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Disproportionate impact of abortion restriction: Implications for emergency department clinicians

Haleigh P. Ferro, BS [a,*], Kelly Williams, MSN, RN [b], Debra S. Holbrook, MSN, RN [c], Katie J. O'Conor, MD [a]

[a] Johns Hopkins University School of Medicine, 733 N Broadway, Baltimore, MD 21287, United States
[b] Johns Hopkins Medicine, 1800 Orleans St, Baltimore, MD 21287, United States
[c] Mercy Medical Center, 345 St. Paul Pl, Baltimore, MD 21202, United States

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ABSTRACT

Individuals experiencing intimate partner violence (IPV) and/or human trafficking (HT) are at increased risk of severe health consequences as a result of legislation criminalizing and/or restricting abortion, which is expected to increase as a result of the Supreme Court decision Dobbs v. Jackson. These risks are further stratified by race, socioeconomics, and other marginalizing demographic attributes. IPV and HT introduce barriers to maintaining physical and mental health, due to control of access to transportation and funds by the abuser, fear of retribution for seeking healthcare, and other barriers. Individuals experiencing IPV or HT often lack reproductive autonomy, as a result of facing reproductive coercion at the hands of their abusers. Following the Dobbs decision, these vulnerable patient populations will face further limitations on their reproductive autonomy and increased obstacles to obtaining an abortion if they medically need or desire one. This will likely result in more patients presenting to the emergency department due to complications from unsafe or unsupervised self-managed abortions, as well as patients being reluctant to report having obtained an unlawful abortion due to fear of legal consequences. This is particularly relevant to individuals experiencing IPV and HT, as they may be more likely to use these methods for obtaining an abortion due to numerous barriers. Emergency medicine clinicians are vital in providing care to these patients, as they frequently present to emergency departments. A multi-pronged approach to better support these patients is essential, involving an increased index of suspicion for IPV, HT or the complications of unsupervised abortion, improved organizational structures, specialized training for staff, improved screening methods, reflection on implicit bias, and recommendations for mindful documentation and legal considerations.

On June 24th, 2022 the United States (US) Supreme Court released their decision on Dobbs v. Jackson Women's Health Organization, which effectively overturned Roe v. Wade [1], disbanding longstanding federal protection for abortions. This decision promptly resulted in drafting or enactment of legislation to criminalize and/or restrict abortion in at least nine states [2]. Many healthcare organizations have decried this decision, with the American College of Obstetricians and Gynecologists stating that the decision is a "direct blow to bodily autonomy, reproductive health, patient safety and health equity in the United States" [3] and the American College of Emergency Physicians expressing that they are "deeply concerned about the medical and legal implications" and that "decisions by nonmedical professionals that interfere with the physician-patient relationship are extremely worrisome" [4]. Furthermore, emergency medicine (EM) clinicians have been grappling with the potential consequences of this ruling, experiencing fear of legal consequences for providing life-saving medical care, or concerns about navigating a new influx of patients with complex pregnancy-related complications [5]. While this decision is unsettling and harmful for many, specific groups may be negatively impacted disproportionately by this decision, particularly individuals experiencing intimate partner violence (IPV) and/or human trafficking (HT). Although IPV and HT dynamics are unique, their shared features contribute to an increased risk of negative consequences related to abortion restriction. This effect will likely be further stratified by race, socioeconomics, and other marginalizing demographic attributes [6]. The restriction and criminalization of abortion may thus lead to negative health outcomes and exacerbate existing disparities. EM clinicians should be prepared for potential consequences and for opportunities to best care for these patients.

* Corresponding author.
E-mail address: hferro1@jhmi.edu (H.P. Ferro), kwill160@jhmi.edu (K. Williams), dholbrook@mdmercy.com (D.S. Holbrook), kjo@jhmi.edu (K.J. O'Conor).

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1. Dynamics causing patients experiencing IPV or HT to be more vulnerable to negative sequelae of abortion bans

1.1. Reproductive coercion

The link between seeking an abortion and IPV/HT has been well established [7-12]; patients who are in violent or coercive relationships are more likely to seek abortion services [13], and there have already been concerns raised about how patients experiencing IPV will be affected by abortion restrictions [14]. IPV/HT dynamics often involve reproductive coercion – behaviors that interfere with maternal reproductive autonomy via birth control sabotage, abortion pressure or prohibition, and/or pregnancy pressure and manipulation [9,11,15,16]. For example, among female patients seen at family planning clinics, one in four women who had experienced physical or sexual IPV also reported pregnancy pressure [15].

