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The Forensic Nurse's Evolving Role in Addressing Elder Maltreatment in the United States

Amy Carney, NP, PhD, FAAFS

ABSTRACT

U.S. forensic nurses' specialization in elder maltreatment has evolved over the last 30 years. Significant progress in research has led to the ability to define and respond to elder abuse. This article describes the foundation for a specialization in nursing that led to inter vention in abuse and neglect, historical milestones as steps to elder justice, and the evolution of forensic nurse practice with senior victims of abuse.

KEY WORDS:

Elder maltreatment; forensic nurse; specialization

Specialization to address elder maltreatment has been developing in forensic nursing for 30 years. Whereas sexual assault nurse examiners (SANEs) became established in the investigation of sexual violence, nurses across the profession were being urged to explore multiple areas in forensics, such as death investigation and child abuse. With a focus on intervening with victims of violence, forensic nursing seemed ideally positioned to assist older adults (Lynch, 1995). Focus on intervention in elder maltreatment can be traced back to two pieces of legislation in the 1960s: (a) the Public Welfare Amendments to the Social Security Act in 1962 that provided payments to states for protective services for those with mental and physical limitations and (b) the Older Americans Act (OAA) of 1965 that established the Administration on Aging within the Department of Health and Human Services. The OAA spurred the Elder Justice Movement leading to changes in legal, medical, and nursing approaches to elder maltreatment. In 1987, with amendments to the OAA, the federal government first described elder neglect, abuse, and exploitation, requiring state agencies on aging to identify the need for prevention services for elder abuse and to create plans for elder abuse prevention. In 1988, the National Center on Elder Abuse was established under the OAA (Blancato & McMahon, 2017). In 2000, Rosalie Wolf wrote that, although British medical journals had briefly addressed elder maltreatment in the 1970s, it was not until 1978 that a U.S. congressional subcommittee on "parent battering" brought elder abuse into national discussion. Wolf noted that, with no model statute and without a database on elder abuse, child abuse law—with its mandated reporting requirement—became the prototype for legislation in many states. As new findings on the prevalence of spousal abuse in the older adults became apparent, it was thought that a domestic violence model would fit this population more closely. However, the multifaceted nature of elder abuse—involving physical, psychological, social, legal, and ethical matters—required action on several levels with multiple systems. This was often frustrating and demanding for practitioners; solutions were difficult for older adults and frequently unacceptable (Wolf, 2000). Lack of education contributed to this frustration . See chronological milestones in Table 1.

Challenging the assumption that elder abuse occurred in a homogenous White population, Toshio Tatara's (1999) "Understanding Elder Abuse in Minority Populations" discussed abuse in African American, Hispanic, Asian American, and Native American populations, the overall impact of elder abuse on all populations, and the need for culturally specific outreach programs. A synthesis of current knowledge on minority elder abuse was also provided.

Author Affiliation: *California State University San Marcos.*

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Correspondence: *Amy Carney NP, PhD, FAAFS, 210 Ivory Gull Way, San Marcos, CA 92078. E-mail: acarney@csusm.edu.*

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TABLE 1. Significant Milestones in Elder American Safety and Health

