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TREATMENT RECOMMENDATION IN VIETNAMESE MEDICAL CONSULTATIONS

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Abstract

This study investigated the doctor's recommendation of treatment to their adult patients in primary-care visits in the Vietnamese context. Data was gathered from 55 audio-recorded consultations at two public hospitals, and examined from a conversation-analytic perspective. We demonstrate that the participating doctors used two main approaches to treatment recommendation with their patients: general and detailed. In the latter case, the doctor recommended a treatment regime, sought the patient's agreement, or offered choices regarding aspects of the treatment. Our overall contention is that, in the Vietnamese public hospital system, the doctor's organisation of talk in the course of recommending treatment tends to be shaped by the institutional and cultural context in which it occurs, regardless of which type of treatment approach is being used.

Keywords

Treatment Recommendation, Doctor-Patient Communication, Vietnam, Conversation Analysis

1. Introduction

The doctor's treatment recommendation is a crucial step in the medical consultation. In effect, it is the solution to the problem that the patient brings into this situation. Moreover, the way in which the doctor delivers their recommendation may constrain the patient's participation in the process of deciding on an appropriate treatment plan, and may even go on to affect the outcome of the consultation itself.

The pre-eminent importance of the treatment-recommendation phase within doctor-patient communication generally is reflected in the volume of research that has been conducted on this topic. In addition, this corpus of work is characterised by a discernible shift in the overall findings of the studies in question. While, in earlier research, decisions about treatment tended to be made by the doctor alone (e.g., Fisher, 1983), there is evidence in more recent studies that patients have started to take on a more active role in this process (Bergen et al., 2017; Koenig, 2008, 2011; Roberts, 1999; Stivers, 2002, 2005a, 2005b, 2006, 2007). At the same time, all of these findings (whether earlier or more recent) are limited by the fact that they emanate from research conducted within the Western cultural context. In a bid to remedy this shortcoming of previous research, the present study explores the phenomenon of treatment recommendation outside this context.

For this purpose, we have selected the cultural context of Vietnam. There are three reasons for this choice. To begin with, in examining medical discourse in a non-Western context, we intend to make scholarly coverage of this area more representative from a cross-cultural standpoint. In recent years, scholars interested in various aspects of healthcare have sought to address this Western bias by turning their attention to non-Western cultures, particularly those located in Asia (e.g., Atienza et al., 2017; Raposo, 2015). The current study, which focuses on healthcare communication, contributes to this growing body of research. Second, relatively little work has been done so far on doctor-patient interaction in the Vietnamese context specifically (for a more exhaustive review than is possible here, see Nguyen et al., 2018). A third reason is that this cultural context seems a promising one within which to investigate the doctor's treatment recommendation. Vietnamese society has a deeply-ingrained hierarchical structure

(Edwards & Phan, 2013) which is, therefore, likely to reveal itself in doctor-patient discourse as well. And indeed this expectation is borne out in the extant literature. In studies on the patient's perspective, the salient finding has been that these participants adopt an inhibited, compliant attitude towards those who are charged with treating them (Fancher et al., 2010; Nguyen et al., 2007; Tran, 2009).

A noteworthy feature of previous work on doctor-patient discourse in the Vietnamese cultural context is that, to date, no study has adopted Conversation Analysis (CA) as its analytical framework (for a comprehensive overview of how this framework has been applied to medical communication, see Gill & Roberts, 2012). The present study is intended to fill this gap.

2. Previous Research on Treatment Recommendation

Treatment recommendation has been extensively investigated over the last three decades mainly in the United States. In earlier work, these recommendations were made mostly by the doctor, whose voice of medicine often silenced the patient's voice of the life-world (Mishler, 1984). In an analysis of oncological consultations at a university teaching hospital, Fisher (1983) found that the doctor's decision-making process was shaped by information obtained by means of questioning, presentational and persuasional strategies. In particular, this process was asymmetrical, in that it was directed mainly by the doctor.

However, the findings of Roberts (1999) saw a change in the role played by the patient in determining the course of their treatment. Within an oncological setting, Roberts focused on how the doctor structures and delivers their treatment recommendation, and also how this recommendation is received by the patient. She reported that doctors construct their turns so as to prevent patients from asking questions or shifting the topic and those patients also miss opportunities to take conversational turns. However, Roberts' findings also show that, far from being disempowered by the doctor's approach, the patient often expects the doctor to justify their recommendation, and even openly disagrees with this recommendation in some cases. In Extract 1, an oncologist is treating a female patient (from p. 95).

