude of course, is that ageism is one form of prejudice against our own self, specifically our "feared future self." (Nelson, 2005) This attitude persists despite the understood inevitability of aging and our exposure to the scale at which it is occurring. The World Health Organisation estimates that the population of people over age 60 will reach 2 billion by 2050 – composing 22% of the global population. One explanation for the cultural willingness to maintain such an attitude is the Terror Management Theory. This theory suggests that a fundamental function of societal ageism is to protect ourselves from the anxiety of our own

mortality. Because of the association between age and death, ageism allows "the younger person to deny the reality that they too will eventually become part of that outgroup." (Nelson, 2005)

As the world transitions to accommodate the realities of normal aging, there are stark consequences of this pervasive prejudice toward older adults. Compared to other forms of discrimination such as sexism and racism, not only is ageism socially acceptable, it is strongly institutionalised, undetected and unchallenged (Officer *et al*., 2016). These attitudes are so deep-seated that older people internalize them and hold negative self-views that affect their well-being. (Moberg and Nelson, 2003) Therefore, it is critical to not only account for these stereotypical concepts of an older person, but also determine how they are detrimental in healthcare – stereotypes by definition fail to recognize the complexity and variation within a population. In Jan Baars' (2012) *Aging and the Art of Living* the author was shocked by the treatment of the elderly as "almost another species who were mainly of interest as objects of care." Conceptualizing older adults in single-dimensional views such as "demented" or even "wise," undermines care that should be "embedded in the life of persons with dignity in their own right, not simply problematic beings needing care." He says that carers for this population should regard patients as "socially located, vulnerable, and unique individuals ready to live possible futures filled with perils and promise." (Baars, 2012)

Ageist societal conceptions have negative impacts on health – those who hold negative views of self have poorer recovery from disability. Furthermore, these values are embedded in the institution of healthcare resulting in poorer health outcomes (Officer *et al*., 2016). This spans from the first point of contact with healthcare personnel, to how systemically institutions like universities and hospitals uphold ageist societal views which results in inequitable outcomes for the aging population.

Healthcare Workers Attitudes Affect Older Adult's Outcomes

There are countless times during busy ward rounds where I observe doctors loudly addressing a patient in a slow, patronising, insincere tone– with bulging eyes and almost cartoonish facial expressions as if instructing a child. "A lot of the older people can't hear, sometimes I'm pretty much yelling at them," one doctor explained to me and another medical student right in front of an older patient. And while it is common sense to speak louder in cases where patients are hearing impaired, in contrast I have seen trained geriatricians able to effectively communicate with almost deaf patients in a manner that upheld respect and dignity for the patient.

A 2015 UK literature review by Kydd and Fleming aimed to determine if age discrimination exists within the health care system and delved into the exact nature of what the consequences of ageist attitudes exhibited by healthcare workers were. The article reviewed 28 articles pertaining to ageism in healthcare and found that stereotypical societal viewpoints of old age were commonly cited; that of being frail, weak, dependent and non-productive members of society. One key concept that emerged time and again was dignity in relation to equality of care. According to Baillie and Matiti (2018), dignity can be conceptualized by 11 attributes: privacy, confidentiality, need for information, choice, involvement in care, independence, form of address, decency, control, respect and patient communication. As such numerous types of

behaviours such as rudeness, indifference, condescension, dismissal, disregard, dependence, intrusion, deprivation, assault among others are characterized as violating dignity. Beach (2005) determined a rather intuitive finding: positive health care experiences require dignity to be upheld – in these cases survey results indicated high levels of patient satisfaction among all populations. Furthermore, dignity is integrated into professional and ethical codes of practice as well as assessed in the inspection of healthcare providers – it has a central role in the healthcare profession. Behaviour that violates dignity is problematic in high risk groups such as travellers, asylum seekers, disabled and homeless people.