Year	Title	Impact
1935	Passage of the Social Security Act	Established old-age benefits for retired workers, as well as assistance to children, the blind, family health programs, and others
1962	Public Welfare Amendments to the Social Security Act	Provided payments to states for protective services for persons with mental and physical limitations
1965	Older Americans Act becomes law, along with Medicare and Medicaid	States mandated to pass OAA funding to Area Agencies on Aging
1974	Title XX Amendment to the Social Security Act	"Social Services Block Grant": adult protective services becomes a state-mandated program
1975	Dr. Robert Butler describes "Battered Old Person Syndrome"	
1980s	Surgeon General Louis Sullivan holds workshop on family violence, declaring it a public health and criminal justice issue. Elder abuse was included under the umbrella of "family violence."	
1987	Amendments to the OAA	Federal government describes elder neglect, abuse, and exploitation, requiring state agencies on aging to identify the need for prevention services for elder abuse
1988	Establishment of the National Center on Elder Abuse (NCEA)	NCEA established as a national resource center dedicated to prevention of elder mistreatment
1990	Secretary for DHHS creates Elder Abuse Task Force	Created an action plan for identifying elder abuse and proposed strategies for research and data collection
1992	Amendment to OAA establishes programs to fight elder abuse	102nd Congress authorizes White House Conference on Aging
1994	Bureau of Justice Statistics reports on elder abuse	
1997	Senator Claude Pepper and the U.S. House Permanent Select Committee on Aging hold hearings on "granny bashing"	
2003	Senator John Breaux introduces the Elder Justice Act	First federal legislation to address elder abuse
2010	The Elder Justice Act is passed	Empowers nurses to act on elder abuse and ensures screening and intervention
2012	Health and Human Services convenes the inaugural meeting of the Elder Justice Coordinating Council	
2016	Victims of Crime Act Amended	Victims of federal crimes and elder abuse are eligible for Victims of Crime Act funded assistance
2017	The Elder Abuse Prevention and Prosecution Act signed into law	Established Department of Justice requirements for investigating and prosecuting elder abuse crimes, and enforcing elder abuse laws
2017	Senior Safe Act passed	Encourages employees of financial institutions to report suspected elder abuse by offering immunity from liability
2020	Reauthorization of the Older Americans Act	Reauthorizes programs for seniors through Fiscal Year 2024

Note. DHHS = Department of Health and Human Services; OAA = Older Americans Act.

Tatara's (1999) assertion that abused older adults are not a homogenous group with a single applicable approach was particularly challenging to the nursing approach in elder abuse.

Like most large countries, the United States faces the challenges of an increased population that is living longer, for example, increased length of retirement, providing services for an expanding number of older adults, and securing services and support for older adults with disabilities (Lakin & Burke, 2019). Born between 1946 and 1964, the "Baby Boomer" generation is driving this growth; the number of Americans aged 65 years and over is projected to increase to 18 million between 2020 and 2030.

Identifying Elder Abuse

In 2006, at a time when abuse had reached an epidemic extent, Burgess and Clements stated there was a lack of clarity in what it comprised. Despite being recognized as a significant societal problem, research was limited in specific areas, for example, sexual assault in the older adult and perpetrator motivation. Forensic nurses were uniquely situated to encounter elder victims of maltreatment in a wide variety of locations and agencies but faced a lack of consistent identification and terminology (Burgess & Clements, 2006). Physical abuse, elder neglect, sexual abuse and exploitation, financial abuse, and psychological maltreatment have been identified as major types of elder abuse, but cultural context also plays a part in defining abuse and how it is researched. Disrespect is seen as a form of elder abuse in some cultures but is difficult to describe and quantify. Furthermore, abuse in one population may not be perceived as abuse in another (Wallace & Crabb, 2017). Scope and prevalence of maltreatment is also difficult to determine: An estimated 5 million older adults are victims of abuse annually, but the Department of Justice and Health and Human Services suggests that, for every reported case, another 23 are unreported (Drake et al., 2019).

Diversifying the Nursing Role

Forensic nursing's diversification into care of older adult victims of violence mirrors the expansion of nursing roles that began in the 1960s. Keeling (2004) noted nursing education developed new areas of focus as professional opportunities became available, for example, the advent of coronary care units at Bethany Hospital in Kansas City in 1962 where "…specialized training beyond basic nursing education was essential in order for nurses to fulfill their role in CCU" (p. 154). New technology and new knowledge shifted nurses' responsibilities, increasing the boundaries of what was considered within their scope of practice (Keeling, 2004). This continued into the 1970s with the implementation of a new approach to trauma care, regionalization of emergency medical services, and establishment of trauma units. The trauma nurse coordinator role was established to develop consistent, high-quality hospital care as well as integration within the regional trauma system (Boyd, 2011). This same type of role expansion was mirrored in forensic nursing in 1997 when the American Nurses Association published *Scope and Standards of Forensic Nursing Practice*, encouraging research to both validate and improve forensic nursing practice (Burgess et al., 2004). During this time, Burgess and Clements (2006) cited the need for forensic nurses as geriatric specialists in elder abuse, along with interdisciplinary paradigms and methodologies for both practitioners and investigators to encourage forensic nursing professionals to widen their scope of practice.

