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Systemic ethical conflicts in Indian hospitals: A case-based nalysis of autonomy, justice, and legal anxiety

Abstract

Bioethics in the Indian healthcare system exists at the intersection of global medical principles, unique sociocultural norms, resource constraints, and an evolving legal landscape. While the four foundational principles —autonomy, beneficence, non-maleficence, and justice —provide a universal framework, their application in India presents formidable challenges. This paper argues that these ethical dilemmas are not aberrations but systemic conflicts arising from tensions between Western-style patient autonomy and Indian family centric decision-making, the collision of a physician's duty of beneficence with patient rights under Article 21 of the Constitution, and the pervasive failure of justice, manifested in catastrophic out-of-pocket expenditure that coerces clinical decisions. This study adopts a practical, case-based approach and analyzes six common scenarios. For each case, the ethical conflict is deconstructed, a robust analysis of the specific Indian legal framework–including the MTP Act 2021, the HIV/AIDS Act 2017, and landmark Supreme Court jurisprudence on end-of-life care–is provided, and a clear, actionable management protocol is proposed. This paper concludes that navigating this complex terrain requires moving beyond perceived legal liability and embracing a structured approach rooted in sound communication, meticulous documentation, and the proactive use of Hospital Ethics Committees (HECs).

Keywords: Bioethics, medical ethics, patient autonomy, end-of-life care, legal framework, case-based analysis

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Defining bioethics: An interdisciplinary field

Bioethics is an interdisciplinary study of the ethical, social, and legal issues arising in medicine and biomedical research. This is not merely academic but a necessary professional practice for navigating complex moral decisions. While medical ethics has ancient roots in India, such as in the Charaka Samhita, modern Indian hospitals face a different set of challenges (Moskop, 2016).

The contemporary landscape is defined by technological advancements, complex regulations by bodies such as the National Medical Commission (NMC), and a sharp rise in medical negligence litigation (Singh et al., 2024). This rise in legal challenges often stems from breakdowns in ethical communication and failure to navigate the moral gray zones of clinical practice. Therefore, a practical understanding of bioethics is a core competency for all healthcare professionals.

The four pillars of clinical ethics

The dominant framework for clinical ethical analysis rests on four key principles, providing a shared vocabulary for conflict resolution.

- Autonomy (Respect for Persons): This recognizes the right of a competent individual to self-determination. In practice, this means informed consent and informed refusal, where a patient may accept or reject treatment after receiving clear information (Schenker, 2011).
- Beneficence (To Do Good): This is the physician's affirmative duty to act in the best interest of the patient, balancing risks and benefits to promote health (Horner et al., 2016).
- Nonmaleficence (To Do No Harm): Encapsulated by Primum non nocere ("first, do no harm"), which obligates physicians to avoid causing unnecessary pain or suffering and to prevent negligence (Gillon, 1985).
- Justice (Fairness): This principle relates to the fair and equitable distribution of healthcare resources, demanding fair allocation of scarce resources (like ICU beds) and avoidance of discrimination (Häyry, 2022).

The Indian contextual conflict

In India, ethical principles frequently conflict because of socio-economic disparities and resource constraints within the healthcare system. The primary challenge is balancing individual patient care with broader public health needs, particularly during crises such as pandemics. This tension underscores the necessity of culturally sensitive ethical frameworks that integrate both universal principles and local realities (Simonds & Sokol, 2009). This article hypothesizes that the direct application of foundational bioethical principles in Indian hospitals generates a series of distinctive and systemic conflicts.

These conflicts are structural and stem from three primary underlying tensions. First, there is cultural tension. The Western, individualistic model that emphasizes patient autonomy often conflicts with the Indian context, which may prioritize communal autonomy," where the family serves as the primary decision-making unit. This is further complicated by a "passive patient" culture, where informed consent may be perceived as a mere formality. Second, there is acute resource tension (Chattopadhyay & De Vries, 2012). The principle of justice is systematically compromised by low public spending and high out-of-pocket (OOP) expenditures. This "catastrophic health expenditure" forces millions into poverty annually and influences clinical decision-making. Finally, there is legal tension. Many physicians, constrained by "misperceptions of legal liability," engage in "defensive medicine," such as continuing futile care, which is ethically problematic. Many dilemmas are not simple two-way conflicts but rather tragic three-way conflicts, where the patient's autonomy (what they want) and the doctor's beneficence (what is best) are both constrained by a failed principle of justice (what the family can afford). The following analysis provides a practical framework for navigating these scenarios in the future (Laureano et al., 2024). The clinical scenarios presented in this analysis are illustrative composites constructed from recurring ethical dilemmas observed across the broader Indian healthcare landscape. While they reflect common systemic challenges, they are hypothetical narratives designed solely for peda-

gogical and legal analysis. They do not represent specific patient records, identifiable individuals, or the operational policies of any single institution.