It is important to note that people of color are disproportionately affected by both IPV/HT and reproductive coercion. In the US, Black or African-American women report a higher prevalence of lifetime IPV than non-Hispanic White women and Hispanic women [17]. Similarly, Black or African-American patients report more instances of reproductive coercion compared to White patients [18,19].

1.2. Decreased freedom of movement

IPV and HT center around control. Abusers will often control an individual's freedom of movement and reproductive autonomy. Abusers may force home pregnancy tests to ensure that an abortion hasn't occurred, follow individuals to their medical appointments, and/or threaten physical harm if the individual attempts to seek an abortion [13]. The expected surge in restrictive abortion laws will likely make it easier for abusers to ensure their partners don't seek an abortion, as the individuals will no longer be able to discreetly travel to a nearby clinic [20]. As a consequence, this allows abusers to exert even more control [21].

1.3. Violence trends during pregnancy

Pregnancy is a known risk factor that increases incidence of violence against women; many individuals report new abuse or intensified abuse when they become pregnant [22]. Women with unwanted pregnancies are four times more likely to experience physical violence by a husband or partner compared to women with intended pregnancies [15,22]. The racial disparities seen in IPV are also pronounced with respect to pregnancy related violence, maternal mortality and homicide. Racial disparities have been well-documented in maternal mortality—the maternal mortality rate is almost three times higher for non-Hispanic Black or African-American women than non-Hispanic White women in the US, which worsened during the COVID-19 pandemic [23,24]. In addition, the ratio for intimate-partner homicide cases was approximately four times higher among Black or African-American women than white women [25-27].

The criminalization and restriction of abortion may result in more patients forced to carry pregnancies to term, which will in turn cause increases in pregnancy-associated violence, homicides, and other negative healthcare outcomes as outlined above, disproportionately affecting patients of color.

1.4. Socioeconomic status

Similarly, these restrictive abortion laws often widen socioeconomic inequity relating to access to abortions and related healthcare, and this inequity is compounded for individuals experiencing IPV or HT. More affluent individuals with financial means will be able to travel to other states for an abortion, while people in lower socioeconomic brackets will be forced to carry unwanted pregnancies to term [28]. The barrier is even higher for individuals experiencing IPV and HT, as they may not have control of their finances, vital documents, or transportation, further limiting their ability to travel to the closest abortion clinic [29]. This has already been observed in Texas following their initial restrictions on abortion in 2018 [30]. This barrier is higher for individuals experiencing IPV, as they are less likely to have insurance coverage [31].

2. Consequences of restrictive abortion legislation

2.1. A surge in unsupervised abortions

With criminalization and restriction of abortion expected in at least 26 US states, it is likely that the rate of unsupervised abortions will increase. This includes self-managed abortions through means of medical interventions, such as misoprostol or mifepristone, or alternative means of abortion that are widely considered unsafe.

2.1.1. Self-managed abortion

In the wake of the COVID-19 pandemic, interest in self-managed abortion increased. This is defined as any form of abortion that occurs outside of a clinical setting without clinician support [32]. The most common methods of self-managed abortions include oral or vaginal formulations of mifepristone, prostaglandin, or combinations of mifepristone and methotrexate, tamoxifen and more [32,33]. Since mifepristone was approved by the FDA in 2000, it has become a popular method of abortion, accounting for about 60% of abortions carried out at less than 10 weeks gestation [32]. Severe complications, such as uterine rupture or severe hemorrhage, are very rare following self-managed abortion, but patients may seek medical care due to common sequelae such as cramping, vaginal bleeding, or uncertainty regarding the completeness of the abortion[34]. Although excessive bleeding is rare, it is defined as soaking through 2 pads per hour, after a minimum of 2 consecutive hours [35]. All of the complications listed above can be managed according to best practice recommendations [36-38].