Extract 1

217 D²: but there are hhh uh some- there is some
218 evidence that uh regimens with adriamycin in them

219 (.) are helpful even in women, uhhh (.) *uh past
220 their menopause.*
221 (0.5)
222 P: Well ih it they did say that it was not helpful.
223 Eh eh as tha- such a small percentage (.) *(was helpful).*

At lines 217-220, the doctor offers a justification for his recommendation. In response, the patient openly objects that chemotherapy will not be effective for someone her age. Through this kind of active resistance, the patient induces the doctor to try to convince her that the treatment he is recommending is appropriate. In short, the treatment plan is not determined by any single party, but is co-constructed by doctor and patient.

While the patients in Fisher (1983) and some in Roberts (1999) took a rather passive approach to negotiating their treatment plans, those in a series of publications by Stivers (2002, 2005a, 2005b, 2006, 2007), Koenig (2008, 2011) and Bergen et al. (2017) were more actively involved in this process. In her work on treatment recommendations in internal medicine, orthopaedics and paediatric settings, Stivers discovered that, although doctors have the professional authority to make treatment recommendations for newly diagnosed problems, both parties contribute to negotiating the treatment plan. Specifically, the patient treats the doctor's recommendation as something to be accepted or resisted; furthermore, in the latter case, the patient utilises various strategies to obtain their preferred treatment plan. Koenig investigated how doctors deliver, and adult patients accept the treatment recommendation in acute medical visits; his main conclusion was similar to that of Stivers. Lastly, in a cross-national comparison of primary care, Bergen et al. (2017) found that both English and North American patients show a high level of resistance to the treatment recommendations made by their doctors.

Hence, recent research on treatment recommendation has seen patients come to assume more responsibility for their treatment plans than used to be the case. However, these studies were all carried out in the West, so that some attention to the non-Western context for medical communication is undoubtedly called for.

3. Data and Method

The data for this study comes from 55 primary care visits at two provincial public hospitals in Vietnam. The visits were recorded between June-August 2016. We utilised 55 audio

recordings of consultations, as well as 70 questionnaires (from 55 patients and 15 doctors) concerned with the participants' demographic information. The data was transcribed using ELAN software in accordance with the techniques and symbols developed by Jefferson (2004), and analysed following the CA approach. Ethical approval was granted by the University of Southern Queensland Human Research Ethics Committee.

4. Analysis

On the basis of various kinds of information solicited during the problem presentation, history-taking and physical examination, the doctor proceeds to the treatment phase. Overall, the doctors in our study used two main approaches to recommending treatment: general and detailed.

4.1 General Treatment

The defining characteristic of this type of treatment recommendation is that it is insufficient (Stivers, 2005a, p. 956). In particular, this means that, rather than specifying the treatment they are going to use with the patient, the doctor merely states a general solution to their health problem (i.e., hospitalisation). By implication, other doctors in the hospital will be expected to work out the treatment plan for this patient. We exemplify this approach in Extract 2, which shows an exchange between doctor Quynh and patient Thuy in the consulting room³. Thuy was treated in this hospital for her back pain last year, but her current concerns are her kneecaps and shoulder.

Extract 2

290 D: → chừ làm+thủ+tụ:c⁴ cho chị vô+việ:n (.) hây?

now arrange for older+sister hospitalise INT

'Shall I arrange for you to be hospitalised now?'⁵

291 (0.2)

292 P: nhạ:

yeah

'Yeah'

293 (1.1)

294 D:→ vô+viện đây thì nằm ba tuần= chị năm ngoái

- hospitalise this COP stay three week older+sister year last
295 chị có năm rồi thì chị biết rồi: (.) hi?=
older+sister PST stay already then older+sister know already INT
'You'll stay here for three weeks. You already know this as you stayed here last year?'
- 296 P: =dạ: (.) dạ:
Yes yes
'Yes, yes'