Case-based analysis of ethical scenarios

Scenario 1: Refusal of life-saving treatment (Blood transfusion)

a. The case

Consider a high-stakes emergency scenario where a young female patient presents in severe hemorrhagic shock following a home delivery. In this hypothetical instance, the patient is unconscious and presents with critical anemia, making an urgent blood transfusion medically imperative to prevent mortality. The accompanying family members, identifying as Jehovah's Witnesses, refuse the transfusion on the patient's behalf, asserting that she shares their religious objection to blood products. Crucially, for the purpose of this analysis, we assume there is no written Advance Directive or "No Blood" card available to confirm the patient's own explicit wishes.

b. The ethical conflict

This is a direct conflict between the medical team's duties of beneficence and non-maleficence versus the patient's presumed autonomy.

- Beneficence and Non-maleficence: The medical team has a clear ethical and professional duty to provide standard-of-care, life-saving interventions. Inaction in this context would lead to a preventable death, violating the foundational principle of Primum non no cere (Varkey, 2020).
- The Limits of Autonomy: The conflict is complicated by the patient's incapacity. Since the patient cannot speak for herself, autonomy is being asserted by surrogates (the family). The central ethical question here is whether an undocumented, surrogate "presumed refusal" possesses sufficient moral weight to override the physician's duty to save an imminently threatened life.

c. The legal and policy framework (India)

The actions of the clinical team are strongly protected by Indian law, ensuring that healthcare professionals can perform their duties with legal safeguards that uphold patient rights and maintain ethical standards in medical practice.

- Doctrine of Implied Consent in Emergencies: In life-threatening emergencies involving an incapacitated patient, the law operates on "implied consent." Doctors are legally expected to provide the necessary treatment to save lives. Refusing to treat in an emergency due to lack of consent can itself be grounds for negligence (Kumar et al., 2015).
- The Constitutional Hierarchy: Article 21 vs. Article 25: The family's refusal is an exercise of Article 25 (Freedom of Religion). The doctor's actions are defended by Article 21 (Protection of Life). The Supreme Court has clarified that Article 25 is explicitly subject to "public order, morality, and health." The fundamental right to life (Article 21) overrides the right to religious practice, especially when asserted by a surrogate for an incapacitated person (Kakar et al., 2014).
- Status of Surrogate Refusal: A competent adult's informed refusal is legally binding, whereas a surrogate's right is limited. Indian law does not empower a family to demand a preventable death in the absence of a clear, written Advance Directive from the patient (Kattamreddy, 2025).

d. Recommended course of action

- Proceed with Transfusion: The clinical team must act immediately based on implied consent and the legal supremacy of Article 21.
- Document Meticulously: This is critical for legal protection. The record must state the following: the imminent, life-threatening nature of the condition; the patient's incapacity; the family's objection and its religious basis; the absence of a patient-signed advance directive; and the legal-ethical basis for intervening (implied consent/Article 21).
- Engage Administration and Legal Cell: Immediately inform the Medical Superintendent and/or the legal cell. Convene an emergency Hospital Ethics Committee (HEC) meeting, even if retro-

spectively, to validate the decision.

- Compassionate Communication: After stabilization, a senior team member should explain to the family why the action was taken from a legal and life-saving perspective while acknowledging their distress and beliefs.

Scenario 2: Patient refusal of recommended procedure (Dialysis)

a. The case

A common clinical challenge involves a patient with End-Stage Renal Disease (ESRD) who requires urgent hemodialysis to prevent life-threatening complications. In this model scenario, we consider a patient who is fully conscious and possesses intact decision-making capacity but explicitly refuses the procedure, citing a personal aversion to machine dependency. The administrative and ethical dilemma intensifies when such a patient simultaneously refuses discharge, demanding to remain in the hospital for management "by other means," despite being counseled that dialysis is the sole effective life-sustaining intervention available.

b. The ethical conflict

This scenario presents a classic clash between the principle of Patient Autonomy and the physician's duties of Beneficence, complicated by the principle of Justice.