Another such high-risk group as identified by the UK's Health Service Ombudsman is older adults. Ageist attitudes among hospital staff and loss of dignity in care resulted in "unnecessary pain, indignity and distress while in the care of the NHS." (Baillie and Matiti , 2018) Kydd and Fleming's literature review determined that of the original aforementioned 11 attributes of dignity, two core elements – relationship and involvement – emerged as core elements of person centred care, a framework originally established by Kitson *et al*. (2012). A lack of these two elements manifested as patronizing and ineffective communication between healthcare providers and older patients, characterized by healthcare providers being less patient, less respectful, less involved and less optimistic with older patients (Ambady *et al*., 2002). But beyond the inherent indecency of ageist behaviour that fails to uphold a patient's dignity, Nussbaum *et al*. (2005) suggest that poor bedside manner affects physical, psychological and social well being of older adults. One study, which analysed the behaviour of physical therapists, found that with older patients, practitioners distanced themselves and showed indifferent behaviour and this was then related to increased negative physical health outcomes for the patient (Ambady *et al*., 2002). The UK Commission on Dignity in Care report asserted that "undignified care of older people does not happen in a vacuum; it is rooted in the discrimination and neglect evident towards older people in British society."

In certain cases, societal ageism permeates so far into the attitudes of healthcare workers that it affects the management of patients. One study revealed that older lung cancer patients were less likely to be referred for surgery or undergo intrusive diagnostic procedures despite many studies showing that postoperative recovery success is not dependent on age. (Wyman *et al*., 2018) Another study by Haigney *et al*. in 1997 showed that despite a higher prevalence of breast cancer among older women, only 11% of these older women received breast cancer screening examinations, and only 7% of physicians conducted routine breast examinations on older women. This was attributed to the ageist belief that older women would respond negatively to aggressive treatments. Likewise, this attitude is evident in a study that showed under-treatment of heart attacks in older adults relative to national guidelines and another study that found older women were more likely to be treated pharmacologically rather than surgically. (Wenger, 1997) Similar age-related discrimination in diagnostic procedures have emerged in other medical subspecialties such as cardiology, oncology and stroke treatment. (Wyman *et al*., 2018) In the case of suicidal tendencies among older adults, one study showed that physicians were less willing to use therapeutic strategies to intervene based on the belief that these ideations were logical and normal among older adults. (Uncapher and Areán, 2000)

Medical Students Have Ageist Attitudes

In my own class of 180 students, I can count on one hand – including myself— the number of people who are interested in pursuing geriatric medicine as a possible career. "I've only heard of one other person wanting to specialize in that," one of my friends remarked after chatting about our prospective careers. I asked another friend why he thought that that field may be unpopular among students. "My guess is that it isn't as glamorous as other fields and doesn't give off that sexy vibe," he said. "Our society glamourizes surgeons or treating the impossible cancer, but rarely does so for things like osteoarthritis."

The first manifestation of negative societal attitudes toward older adults may be exhibited in professional healthcare education settings. With rapidly changing demographics the AAMC has recommended core competencies in geriatrics be taught, however there is no consensus on how to best achieve this. (Meiboom *et al*., 2015) The geriatric field is lagging behind, with medical students commonly reporting little interest in caring for older patient groups. (Samra *et al*., 2013) In the United States, 44% of the geriatric medicine first-year fellowship training slots were left unfilled in 2008. (Meiboom *et al*., 2015) While the situation in the UK may be more hopeful – consultant applications and positions in geriatrics are increasing – proportions of positions filled are still well below 100%, and consultant workload is increased (Fisher *et al*., 2014).