While accessibility of utilizing these methods for abortion increased with the use of telehealth, particularly in the COVID-19 pandemic, following the Dobbs vs. Jackson decision almost half of U.S. states now have laws criminalizing persons attempting or assisting with these methods, and three states currently have laws explicitly criminalizing these methods of abortion [34]. However, there are still means for many patients to access these medications even outside of the typical channels, so it is important for EM clinicians to be aware of them, and how patients may present after their use.

2.1.2. Unsafe abortions

To date, unsafe abortion predominantly occurs in countries where abortion is highly restricted by law or not easily accessible due to barriers including cost, transportation, and culture [28,39]. Worldwide, there are an estimated 70,000 deaths annually due to unsafe abortions, with millions more experiencing severe health consequences [40]. While this value is alarming, it is also likely to be an underestimation.

In contrast, the numbers of deaths and emergency department (ED) visits in the US resulting from unsafe abortion have been negligible due to abortion's legal status, the number of clinicians trained to provide the procedure safely, and the availability of follow-up care in the event of a complication [40,41]. Following the Dobbs decision, these morbidity and mortality rates may increase. In states that have criminalized or restricted abortion access, individuals who feel as if they do not have any other choice (such as those experiencing IPV or HT) may turn to a variety of nonmedical or traditional methods to attempt to terminate their pregnancies. Some of these methods include:

- inserting non-sterile objects into the vagina or cervix (such as broken bottles, branches, wires, clothes hangers, swabs soaked in acids, corrosives, herbal drugs, or soaps)

- inserting liquids into the vagina (such as hydrogen peroxide, bleach tar, soapy water, gasoline)
- drinking substances (such as alcohol, massive doses of castor oil, or bleach)
- engaging in traumatic physical activity (such as carrying heavy loads, jumping, falling, or being pushed down stairs)
- taking non-indicated pharmaceutical products (such as aspirin, sleep aids, chloroquine, or veterinary drugs)
- manipulating the abdomen or locating the fetal mass and attempting to dislodge it with harsh massage/strong compressions [39].

The expected morbidity and mortality resulting from these unsafe procedures is extensive, such as traumatic injury, hemorrhage or sepsis [42]. An increase in these complications will likely result in increased ED visits [43,44].

3. Next steps and recommendations for emergency medicine clinicians

There are many opportunities for EM clinicians to best serve this patient population and mitigate potential barriers that individuals experiencing IPV or HT face related to abortion access and reproductive autonomy.

1. **Clinicians should have a high index of suspicion for patients presenting with histories concerning for IPV, HT, complications due to self-managed or unsafe abortions, or any combination of these factors.** Clinicians must understand that patients may be reluctant to report a history of abortion or obtaining an unlawful abortion due to stigmatization, fear of legal consequences, or for individuals experiencing IPV or HT, fear of discovery by their abuser. EM clinicians may encounter more patients suffering severe complications such as bleeding or infection, as well as patients experiencing psychological distress or uncertainty following self-managed abortion at home [45].
   a. **Unsafe Abortions:** A high index of suspicion for patients presenting with complications of unsafe abortions, such as uterine and bowel injury or perforation, hemorrhage, or infection is critical. ED teams should be educated in the identification of these adverse outcomes and be trained in trauma-informed history taking as patients may not be forthcoming with histories of unsafe abortions due to fear of legal consequences or stigma.
   b. **Human Trafficking:** In addition, providers should have a high index of suspicion that a patient may be experiencing human trafficking when they present with these characteristics: the patient has no identification documents, or they are in the possession of an accompanying individual, an accompanying individual insists on answering questions for the patient, the patient is reluctant to explain their injuries, the patient is unaware of their location or home address, the patient exhibits fear, tension, nervousness, blunt affect, or eye contact avoidance, and more. Medical red flags that may raise provider suspicion for the possibility of HT are: recurrent UTIs, frequent treatment for STIs, a high number of sexual partners, multiple pregnancies or abortions, substance use, frequent colds, weight loss/malnourishment, undertreated prior injuries, bruises, shows of physical restraint, branding (through means of tattoos or other markings), etc [46,47].
   c. **Intimate Partner Violence:** While patients who experience IPV share some of the characteristics described above that can be red flag features for HT, such as altered affect, undertreated prior injuries and others, clinicians should have a high index of suspicion for IPV when patients present with repeated ED visits, suicidal ideation, substance use, head injuries, neck injuries, facial fractures, wounds or bruises in different stages of healing, and more [48].
   d. **Relationship Between IPV, HT, and Abortion:** As outlined in the first section of the article, patients experiencing IPV/HT are more likely to seek abortion services, and therefore more likely to present with complications of self-managed or unsafe abortions after the Supreme Court ruling. Because of this, EM clinicians should have a low threshold to consider IPV or HT in patients presenting with these complications, and vice versa.