- Autonomy: A fundamental tenet of bioethics is the competent adult's right to refuse any medical treatment, even if that refusal inevitably leads to death (Partel Araujo et al., 2024). The patient's right to self-determination allows them to reject the "standard of care."
- Beneficence vs. Non-maleficence: Physicians are professionally obligated to provide the best possible care. Allowing a patient to deteriorate when a viable treatment exists feels like "permitting harm," creating moral distress for the clinical team who view the refusal as preventable suicide.
- Justice (Resource Allocation): This scenario introduces a third dimension: Distributive Justice. By refusing the indicated treatment while simultaneously refusing discharge, the patient oc-

cupies a scarce hospital bed without utilizing the specific care that the bed is designed to facilitate. This raises ethical questions regarding the fair allocation of limited healthcare resources to those who are willing to accept treatment (Pu, 2021).

c. The legal and policy framework (India)

- Right to Informed Refusal: A mentally competent adult's right to refuse medical treatment is legally recognized, stemming from the right to bodily integrity under Article 21 of the Constitution. NMC regulations support this, provided the refusal is informed (Nandimath, 2009).
- Discharge Against Medical Advice (DAMA)/Leave Against Medical Advice (LAMA): When a competent patient refuses standard-of-care, the appropriate legal mechanism is a "Discharge Against Medical Advice" (DAMA). A hospital cannot detain a patient for refusing treatment (Rao, 2021).
- Limit of Hospital Obligation: The patient's right to autonomy (refusing dialysis) does not create an obligation for the hospital to provide medically futile or non-indicated "other means." The hospital is not bound to provide services that contradict all medical rationale (Chand et al., 2009).

d. Recommended course of action

- Conduct Formal "Informed Refusal" Counseling: This must be a structured session with the senior nephrologist, a counselor, and (with patient consent) his family.
- Document the Counseling: The patient must be clearly informed, in simple language, of the lethal consequences of refusing dialysis and that "other means" do not exist for his condition, only palliative (comfort) care.
- AMA Documentation: If the refusal persists, the patient must sign a detailed "Against Medical Advice" (AMA) form listing the specific risks (including death) that were explained. If he refuses to sign, please document this with witnesses.
- Scope of Continued Care: Clearly document and communicate the care the hospital will (palliative care, pain relief) and will not (medically futile interventions, ICU admission) provide.
- Ethics Committee Review and Discharge Planning: If the pa-

tient refuses both dialysis and discharge, the case is escalated to the Hospital Ethics Committee. The HEC), which mediates, re-confirms capacity, and develops a formal, legally sound discharge plan.

Scenario 3: Confidentiality in HIV/Hepatitis-B diagnosis

a. The case

A recurring bioethical dilemma in infectious disease management involves the tension between patient privacy and public safety. Consider a hypothetical situation where a married male patient is diagnosed with a sexually transmissible infection, such as HIV or Hepatitis B. In this scenario, the patient explicitly invokes his right to confidentiality, issuing a strict directive to the medical team to withhold this diagnosis from his spouse. The clinical team is thus placed in a precarious position, fully aware that the patient's partner is at significant, ongoing, and unknowing risk of infection while the patient forbids disclosure.

b. The ethical conflict

This scenario epitomizes the "duty to warn" dilemma, where healthcare professionals must balance the obligation to maintain trust through confidentiality against the imperative to prevent foreseeable harm to others.

- Autonomy (Confidentiality): The patient possesses a fundamental legal and ethical right to the confidentiality of his medical data. Breaching this trust can deter future patients from seeking testing or treatment.
- Non-maleficence (Duty to Prevent Harm): Simultaneously, the medical team has an ethical duty to prevent foreseeable and serious harm to an identifiable third party (the spouse). Remaining silent in this context could be interpreted as complicity in the transmission of a life-altering disease.
- Justice: The principle of justice is also implicated, as the spouse has a moral right to health and access to the information necessary to protect her own life and well-being

c. The legal and policy framework (India)

This area is now legally clear, and physicians have established a

standardized protocol to guide their practice.