Several preconceptions about geriatric medicine were revealed in Meiboom's (2015) systematic review that aimed to determine different factors that medical students considered when choosing a career in the field. Chronicity and complexity of disease were deterrents because of the notion that it would be impossible to see the direct effects of treatment or curation – and that experiencing patient decline and death would be depressing. Some found the number of medical problems, atypical diseases and polypharmacy to be too complex, and that assessment would take too much time. (Bagri and Tiberius, 2010) The low financial reward, and five-year length of training, were other negative influencing factors while part-time work and lighter call schedules were positive influencing factors. Prestige or status was found to be another deterring factor, albeit a smaller one. A survey of doctors and students showed specialties that are considered a less biomedical type of medicine were less prestigious and furthermore specialities associated with elderly patients, chronic conditions and less visible treatment procedures were associated with low levels of prestige. (Album and Westin, 2008) One study showed that some students who did not have an interest in geriatrics perceived working with older patients as not rewarding in contrast to the prospect of working in areas that were "fast and exciting, with the goal of adding many years to the life of the patient." (Schigelone and Ingersoll-Dayton, 2004) Interestingly, one study showed that students uninterested in geriatrics rated caring for younger patients as an important characteristic of practice. (Diachun, Hillier and Stolee, 2006)

One explanation for these ageist attitudes persisting is the lack of exposure of medical students to the geriatric field. (Bensadon, Teasdale and Odenheimer, 2013) In my ongoing experience I have had very little exposure to geriatric curriculum and having a clinical rotation in 'medicine for the elderly' was not mandatory. However, in the UK, the number of medical schools teaching geriatrics as part of the curriculum is on the rise. Gordon *et al*.'s (2013) review of UK medical school curriculum found that common medical geriatric conditions are being taught and

examined more than ever before. The study, which surveyed 31 universities, found that while cellular and physiological aging may be taught, some gaps exist in the teaching of psychosocial aspects of aging. Only 68% of schools taught about elder abuse, a troubling statistic considering 2.6% of over-65s have experienced such abuse. Similarly, the survey showed that while schools taught about dementia, there was a widespread failure to focus on behaviours and attitudes toward people with dementia. Tinker *et al*. (2016) go further to say, "teaching on mental health conditions such as dementia in medical schools is undoubtedly prevalent, but predominately from a biomedical perspective."

In 2013, the British Geriatric Society published guidelines to promote teaching of geriatric medicine and gerontology in order to ensure doctors possessed the necessary skills, knowledge, and attitudes to care for aging patients. Tinker *et al*. argue that while leaps have been made in including and teaching aging from a biomedical framework, an equal emphasis should be made on social gerontology to combat ageist attitudes: "The sociology of aging should encourage medical students to appreciate the highly individualized experience of aging… and persuade medical students to view older people in the context of their life course, considering their life experiences and thereby avoid ageist attitude and negative stereotypes." The evidence suggests that exposure to teaching medical students about aging in a holistic manner led to improved attitudes towards aging. (Tullo, Spencer and Allan, 2010)

This was demonstrated in a 2013 U.S. study by Bensadon *et al*. that showed exposure to diverse geriatric teaching and clerkship for third year medical students was enough to change their attitudes about care for the elderly. The four-week program included lectures about topics such as "common geriatric syndromes (e.g., falls, delirium), elder law (e.g., advanced directives), older drivers, aging demographics, pain management, Medicare, hospice, and palliative care." Lectures were supplemented by creative opportunities to meet and work with older adults in clinical outpatient settings, home visits and specialized clinics as well as collaborate with multidisciplinary teams. Not surprisingly, when these students then took the Palmore Test – a widely used tool to measure geriatric knowledge and attitudes – overall mean scores increased. The study found that teaching had a greater impact on psychosocial rather than biomedical information. Almost all students strongly recommended the experience and many singled it out as their favourite experience in medical school.

A similar study by Jeste *et al*. (2017) found that short-term research training programs focused on aging had a positive impact on medical students' attitudes toward older adults including reduction of ageism, and interest in geriatrics. The study identified five major components that led to improved attitudes. 1) exposure to aging-related research, 2) participation in didactics on successful aging 3) role modelling of mentors and program staffing with strong interest and optimism for geriatrics, 4) geriatric clinical experience with personal exposure to older adults, and 5) administration of programs in an environment with a focus on healthy aging.