The passage of Medicare and Medicaid as Social Security Amendments in 1965 focused greater attention on working with the older adult population, giving rise to geriatric nursing. In the 1970s, the Standards for Geriatric Nursing Practice were established, and the American Nurses Association initiated certification for the geriatric nurse practitioner specialization. This highlighted a shift from the emphasis on illness and disease management in the older adult to healthy aging and wellness. The need for a stronger body of literature on the older adult's care needs was also identified, leading to increased research covering a broad spectrum of challenges older adults may face (Fulmer, 2015). This awareness included a growing body of knowledge in abuse and neglect of older adults. King et al. (2018) stated specialized knowledge in gerontology was warranted because of not only the size of this population but also the breadth of care needed over the length of their lifetime. Whereas themes such as "competency" and "service delivery" are seen in the literature, "communication" and "expertise" were also cited as necessary components of geriatric nursing specialization (King et al., 2018).

Expanding Specialty Care

While geriatric nursing was developing as a specialty, two practice areas of particular importance for identifying and working with victims of violence were identified: hospital emergency departments (EDs) and intensive care units (ICUs). Patients across the life span were routinely seen in the ED, but elderly patients were often seen in the ICU and coronary care unit. Lynch (1991) distinguished clinical forensic medicine, also called living forensics, from forensic pathology: Clinicians are concerned with patients' injuries, whereas forensic pathology answers legal questions about a deceased person. Living forensics includes injury detection and evaluation, evidence collection and preservation, and protecting patients' rights. The forensic clinician is able to determine physical and emotional torture and neglect coming from nursing homes and other institutions, as well as spousal and child abuse. Lynch stated that elder abuse, which is often underreported, had been found to be commonly encountered in hospital EDs, police departments, and social service agencies. The forensic nurse in the ED may be the first to identify these victims of violence (Lynch, 1991), serving several purposes for the hospital, law enforcement, and the patients themselves.

Given the nature of the clientele and setting, emergency personnel will inevitably care for such victims. McCracken (1999) cited domestic violence injuries, abuse, and neglect in the older adult and young, the addictive client seeking emergency care, the sexual assault victim, and sufferers of occupational injuries as but a few of the cases in the forensic arena. Forensic nurses working with victims in the ED are also in a position not only to identify types of maltreatment but also as perpetrators of violence, such as abuse by caregivers. How and when to report, if evidence collection is

allowed by local laws, and the knowledge of current institutional policies on caring for victims of abuse are all domains of forensic nurse practice (McCracken, 1999).

Further advancement in the forensic nurse role in patient care resulted in the advanced practice nurse care model for victims and perpetrators in the ED. Roles at the advanced practice level include educators, colleagues as consultants, and researchers (Sekula, 2005). Consultation at the advanced level may include legal issues regarding medical records and documentation, the triage process, consent/lack of consent for treatment, legal reporting issues, and organ donation. The nursing role in the ED would include violence screening, evidence collection, and forensic documentation. In addition to nursing expertise, the advanced practice forensic nurse has broad knowledge in social sciences, medicine, and law and can interact expertly with disciplines including social services, public health, psychology, and public policy. Education at the graduate and doctoral levels prepares forensic nurses to take on the advanced role not only with the older adults but also with victims across the life span, in and out of the ED (Sekula, 2005). The forensic nurse working with older adults can also have an impact in the ED as part of a multidisciplinary intervention team. Rosen et al. (2018) concluded that the EDs increasingly saw the value of having a social worker available, particularly for older patients, and sought input on the design for a multidisciplinary intervention. As a member of a multidisciplinary team, the forensic nurse specialist could play a critical role in assessment, evaluation of wound and injuries, and psychological effects of abuse; act as liaison with law enforcement and other members of the team; and assist in discharge planning and safety (Rosen et al., 2018).