- The Old Precedent: Mr. X vs. Hospital Z (1998): This Supreme Court case ruled that the "duty to warn" and protect public health overrode the patient's right to confidentiality in a conflict between two Article 21 rights (Offit, 2004).
- The Current Law: The HIV and AIDS (Prevention and Control) Act, 2017: This Act is now the definitive law, and it codified the "duty to warn" into a formal procedure (Verma et al., 2018).
- The "Partner Notification" Protocol (Section 9): The Act permits a physician to disclose a patient's HIV status to their partner without the patient's consent if all the following conditions are met:
- The provider reasonably believes the partner is at "significant risk".
- The HIV-positive patient was counseled to inform their partner.
- The provider is satisfied that the patient will not inform their partner.
- The provider informed the HIV-positive patient of their intent to disclose the information to the partner.
- NACO and NMC Guidelines: Guidelines from the National AIDS Control Organization (NACO) and the NMC Code of Ethics align with this structured approach.

d. Recommended course of action

- Intensive Counseling (First Step): The First Step is not disclosure. It is intensive counseling to explore the patient's fears (stigma, rejection) and empower him to disclose voluntarily, perhaps with "assisted disclosure".
- Formal Notification of Intent: If counseling fails, the physician must formally inform the patient: "As per our legal duty under Section 9 of the HIV/AIDS Act of 2017, we are now required to notify your partner. We are informing you of this action as required".
- Document the Process: Meticulously document (a) the counseling, (b) the patient's repeated refusal, and (c) the formal "notification of intent" provided to the patient.
- Execute Conditional Disclosure: Arrange a private, in-person meeting with the wife and provide full counseling support. Frame the disclosure as a medical necessity for the patient.

This action, when following this protocol, is fully protected by Indian law.

Scenario 4: Institutional refusal of a legal procedure (MTP)

a. Illustrative case scenario

A profound legal and ethical tension frequently debated in Indian bioethics involves the collision between institutional values and statutory mandates. Consider a scenario where a patient presents to a hospital with a ruptured ectopic pregnancy - a condition universally recognized as a life-threatening surgical emergency. The patient, fully informed of the risk, provides explicit consent for the requisite life-saving intervention, specifically the Medical Termination of Pregnancy (MTP). The conflict arises if the institution, citing a "conscientious institutional policy," declines to perform the procedure regardless of the medical indication, thereby placing the administration's values in direct opposition to the immediate clinical needs of the patient.

b. The ethical conflict

This scenario serves as a stark example of the conflict between a patient's fundamental rights and the concept of "Institutional Conscience."

- **Autonomy vs. Institutional conscience:** The central conflict lies between the patient's autonomy (specifically her legal right to life-saving care under the MTP Act) and the hospital's claim to a collective moral objection.
- **Failure of beneficence and non-maleficence:** From a clinical ethics perspective, refusing to intervene in a ruptured ectopic pregnancy represents a catastrophic failure of beneficence (the duty to act in the patient's best interest) and non-maleficence (the duty to do no harm). By allowing a preventable, life-threatening condition to progress due to policy rather than medical incapacity, the principle of *Primum non nocere* is severely compromised.

c. The legal and policy framework (India)

The hospital's position is legally indefensible. The hospital's position is legally indefensible because it fails to comply with established

regulations and lacks sufficient evidence to support its claims.

- This is Not an "Abortion" (in the elective sense): A ruptured ectopic pregnancy is an acute surgical emergency. The MTP Act 2021 is clear: termination to save the life of the woman is its primary, non-negotiable indication.
- Patient's Right to Bodily Autonomy (Article 21): The Supreme Court's 2022 judgment in X vs. Principal Secretary (NCT of Delhi) unequivocally grounded a woman's right to access safe abortion in her fundamental right to "bodily autonomy" under the Article 21. Denying her this right, especially when her life is at stake, is a severe violation of her rights.
- The Myth of "Institutional Conscientious Objection": This is not a recognized legal right in India. The right to conscience is held by individuals, not corporate entities. Institutions have a duty of care.
- Limits on Personal Conscientious Objection: Even an individual doctor's right to object cannot be invoked in an emergency or life-threatening situation. Furthermore, the objecting physician has a duty to refer and not obstruct care.