The implication of these studies suggest curriculum should be improved to change the ageist image that trainees have of older adults. Improvements can be made in teaching the limits of medical intervention, exposure to healthy older persons in order to dispel and revise stereotypes. However, further research into the psychosocial curricular content is required. (Bensadon, *et al*.,

2013) The authors conclude their article by outlining the importance of altering attitudes at the level of education. “If the geriatric medical establishment cannot persuasively communicate to trainees the joy and professional fulfilment associated with caring for older patients, career decisions may well be guided by poorly informed personal biases and stereotypes reinforced by a health care system and society that devalue and render invisible their most seasoned members.”

Structural Ageism Results in Inequity in the Healthcare System

If a person comes in to hospital with chest pain, doctors have an almost exact algorithm indicating what questions to ask, what investigations to order, and how to treat them. In other words, our system is very good at treating patients with one illness.

The current system fails to account for the complexity of older adults. When they are discharged from hospital we fail to properly inquire: what about their mobility, polypharmacy, disability and social problems?

“Our success with a single illness approach has biased us to think that this is the approach we should always take. When frail people show up with all their health and social problems, we see them as illegitimate — as unsuited for what we do,” Dr. Rockwood explains in his op-ed about ageism for Evidence Network.

As the population ages and fertility rates decrease, demographic changes are occurring faster than the healthcare system can adapt. In the UK, the old age dependency ratio (OADR) which is the number of people aged 65 and above per 1,000 working aged people (aged 16-64) is increasing. In the past decade the OADR has changed from 244 to 289 and is projected to reach 419 in the next 25 years. (Office for National Statistics UK, 2018) Not only will this affect the quality of care for older patients who depend on the current system but may also have an economic burden. Kydd *et al*.’s literature review found that the rise in the numbers of older adults in poor health may not be sustainable, suggesting that acute target driven hospitals are not the right place for a vulnerable frail person with multiple needs. Despite this, the authors, found healthcare moving in the opposite direction, with 10 articles pertaining to age discrimination in the context of the changing role of hospitals.

“Hospitals and wards that specialised in the care of older people have been closed and replaced by large acute hospitals. The specialist services of geriatricians have diminished at a time when the numbers of the oldest old (85+) are increasing. With this comes a lack of specialist staff, which is apparent in the prescribing practices of doctors working in acute services.” (Kydd and Fleming, 2015)

In a qualitative study conducted by Spinewine *et al*. (2005), a reliance on acute problems was noted by interviewed doctors. “I think that doctors pay a lot of attention to the acute problem, but they don't give enough consideration to other medicines that patients are on. For example, a

patient had been admitted for syncope secondary to atrial fibrillation. They started to give digoxin to control the fibrillation. But at the same time, pain care, for example, was inadequate: the patient was on paracetamol and amitriptyline at home, and these were not re-prescribed in the hospital." In addition to undermedication, the study found that inappropriate prescribing such as not adjusting medication to renal status was prevalent – occurring mostly with junior doctors and external consultants.

When hospitalized, older adults are at risk of experiencing functional decline including falls, pressure ulcers and delirium. (Kleinpell *et al*., 2008) Furthermore, hospital-acquired functional decline is associated with greater hospital expenditures, institutionalization, and mortality in older adults. While acute geriatric unit care has shown to be beneficial in reducing functional decline, this is arguably a band-aid solution for a larger problem. (Baztan *et al*., 2009)