2. **EDs should incorporate more supportive measures for individuals experiencing IPV or HT.**
   a. **Electronic Clinical Pathways:** One way that EDs can improve their care of patients experiencing IPV or HT, particularly in the wake of the Supreme Court Decision, is by incorporating screening for IPV/HT into their EMR system. For example, at Johns Hopkins Medicine, ED physicians used a software called AgileMD to create Evidence-Based Guidelines within their EMR. This allows EM staff to click guidelines for chief complaints their patients may have, showing them stepwise methods for assessing patients, differential diagnoses of consequence, and linking them to order sets [49]. Using a system like this, guidelines could be created for both HT and IPV with a variety of screening tools, local organizations that provide support to vulnerable patients, such as shelters or legal services, specific telephone numbers to hotlines that may be helpful (such as the National Human Trafficking Hotline [50]) instructions for how staff should engage with law enforcement if necessary, etc.
   b. **Visual Information:** In addition, EDs can prepare to better support patients experiencing IPV/HT by displaying posters addressing IPV and reproductive coercion, as well as information including hotline numbers, safety and resource cards for local organizations or other entities of support in common and private areas. For example, some of these could be in patient rooms, restrooms, or the waiting room [15].
   c. **Advocates:** Providing IPV and HT advocates in EDs and partnering with community resources can provide support and may reduce readmission and recurrent violence [51,52]. This type of advocacy intervention could prove even more helpful in the wake of the criminalization and restriction of abortion, as patients may be dealing with increased challenges associated with lack of access to reproductive healthcare. Similarly, involving social work early in the course of these patients' ED visits can provide similar support, and aid them in connecting with resources in the community [53].

3. **Ensuring that all clinicians and staff are specifically trained in how to identify and care for patients experiencing IPV/HT, as well as in trauma-informed care.** While the majority of clinicians support implementing evidence-based screenings for IPV and HT, there have been barriers to effectively executing these policies in EDs. This is influenced by lack of adequate time with patients, discomfort and uncertainty regarding how to approach these types of conversations with patients, lack of knowledge about the red flag signs of IPV/HT, or not being aware of current screening tools [54,55]. These factors have also negatively influenced the patient experience. Patients reported negative encounters relating to a lack of trauma-informed care training, with clinicians appearing unconcerned or judgmental, becoming frustrated when patients declined legal involvement, and the conversations occurring in clinical spaces that lacked privacy [56].
   a. **IPV and HT Trainings:** There are multiple methods that EDs can use to combat the barriers detailed above. First, departments should ensure that all staff receive standardized training on how to look for IPV/HT. There are a variety of training formats that can be offered for staff, and these trainings can be used for Continuing Medical Education (CME) credits as a further incentive for staff to complete the trainings. For example, a training for medical students on IPV during their Emergency Medicine Core Clerkship

was created that involved a 20 min slide presentation, 1 h case-based conversation, and an evaluation with a 13 item self-assessment on knowledge following the training [57]. This is something that could be adapted to educate all ED staff. Other trainings include an evidence-based online training module located at HTEmergency.com [46], as well as the HEAL Trafficking and Hope for Justice Protocol Toolkit. This toolkit is a 44-page document created in 2016 by experts in the field, and whose directions are condensed on the healtrafficking.org website that can be used to guide ED clinicians in developing a HT protocol [58].

b. **Trauma-informed Care:** A similar approach to training should be taken to educate staff in trauma-informed care (TIC), which is critical in the provision of compassionate and quality care to this patient population [59]. While every patient may exhibit unique trauma responses, these may range from agitation or hyperarousal to blunted affect or dissociation, or even appearing "neutral" or unaffected while recalling profound trauma. Physical and behavioral manifestations of trauma may include fatigue, appetite and digestive changes, sleep disruption, mental health changes, and substance use [60]. Basic principles for TIC may include recognizing the prevalence of psychological trauma, knowing the signs and symptoms, using methods to minimize retraumatization, and responding to patients in ways that foster privacy, safety, nonjudgment, and patient autonomy [61,62].