d. Recommended course of action

- Perform the Procedure (The Unambiguous Duty): The obstetrician's primary legal and ethical duty is to the patient, not to follow the hospital's illegal policy. The NMC, Article 21, and the MTP Act require them to perform life-saving surgery immediately.
- Referral (A Dangerous and Poor Alternative): If the hospital administration actively prevents the surgery, its only (and ethically fraught) alternative is an immediate, documented, and stabilized transfer to a non-objecting facility.
- Legal Warning: Any delay in this referral or any attempt at "patient dumping" (transferring an unstable patient) would be gross negligence and a violation of the patient's Article 21 rights.
- Documentation and Reporting: Physicians must document their medical findings, the "life-saving" nature of the MTP, the patient's consent, and the hospital's specific refusal. This incident should be reported to the District Medical Officer (DMO) and State Medical Council.

Scenario 5: Family requests ventilator withdrawal (Against medical advice)

a. The case

A prevalent ethical dilemma in Indian critical care units involves the request for "passive euthanasia" driven by economic rather than medical factors. Consider a patient receiving mechanical ventilation following a severe neurological event, such as a cerebrovascular accident, who remains in an unconscious state. In this representative scenario, the medical team assesses that the condition is potentially reversible and that a "reasonable chance" for meaningful recovery exists, thereby classifying the treatment as non-futile. However, the patient's surrogates (family members) advocate for the discontinuation of ventilatory support. Their request is not based on the patient's prior expressed wishes or medical hopelessness, but is explicitly driven by the "significant financial burden" of prolonged ICU care.

b. The ethical conflict

This situation moves beyond a simple binary conflict and represents a complex "three-way conflict" involving the patient, the physician, and the socioeconomic environment.

Surrogate Autonomy vs. Medical Beneficence: There is a direct clash between the family's request (Surrogate Autonomy) and the physician's obligation to continue effective treatment (Beneficence). The medical team cannot ethically withdraw life support from a patient who has a chance of recovery, as this would constitute active killing rather than allowing a natural death.

The Failure of Justice: The central ethical distortion here is the failure of the principle of Justice. The family's decision is likely not a true exercise of free will but a reaction to financial duress caused by "catastrophic" out-of-pocket expenditures. The family is effectively coerced by the economic system to demand a preventable death, creating a tragic scenario where clinical decisions are dictated by poverty rather than prognosis.

c. The legal and policy framework (India)

- The Old Law: Aruna Shanbaug v Union of India (2011): This case legalized "passive euthanasia" (withholding/withdrawing

treatment) but mandated an "unworkable" High Court approval process for every case.

- The New Right: Common Cause v. Union of India (2018): This SC judgment declared the "Right to Die with Dignity" a fundamental right under Article 21 of the Constitution. It also provided legal sanctity to "Advance Medical Directives" (Living Wills).
- The Crucial New Procedure: SC (2023) and ISCCM-IAPC (2024): The 2018 procedure was still "onerous." In January 2023, the Supreme Court significantly simplified this process. New joint guidelines from the ISCCM and IAPC (2024) codified this simpler, hospital-level, two-board system for approving withdrawal in futility cases.
- Protocol vs. Case: The 2023/2024 protocol applies to cases of medical futility. In this scenario, the team believes that care is non-futile. The law is clear: a family's surrogate autonomy does not extend to compelling a physician to stop non-futile life-sustaining treatment.

d. Recommended course of action

- Multidisciplinary Family Conference: Conduct structured and empathetic meetings. The team must address this financial burden. Involve the medical social worker. Resolving financial duress (e.g., exploring schemes, charity beds) often resolves the ethical conflict.
- Engage Ethics and Palliative Care: Refer the case to the HEC and Palliative Care team for mediation and support.
- Offer a Second Opinion: To build trust, offer the family a second medical opinion from an independent specialist.
- Clarifying the Legal Boundary: Compassionately but firmly explain that because the medical team believes recovery is possible (care is non-futile), the hospital cannot legally or ethically withdraw the ventilator. This is not the case for passive euthanasia.
- Document Everything: Record all clinical findings, family conferences (including finance discussions), HEC consultations, and the team's final rationale.