Kydd and Fleming (2015) suggest that maintaining the status quo of an acute care healthcare setting and not moving towards solutions for better treating the complexity of aging adults is inherently ageist. "Hospitals are not an environment for those who no longer need medical treatment. Yet the lack of restorative or rehabilitative facilities, especially for the oldest old, can mean that some people have little or no opportunity to reach their health potential." In an article published in the Journal of the American Geriatric Society, Dr. Desmond O'Neill argues that these barriers prevent an "age-attuned" healthcare system that accounts for the complexity of illness experienced later in life. "Not only do the targets need to be redrawn, adding stroke, dementia, and gait instability to the usual chronic disease canon of diabetes mellitus, chronic obstructive pulmonary disease, and heart failure, but also a review is needed of the outcomes in terms of quality measures so as to age-proof them." (O'Neill, 2011)

Healthcare reimbursement plays a role in the differential treatment of older adults, in particular the myth that the aging population will be a large drain on the economy. Simplistic discourse which frames aging as an expensive burden on public spending may also play a role in influencing global health policy, limiting the allocation of resources. In reality, older adults contributed to only 2% of the increase in health expenditures between 1940 and 1990, compared to 51% related to technological innovation. (Officer *et al*., 2016) As a result of these myths, and in accordance with the acute medical system of care, "current payment mechanisms incentivize medical procedures and technology-driven tests, but do not reimburse providers for the often complicated and time-consuming process of geriatric care. (Wyman *et al*., 2018) One study in Belgium from 2012 showed that almost 40% of people in Flanders were convinced that people beyond age 85 were "not worthy" of expensive medical treatment. (Age Platform Europe, 2018) Ironically, older adults may have an opposite effect on the economy. O'Neill (2011) says that one of the strongest arguments against the myth of older adults causing a drain on society is the

economics paper "The value of health and longevity" that demonstrates that greater longevity after 1970 has added $3.2 trillion a year to the U.S. economy.

The false notion of aging people as a financial burden on society results in policy with age cut-offs: Greece has a policy of sending stroke patients over 65 to the internal medicine ward rather than neurology, Finland does not provide coverage for medical rehabilitation in adults over 65. A 2008 study in the UK found that spending on older people's services would have to be increased by 25% to achieve equality of outcomes with services for younger adults. (Age Platform Europe, 2018)

With limited resources, is the only solution to cut down on services that are already sub-optimal for the elderly? One Canadian study suggests that an organized and integrated healthcare service that includes preventative home care may be a solution. In a 2011 study, Chappell and Hollander showed that when cuts were made to home-care services, the cost of hospital and nursing homes increased compared to health units that did not cut services. If a person with poor mobility tries to vacuum their home and falls, they may break their hip and be admitted to hospital and have to endure the risks of surgery. After, they may become immobile and restricted to a wheel chair and subsequently must move into a nursing home when they become more dependent. A geriatric home assessment and supportive care could have prevented this scenario. Chappell and Hollander showed that a 20% decrease in falls experienced by older adults would result in 7,500 fewer hospitalizations, 1,800 fewer permanently disabled older adults and a healthcare cost savings of $138 million per year.

Another piece of the puzzle is the cohort of unpaid caregivers, primarily family and friends, who are estimated to be a major form of care for older adults that far exceed formal healthcare. These included contributions such as meal preparation, clean-up, house cleaning, laundry, grocery shopping and personal care. The National Health and Aging Trends Study and national Study of Caregiving estimated that in the United States there are 14.7 million caregivers assisting 7.7 million older adults. A significant proportion of older adults relied on unpaid caregivers such as family. (Wolff *et al*., 2016) The key is not just funding better preventative homecare, but to integrate this form of care within the entire system. Countries like Australia, Japan and Denmark offer national home care or long-term services within their system of care which substitute less costly care that allows individuals to function independently as long as possible. (Chappell and Hollander, 2011)

How Can We Combat Ageism?

While volunteering in a long-term care centre a few years ago, I spent a large part of my time with a pleasant gentleman named Walter. The octogenarian, now confined to a wheelchair, told me his story: his wife had passed away a few years ago, he had buried one of his children, and many of his closest friends were now gone. But despite his hardships and his loneliness, Walter was friendly and gentle and exuded warmth. Every day, I would take Walter outside into the courtyard where he enjoyed the sunshine and we would chat. He told me about his passion for music, and how he played piano in bars and clubs when he was a younger man, "We called it pop music, it's different from what the pop music is now," he said.