4. **ED clinicians should work to implement better screening methods for IPV/HT into their daily workflow.** While there are more screening methods than those listed here, these are some examples for tools that EM clinicians can use to better identify and serve patients who may be experiencing HT or IPV. In addition, these could be incorporated into a clinical pathway located within a department's EMR system as described above.
   a. **IPV Screening:** The first example of a screening tool departments could utilize is one called the Technology Enhanced Screening and Supportive Assistance (TESSA), which was utilized in primary care clinics in Texas in 2017 [63]. This screening questionnaire was completed on a tablet, utilizing the TESSA mobile app. The questions related to high risk indicators, such as if a partner has ever used a weapon against the patient, past partner abuse, child abuse, sexual assault, quality of life problems, somatic symptoms, alcohol misuse, and others. Of the screened patients, 28.6% reported past or current abuse, and of these patients, 30.9% were able to be connected with an advocate.
   Another example of a screening tool that can be utilized by Emergency Clinicians is the Lethality Assessment Protocol (LAP) utilized by law enforcement, which determines a patient's risk of their violent partner escalating to homicide [64]. Some of the benefits of this screening tool are that it identifies individuals at risk of severe harm, connects them to safety and referral services before violence escalates, and it is quite brief, making it ideal for busy healthcare environments such as the emergency department [65]. This is also an opportune time to screen patients for reproductive coercion using a patient-centered approach [66].
   b. **HT Screening:** It may be more difficult for ED clinicians to screen patients for HT due to some of the characteristics described above (an accompanying party refusing to leave the patient for long and fear of disclosure on the part of the patient), but there are screening tools created that may still prove useful. One example of these is the Rapid Appraisal for Trafficking (RAFT), which was created from the Trafficking Victim Identification tool and has been used for stable, adult ED patients [67]. This screening tool is composed of four yes or no questions, and this brevity allows the screening to be conducted quickly in busy EDs as well. One thing ED staff noted was that prior to implementing this screening, clinicians needed education on how to recognize patients who may be experiencing HT. This barrier could be solved by implementing some of the trainings as detailed in point 3 above.

5. **EM clinicians can reflect on their own biases (based on race, perceived gender, socioeconomic status, pregnancy and related prenatal care, and other factors) and increase their knowledge on how racial disparities influence the prevalence of IPV, reproductive coercion, and race-based inequity in maternal mortality.** In order to do this, EM clinicians should be well-informed regarding the significant IPV, HT and maternal mortality disparities facing patients of color. These patients are also less likely to seek help from or even disclose abuse to healthcare clinicians due to historic experiences of racism and trauma in the medical system, medical mistrust, perceived discrimination, and immigration status [17]. This is important, as both Black/African-American and Hispanic women have been found to utilize the ED more than White women, and individuals experiencing IPV or HT are significantly more likely to utilize the ED [9,68,69]. This can be incorporated into education sessions sponsored by ED leadership. Addressing bias may include utilizing the Five Rs of Cultural Humility or the PLACE strategy [70,71]. In addition, for patients who come into the ED and are diagnosed as being pregnant, it is important for clinicians to be mindful of the fact that patients may have a wide range of reactions to this news. Clinicians should be prepared and open to discuss options with the patient, ranging from carrying the pregnancy to term or termination, and provide resources if the patient desires. The clinician's approach to this conversation may vary based on local laws and personal preference [72].
6. **EM clinicians can be mindful about how they interact with these patients, as well as how they choose to document in the patient's chart.** There have already been cases of patients reporting to EDs seeking help, only to find themselves reported to authorities by hospital staff and being charged for self-managing an abortion [73]. If this continues, it will further discourage these patients from seeking necessary medical care, especially if they are experiencing concomitant HT or IPV.
   a. **Information Gathering:** In order to mitigate this, one thing clinicians can do is to frame their care of these patients in the same way as they care for patients who are undocumented, or those who use illicit substances. It is crucial that patients feel comfortable, and the clinician explicitly explains that the medical system is separate from the legal system [74]. Similarly, clinicians must determine what information they actually need to provide medical care to a patient who is presenting with potential complications of an unsafe or self-managed abortion. For example, it may not be necessary to determine if a patient is suffering sequelae of a spontaneous abortion or a self-managed abortion, as the complications often require the same interventions [34]. An example of what clinicians can say to patients presenting in this situation is "You are safe here, and my only concern is your health. The medical care you need is the same whether you are having a spontaneous miscarriage or you took pills to end your pregnancy. I only need information regarding your current physical symptoms and your medical history to take care of you, and this information remains confidential" [73].
   b. **Documentation:** Clinicians should think critically about what they document in the chart. EM clinicians should only document the minimum amount of information required, and do not need to specify the patient's history of an abortion if it puts them at legal risk [74]. There has been some suggestion for phrasing clinicians can use, such as documenting that "a patient believes they were pregnant and are now bleeding" [34]. This allows EM clinicians to develop a relationship with their patient based on trust and safety at a time when they are already likely experiencing significant