At line 290, Quynh poses a closed question to seek Thuy's confirmation. Both the action-type preference and polarity of this question, which ends with the particle *hây*, are aligned with its preference for 'yes' (Ngo, 1999). On receipt of Thuy's minimal conforming response (line 292), Quynh pauses for 1.1 seconds (line 293), then states the minimum length of a treatment course in the stressed form, *ba tuần* ('three weeks'; line 294). However, Quynh does not terminate her turn there, but speeds up her talk at *tuần* ('week') so that it joins onto *chị* ('you') quickly (symbolised by the equals sign). In so doing, she rushes through (Schegloff, 1982) the transition-relevance place (Sacks, Schegloff & Jefferson, 1974) to secure an additional unit of talk before Thuy can rightfully take her turn. In response, Thuy's rushed manner foreshadows an aligned answer (Lindström, 2009), which consists of two 'yes'-s (line 296).

In terms of its content, Quynh's turns (arrowed) do not address any specific plans for treatment. The first turn (line 290) mentions the general solution of hospitalisation: it does not specify any kind of treatment (e.g., acupuncture, or physical therapy). More importantly, Quynh only proposes one option for hospitalisation instead of offering several (e.g., hospitalisation, outpatient treatment, or treatment at home). This is because Thuy has expressed her wish to be hospitalised (data not shown). In the second turn (lines 294-295), the first TCU *vô viện đây thì năm ba tuần* ('You'll stay here for three weeks') seems to announce the arrival of new information. However, Quynh's second TCU rejects this presupposition. In doing so, she adheres to the interactional norm of not telling someone something that they already know (Terasaki, 2004). This second TCU implies that Thuy will already know what her treatment will entail, as she was hospitalised here last year.

4.2 Detailed Treatment

A recommendation of detailed treatment implies the use of specific methods intended to ameliorate the patient's condition. They range from tests (e.g., a blood test or an X-ray test) to medication. The doctors in our data deployed three strategies in making a recommendation of detailed treatment: (i) imposing the treatment, (ii) seeking the patient's agreement, and (iii) offering choices.

4.2.1 Imposing the Treatment

In imposing the treatment, the doctor makes a final decision about the treatment plan (which may or may not be accompanied by a rationale) without seeking the patient's agreement. We exemplify this approach (called a pronouncement by Stivers et al., 2017) in Extract 3. This is a consultation between doctor Hung and patient Tuyen, who has hypertension, high cholesterol and an ankle problem (her main concern). An earlier degenerative spinal condition improved after the first treatment course, but her ankle problem remains.

Extract 3

- 155 D:→ cho mẹ chụp cái phim lại:i để xét+nghiệm lại (.)
want grandma have CLA X-ray again to check again
- 156 ↑hi (.) xét+[nghiệm] lại cá::i à:::.....
PRT check again CLA uh
'I want you to have an X-ray again to re-check, re-check-'
- 157 P: [dạ]
yes
'Yes'
- 158 thử máu
test blood
'A blood test'
- 159 D:→ ↑khớ:p (0.2) [coai] thử [máu]
arthritis see test blood
- 160 P: [dạ] [dạ d]ạ
OK OK OK
'OK. OK, OK'

- 161 D: nhin+đoá:i (.) để coai [thử]
fast to see PRT
Lines 159 & 161: **‘for arthritis, and you need to fast before you take the blood test to see if-’**
- 162 P: [dạ: dạ::]
OK OK
‘OK, OK’
- 163 D: cái- à (.) cá:i kiểm+tra #hắ# viêm+khớp hay+là
CLA uh CLA test it arthritis or
‘it’s arthritis or-’
- 164 (0.4)
- 165 P: ừ
mmm
‘Mmm’
- 166 (0.2)
- 167 D: → đợt trước::c à::: (0.5) #không#- #không# #không# biết đã
visit last uh not know PST
- 168 kiểm+tra gút ↑chưa (.) đợt ni cho mẹ kiểm+tra
test gout yet visit this want grandma test
- 169 thêm cái [gú::t nữa.]
also CLA gout PRT
‘I don’t know if you took a gout test on your last visit, so I also want you to take a gout test this time’
- 170 P: [dạ] cho cái gú::t nữa
yes want CLA gout too
‘Yes, I want a gout test too’

Hung prescribes three tests: an X-ray, a blood test, and a gout test (arrowed). The first and second tests are accompanied by their rationales (lines 155-156, 159, 163), but the third is not. The first TCU (lines 155-156), ending with the final-rising-intoned hi, registers the whole TCU as a declarative question (Luu, 2010) in pursuit of Tuyen’s agreement. Nevertheless, it seems more like an announcement, as there is no opportunity for Tuyen to express her voice.