I asked him if he knew there was a piano in the gymnasium area of the centre, which he was surprised to hear. I'll never forget the first time I excitedly wheeled Walter down to the piano. I removed the bench and rolled his wheelchair into the proper position. Without missing a beat, his fingers danced on the keys and a crowd slowly gathered around the piano of other patients and residents smiling and clapping their hands. Walter was beaming. For the rest of my time in that centre, the favourite part of my day was taking Walter down to the piano whenever he asked, to be treated to a display of the beauty and compassion of a man through his music.

To see an older adult as less than what they are – an amazing human being – is not only detrimental to them, but to ourselves. When my grandmother was dying in Sri Lanka, the last time my family visited, I watched my dad transfer her emaciated body from the wheelchair to the bed and clear her airway with a suction catheter. This wasn't just a frail old woman, who could barely speak and was dependent on caregivers. It was a woman who gave birth to and raised 9 children from a small mountain village in Sri Lanka. A woman who saw me grow up and took care of me. A woman who despite the language barrier I loved to make laugh with my goofy behaviour. She was my grandmother.

According to Butler (1975), "Ageism allows the younger generations to see older people as different from themselves; thus, they subtly cease to identify with their elders as human beings."

Evidence suggests that overcoming this paradoxical distinction of future-self discrimination is quite intuitive. The more time people spend caring for older adults, the more these ageist attitudes recede. In Lytle and Levy's (2017) study that tested The Positive Education about Aging and Contact Experiences (PEACE) model, they determined two key factors for reducing ageism: education about aging, and extended contact. Just as medical students who were taught about geriatrics, and experienced clinical clerkships changed their attitudes of aging, a systematic review found that pedagogical interventions designed to increase aging knowledge resulted in improved attitudes toward older adults and greater aging knowledge. (Chonody, 2015) In Jonson's (2012) article published in the gerontologist he suggests that society is struggling to update the stereotypes of old age "a misunderstanding that can be corrected with factual information…The health, mental abilities, financial security, social activity, and life satisfaction of older people has increased, but most people have not heard the good news." Research also suggests that negative attitudes stem from lack of positive contact between group members. Positive contact with older adults is predominately associated with less ageism with the strongest

effect observed for close relationships such as friendships. This exposure allows for individual identities to become more salient and have a richer more holistic view of individuals. (Lytle and Levy, 2017)

In 2016, World Health Organization adopted the first global strategy and plan of action on ageing and health, which spans a 15-year period and calls for a global campaign to combat ageism. The campaign seeks to inform the public about the individuality of older persons, influences on health, and aspects of healthy aging. The program mandates changes in societal attitudes, more accessible environments, and changes to health care systems that align with the needs of older people.

While working with geriatric practitioners who are attuned to these needs, the patients are treated holistically, with both their medical and psychosocial needs accounted for. I had the pleasure of hearing the colourful stories of many patients and getting to know them as human beings rather than "objects of care." Besides the patients leaving the hospital showing so much gratitude, each day I walked away feeling fulfilled. While it may not be for everyone, I can understand why geriatricians are ranked as the subspecialty with the highest job satisfaction (O'Neill, 2011) – and maybe this should be another selling point for a career that is overlooked in a profession where burnout is so prevalent.

On that windy day in Dublin, I stopped for a moment when I saw the man's hat blow off on the platform, and I ran around the enclosed part of the parking lot until I could enter it. I picked up his hat and handed it to him through the gap of the iron fence.

"Thank you, God bless you," the man said.

When I came back around to the platform, I chatted with him for a few moments until the next tram arrived and he shook my hand. I won't forget how appreciative he was of such a small gesture. I can only hope that when I am in that man's shoes someday, others would take the time to do the same.

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