stress, and may lead them to feel comfortable requesting supportive resources, or disclosing experiences with IPV/HT.

7. **Finally, it is important that EM clinicians understand the laws pertaining to abortion in their area and in surrounding areas that patients may travel from, educate themselves on legal protections for themselves, and legal protections for their patients.**
   a. **Local Abortion Laws:** While it is a core ethical principle of ED clinicians to care for all patients regardless of their legal status, the changing landscape of abortion laws is still important to understand. A knowledge of the local and regional abortion laws will help clinicians prepare to best care for their patients in this new landscape. For example, if a clinician diagnoses a patient as being pregnant while they are in the ED, understanding the legal status of abortion in their state is imperative for advising patients on what resources are available to them, for whatever they may wish to do next. Similarly, it is important that clinicians know the laws in their own state for when they would be prescribing self-managed abortion medications, such as mifepristone. The Guttmacher Institute has also created an interactive map that details abortion policies for each state, demographics about who may need an abortion and who is most vulnerable to restrictive legislation, and statistics about abortion specific to that state [75]. This resource could aid EDs in keeping their staff up to date on the legal situation in their surrounding areas.
   b. **Mandatory Reporting:** There are not currently any states that mandate clinicians to report patients they believe had an abortion to law enforcement or health agencies. If a state law does not explicitly require reporting, sharing a patient's health information with law enforcement constitutes a breach of HIPAA [73]. Currently, the only way that clinicians can be required to report personal health information to law enforcement is due to court order or warrant, a grand jury subpoena, or an administrative subpoena meeting certain requirements [76]. In addition, clinicians should be aware of mandatory reporting laws for suspected IPV or HT, as these can vary by state, as well as with age and capacity of the patient in question [77,78].
   c. **Legal Protections for Clinicians:** As referenced in the introduction, many clinicians have been concerned about consequences for their own careers, with fears of being sued for assisting with abortions when it is necessary for the health of their patients [5,74]. EM leadership should provide clear guidance to clinicians on the relevant legal protections, or what activities are prohibited, for clinicians in their state. Leadership should also make individual guidance available through hospital legal departments. These steps will allow clinicians to care for these patients without fear for their own safety and career. ED clinicians may also have concerns about legal implications when managing a patient who requires an abortion to prevent morbidity and mortality. The Department of Health and Human Services released a memorandum that physicians are required to provide stabilizing measures to pregnant patients in a medical emergency, including abortion, which preempts state laws restricting abortion [79]. State-specific considerations regarding these implications are in progress in some states [80,81].

In conclusion, the Dobbs v. Jackson Supreme Court ruling has led to a surge in restrictive abortion laws, placing individuals experiencing IPV and HT at increased risk for healthcare access inequities and complications from unsafe abortions. Many of these adverse consequences will likely manifest in our EDs. EM clinicians should be prepared to recognize patients who are at risk, offer screening and assistance if they suspect violence, reproductive coercion, or human trafficking has occurred, know the legal ramifications of restrictive abortion laws if enacted in their state, be mindful of their documentation, and advocate for these patients in order to address the increased barriers to autonomy and quality of care that these vulnerable patients may face as a result of this new legislation.

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None of the authors have any conflicts of interest to disclose.

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