Hung produces further talk beyond the possible completion point hi plus a micro-pause to offer a rationale for the X-ray test; this leads to a mid-turn progressional overlap onset (Jefferson, 1984) with Tuyen's minimal agreement. The blood test (line 159) is followed by an instruction, *nhìn đoán* ('fast'), and then a rationale. Hung's recommendation (lines 159, 161 and 163) sounds like a final decision in response to the patient's prompt (line 158). The last test is prefaced with a rationale, and also serves as an announcement. Rather than opening up the possibility of negotiation, Hung's recommendation that Tuyen have this test places an imposition on her compliance.

In Extract 3, Hung prescribes various specific tests in the course of making a treatment recommendation. He states his reasons for choosing these tests, but does not seek Tuyen's agreement to his treatment plan; rather, he announces his final decisions according to his own agenda. In response, Tuyen shows no resistance; on the contrary, she conforms to Hung's treatment agenda. The whole interaction suggests that Hung's imposition is welcomed by Tuyen, and willingly adhered to as a result.

4.2.2 Seeking the Patient's Agreement

Another way of recommending treatment is to pose a declarative question plus a rationale with the aim of obtaining the patient's agreement. This is exemplified in Extract 4 below. It is a first visit between doctor Vinh and inpatient Kieu, who has had spondylosis for a long period and has undergone treatment at several health centres before.

Extract 4

- 296 D: → *giờ+chừ mệ vô đây mệ:.....: (.)*
now grandma hospitalise here grandma
- 297 *uó:.....:ng thuốc:.....:c (1.3) HOÀN (.) hây? (0.5) máy*
take medication tablet HON PL
- 298 *ngày hoà:n rồi sau+đó ún thút thang (.) hây?*
day tablet and later take medication traditional INT
'Now, you take tablets for the first few days while you're in hospital, and traditional medication later, OK?'
- 299 (0.3)
- 300 P: *oo dqaoo*

- yes
'Yes'
- 301 (0.5)
- 302 D: *chờ+còn mẹ đau dạ+dày ri mà con mà*
because grandma ache stomach like+this and offspring PRT
- 303 *cho mẹ uống thuốc tây là mẹ đau*
prescribe grandma take medication western COP grandma ache
- 304 *mẹ chịu #không#+nổi mô (0.6) hây*
grandma bear not at+all PRT
- 'Because you have a stomachache, the pain will become unbearable if I prescribe you Western medication'**⁶

At lines 296-298, Vinh projects two questions in seeking agreement. He proposes a specific treatment agenda by providing the name of the medication to be taken, *hoàn* ('tablet'; line 297) and *thang* ('traditional medication'; line 298). He poses two questions in the same turn, separated by a pause of 0.5 seconds (line 297) for Kieu's response. The first TCU is stretched and followed by a pause of 1.3 seconds (line 297) to indicate thinking or a mental search (Boyd & Heritage, 2006) for the type of medication, *hoàn* ('tablet'). Without any response from Kieu, Vinh goes on to pose one more declarative question to supplement the first one, thereby completing his recommendation for Kieu's treatment plan. Kieu's sotto voce uptake (symbolised by double degree signs; line 300) registers her alignment with Vinh's recommendation, from which Vinh launches into a detailed account of his decision using a turn-initial compound format marker (Lerner, 2006), *chờ còn ... mà* ('because'; lines 302-304).

Vinh's two questions (arrowed) both end with the particle *hây*. According to Ngo (1999), of all the alternative questions types in Vietnamese, this one conveys the strongest belief that the recipient will agree with the speaker. In posing these questions, Vinh expects conforming responses (Raymond, 2003) from Kieu. This means that, in the course of seeking Kieu's confirmation, Vinh seems to be informing Kieu of his treatment plan instead. However, in keeping with the principle of recipient design (Sacks et al., 1974), Vinh is giving Kieu an opportunity to express her voice. This is further supported by his accountability later at lines 302-304. These linguistic features demonstrate Vinh's respect for Kieu.