Scenario 6: Family refuses to pay hospital bill after death, demands body

a. The case

A distressingly common source of public outrage and litigation in the Indian private healthcare sector involves the detention of a deceased patient for non-payment of dues. In this representative scenario—often cited in media reports and consumer court judgments—a patient expires in the Intensive Care Unit (ICU) after a prolonged and costly hospitalization. The bereaved family, financially exhausted, is unable to settle the final "outstanding medical bill" immediately and requests the release of the body for cremation in accordance with their religious customs. The conflict arises when a hospital administration, prioritizing revenue recovery, refuses to release the mortal remains, suggesting that the body will be retained as "collateral" or security until the debt is cleared.

b. The ethical conflict

This scenario differs from the previous ones as it transitions from an ethical dilemma into a clear violation of law and human rights.

- Financial Interests vs. Human Dignity: The conflict is between the hospital's legitimate right to be compensated for services rendered and the fundamental Human Dignity of the deceased and their family.
- Commodification of the Body: By holding a body as security, the institution implicitly treats the deceased as "chattel" or property. This violates the principle of Respect for Persons.
- The Legal-Ethical Boundary: Unlike other scenarios where two rights conflict, here, one action (detention of a body) is legally classified as "Wrongful Confinement" (a criminal offense). The ethical analysis clarifies that while the debt is a civil reality, it cannot be ethically or legally enforced through the violation of the fundamental "Right to Die with Dignity" protected under Article 21.

c. The legal and policy framework (India)

The law is absolute, unambiguous, and firmly supports the in-

terests and rights of the family in all relevant matters.

- Violation of Article 21 (Dignity in Death): The Supreme Court has repeatedly held that Article 21 includes the right to die with dignity. A deceased person is not "chattel" or "property" that can be held as "security."
- Criminal Act (Wrongful Confinement): Detaining a dead body over a financial dispute is a crime. According to the Indian Penal Code (IPC), this constitutes "Wrongful Confinement" (Sections 340-342). The administrators are criminally liable.
- Judicial Precedents and Government Mandates: Multiple High Courts and the National Human Rights Commission (NHRC) "Charter of Patient's Rights" explicitly bans this practice.
- Legal Separation of Issues: The law separates the two issues.

> Issue 1 (The Body): This is a matter of fundamental right. The body must be released.

> Issue 2 (The Bill): This is a civil matter of debt. The only legal recourse available to the hospital is to file a civil suit for recovery.

d. Recommended course of action

- Immediate and Compassionate Release: The body must be released to the family immediately and with dignity. There are no other legal or ethical options.
- De-escalate and Apologize: The team must be trained to de-escalate conflicts resulting from illegal hospital policies.
- Separate Financial Discussion: A trained medical social worker should separately and compassionately discuss the bill, ideally after the body is released.
- Offer Financial Options: Offer a deferred payment plan, accept a token payment, or use a "charity fund" to write off the bill. The family can be asked to sign an "Acknowledgment of Dues" to formalize the civil debt.
- Mandatory Institutional Policy Change: The hospital must have a clear, written, and displayed policy (as required by law in many states) stating: "A deceased's body will not be held for non-payment of bills".

Conclusion

This study demonstrates that the primary bioethical challenges in Indian hospitals are embedded in the nation's legal, cultural, and economic realities. The analysis identifies recurring tensions: the cultural friction between individual and family autonomy; the financial failure of Justice, where catastrophic out-of-pocket costs coerce decisions; and legal anxiety, where a perceived fear of liability, rather than actual law, drives unethical decision-making.

The pedagogical goal is to provide a legally defensible framework that moves decision-making beyond ambiguity. The law—specifically, the expansive interpretation of Article 21 and its corollaries in the MTP Act, the HIV/AIDS Act, and new jurisprudence on end-of-life care—provides a surprisingly clear pathway. Knowing this law transforms "dilemmas" into "protocols".

The tools for walking this path are threefold. First, Communication: empathetic and structured communication is the primary intervention. Second, Documentation: Meticulous contemporaneous documentation of the facts, conflict, legal basis for action, and family communication is the physician's greatest defense. Finally, Hospital Ethics Committees (HECs) must be empowered and used proactively for real-time consultation and mediation, not just as reactive punitive bodies. A robust HEC is the cornerstone of a safe, equitable, and ethical hospital environment.

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