4.2.3 Offering Choices

Besides imposing treatment or looking for agreement, some doctors adopt a more democratic approach by incorporating one or more choices (labelled as offers by Stivers et al., 2017) into their treatment decisions. Perhaps not surprisingly, this approach is endorsed by many health policy researchers (Emanuel & Emanuel, 1992). For instance, in Extract 5, doctor Quynh proposes two options for patient Phong to choose from. Phong has pain in her arm running up to her shoulder.

Extract 5

- 184 D: *giờ+chừ:::.....: à:: (.)* *lần ni chị*
so uh time this older+sister
- 185 *vô:::.....: (0.2) châm+cứu?*
come acupuncture
‘So, you’ve come here for acupuncture?’
- 186 P: *dạ::*
yes
‘Yes’
- 187 (0.4)
- 188 D: → *nằm+viện ở+lại hay+là chị muốn vừa đi*
hospitalise stay or older+sister like half hospitalise
- 189 [*vừa*] *v[ề]?*
half home
‘Would you like to have inpatient, or outpatient treatment?’
- 190 P: [*thì:::..:*] [*cô*] *cho em ở+lại thì*
PRT doctor prescribe older+sister hospitalise COP
- 191 *em ở+lại (.)*
younger+sister hospitalise
‘I’ll have inpatient treatment if you prescribe it’
- 192 *còn về thì hẳn quá khổ a+đó:¿*
about home COP it very troublesome PRT
‘If you don’t, outpatient treatment will be very troublesome for me’

193 (1.1)

194 D: °dạ° (.) ríta+thì: nằm+việ:n ở+lại nghe?

OK so hospitalise stay INT

‘OK. So, you’ll have inpatient treatment?’

195 (0.2)

196 P: dạ:

yes

‘Yes’

This encounter takes place in the consulting room. As mentioned in endnote 3, this is where each patient is categorised as a consulting patient, an inpatient or an outpatient. This categorisation is often finalised in the treatment phase, as Quynh does at lines 188-189. She prefaces her treatment recommendation with a declarative request-for-confirmation question, and then poses a two-option alternative question: *nằm viện ở lại* (‘inpatient’) or *vừa đi vừa về* (‘outpatient’). In response, Phong’s early start (line 190) gives rise to a terminal overlap with Quynh’s last two words (line 189), but does not lead to a mishearing or misunderstanding on the part of either speaker. At first glance, the first TCU, *cô cho em ở lại thì em ở lại* (‘I’ll have inpatient treatment if you prescribe it’; lines 190-191), seems to put the decision in Quynh’s hands, but the second TCU, *còn về thì hẳn quá khổ a đó* (‘If you don’t, outpatient treatment will be very troublesome for me’; line 192), orients to the first option: *nằm viện ở lại* (‘hospitalisation’). Mindful of this, Quynh proposes a declarative question (line 194) in an attempt to obtain Phong’s confirmation that she is willing to be hospitalised.

5. Conclusion

This study has shown that, in the Vietnamese public hospital system, the doctor’s organisation of talk in the course of recommending treatment is mostly shaped by the institutional and cultural context in which it occurs—in particular, by its hierarchical organisation. Within medical communication, this aspect of Vietnamese social relations manifests itself as the dominance of the voice of medicine over the voice of the life-world (Mishler, 1984), such that doctors tend to make treatment recommendations with little or no input from their patients. Moreover, in our own data, these institutional and cultural forces came into play regardless of which type of approach (i.e., general or detailed) was being used

(Excerpts 2 to 4). In short, the doctors in our study made these recommendations in a similar way to doctors in earlier studies conducted in the West (cf. Fisher, 1983). It is also noteworthy that, in response, the patients tended to show respect towards their doctors by being unassertive and avoiding conflict, challenge, or disagreement; instead, they often acquiesced to their treatment plans passively.

To some extent, this hierarchical disparity between doctor and patient (whether in the West or in the Vietnamese context) is understandable. First of all, therapeutic relations are inherently asymmetrical: lacking the technical capacity to help themselves, the patient is in a position of dependency vis-à-vis the doctor, the so-called trained expert (Yang, 2009) who, “in almost any social situation, ... commands more respect and more prestige than does the patient” (Wolinsky, 1980, p. 164). This asymmetry is further “organised” and “institutionalized” (Van Dijk, 2002, p. 110) by the predominant pattern of interaction that we encounter in medical consultations (i.e., there is little opportunity for the patient to take the initiative). Moreover, the doctor’s specialist qualifications enhance their professional prestige in society, thereby legitimising their dominance over their patients.

However, doctors in the Vietnamese context enjoy even higher status in this culture than in many others (LaBorde, 1996). They occupy a privileged position, and are treated with great respect and admiration by patients and the whole society. This augments the power that they exercise over the consultation, so that they will be even more able to direct it according to their own agenda. Our data bears this out.

While the dominant pattern overall was that the doctors in our study made treatment recommendations with little or no input from their patients, it is worth noting that there were also some doctors who did offer their patients some input into their treatment plans (Excerpt 5). In this regard, these doctors exhibited the same willingness to involve patients in treatment decisions as in more recent work in the Western context (e.g., Roberts, 1999; Stivers, 2005, 2006, 2007; Koenig, 2008, 2011). It remains to be seen if this finding is indicative of a more widespread shift towards greater involvement on the patient’s part in treatment decisions in the Vietnamese context.

Finally, we will present some quantitative data which supports our overall contention that, in the Vietnamese context, the doctor’s recommendation of treatment is, to a large degree, informed by the hierarchical organisation of this society. In Table 1, we show the number of

consultations associated with each of the two main approaches to treatment recommendation (i.e., general and detailed), as well as the numbers for the three different subtypes of the detailed approach.

Table 1: Approaches to Treatment Recommendation Plus Subtypes

General (N = 16)	Detailed (N = 39)		
	Impose treatment	Seek agreement	Offer choices
16	20	13	6

Notice in particular that, among the consultations featuring detailed recommendations, the largest number was for consultations in which the doctor imposed the treatment on the patient (N = 20), while the smallest number was for consultations in which the doctor offered the patient choices (N = 6).

6. Directions for Future Research

In the course of carrying out this study, three main directions for future research have occurred to us. First of all, we have focused mainly on the doctor's perspective in the practice of recommendation. In order to reach a better understanding of the treatment process overall, further research should be done on the patient's negotiation of the treatment plan as well. Our investigation is also limited by a reliance on audio-recordings. As this type of recording is unable to pick up the participant's non-verbal behaviour, some aspects of communication (e.g., a nod or headshake) will inevitably be lost (Williams, Herman & Bontempo, 2013). We suggest that future studies use video-recording instead. Another limitation of the current study is that our findings were obtained in only one clinical environment (i.e., the public hospital). In order to substantiate the findings of the current study, future research on treatment recommendation within the Vietnamese context should expand the scope of research on this topic by examining other such environments (e.g., private hospitals, or private clinics).

¹ In this paper, the gender-neutral pronoun 'they/their etc.' is used if the referent's gender is unspecified.

² The following abbreviations are utilised in this article: CLA - classifier; COP - copula; D - doctor, HON - honorific; INT - interrogative; P - patient, PRT - particle; PST - past tense; TCU - turn construction unit.

³ Each consultation in our study was conducted either in the consulting room or in the ward. All patients who visit a Vietnamese public hospital are sent to the consulting room initially. Here, the patient is

examined by a doctor, and classified as a consulting patient, an inpatient or an outpatient. An inpatient or outpatient then moves to the ward to be re-examined. Doctors from different units then attend to them on a daily basis to monitor their condition (for more information, see Nguyen et al., 2018). (This background information is relevant to Extract 5 especially.)

⁴ A plus (+) sign is used to join together two or more words in the Vietnamese transcription. The other symbols conventionally used for this purpose (e.g., a period or a hyphen) are not suitable, as both have values within the CA transcription system. For consistency, the same symbol is used for this purpose in the interlinear morpheme glosses as well.

⁵ On a morphosyntactic level (including the use of ellipsis), Vietnamese and English differ considerably (Nguyen, 2009). Our priority in the translations is to strike a compromise between the naturalness of the English on one hand and faithfulness to the original on the other. For the sake of clarity, we also occasionally add some information that is left implicit in the original.

⁶ Our interpretation is that, on top of the pain caused by her health problems, Kieu will have some additional pain if she takes Western medication for it. Hence, her total pain will become intolerable.

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