The ICU was also identified as a practice arena for the forensic nurse. In 1999, Goll-McGee stated, "A clinical setting becomes a forensic area when a medicolegal focus defines nursing practice" (p. 9). Utilizing advanced education, the clinical forensic nurse can identify possible evidence found with an ICU patient, follow established protocols on reporting this finding, and ensure proper collection and handling as well as documentation of condition and transport. The forensic nurse in the ICU may be instrumental in working with families and their understanding of advanced directives and organ donation, especially if they have been victims of crime or violent trauma (Goll-McGee, 1999). As identifiers of physical abuse were being described, critical care nurses were also aware of the need to assess for neglect and the caretaker's failure to attend to the patient's medical needs and to keep the older adult safe from health and safety hazards. It was found that written protocols for this assisted in detection and documentation of elder abuse. White (2000) recognized that the forensic nurse in critical care is in a position to assist medical team members in identifying abuse, and help facilities establish protocols, to aid both the victims and their families.

Sexual Assault and Interpersonal Violence: Early Forensic Nursing Roles Informing Advances in Elder Abuse Intervention

When forensic nurses began working with victims of elder abuse, they had much background and research in other areas of interpersonal violence (IPV) to guide them. Beginning in the 1970s, nurses volunteered in newly established rape crisis centers, working with victims of sexual assault (Morse, 2019); by the 1980s, it was recognized as a form of expertise. During this time, nurses had begun to advocate on behalf of predominantly female victims of rape to be examined by female clinicians, advocating for the rights of women as patients. Women's rights activists were also questioning the treatment of victims who reported sexual assault, noting that law enforcement and healthcare personnel were often suspicious or dismissive of women who reported these crimes. Nurses began seeking greater autonomy and a more recognized role, linking medical evidence collection with specialized and compassionate care. This early advocacy resulted in sexual assault response teams (Morse, 2019). These teams were formed to build positive relationships and increase collaboration among entities working with victims of sexual assault, chiefly the medical, legal, and advocacy/mental health systems. The sexual assault response team model expanded widely, ultimately resulting in hundreds of teams in operation across the United States (Greeson & Campbell, 2013). However, there was very little mention of sexual assault of older adults in the literature. A 2005 study showed that, although elder victims of sexual abuse were a vulnerable and neglected population, there were unique barriers to reporting: cognitive impairment, reluctance to disclose because of shame and embarrassment, and fear of not being believed. Consequently, many cases were thought to have gone unreported (Burgess et al., 2005). A higher standard was established for forensic nurses working with adults and adolescents with the first certifying examination as a Sexual Assault Nurse Examiner-Adult/Adolescent in 2002 and in pediatric forensics with the certification as a Sexual Assault Nurse Examiner-Pediatric/Adolescent in 2007 (Orr, 2016).

Groundwork in IPV: Introduction of Screening Tools

IPV work has also influenced forensic nurses working with older adults. Identified in early literature as "domestic violence," the term IPV became common as it more broadly addressed victims of violence in a variety of relationships and settings. IPV occurs across all socioeconomic levels and is not specific to gender or geographic setting (Herzog et al., 2019). A nurse in the ED is often the first person to identify an IPV victim. These victims have higher rates of visits to an ED than the general population and often have complaints indirectly associated with injuries, such as headaches

or abdominal pain. Alcohol or substance use may mask IPV, and many times, patients are in denial (Herzog et al., 2019), making screening for IPV difficult. Nurses began to note several barriers to mandated IPV reporting: the threat to nurse–patient confidentiality, the desire to not cause the victim further distress, and not knowing what constitutes abuse (Smith et al., 2008). This is an area where forensic nursing is essential, with the ability to teach victim recognition, wound identification, and methods of reporting. Injuries in older adults because of IPV are often mistaken for age-related changes and require skilled geriatric assessment for signs of abuse (Thimsen, 2020).

These changes in approach to patient care necessitated states to reexamine their nurse practice acts and reevaluate the nursing scope of practice. Multiple aspects of forensic nursing practice were questioned. The result was a new domain where a forensic nurse could conduct a pelvic examination, render a clinical judgment and interpret presence or absence of injury (Morse, 2019), and collect and package evidence (biological samples including blood, semen, and saliva) for testing by forensic crime laboratories. Overcoming resistance to these changes varied by legal jurisdiction but was often driven by public pressure to increase prosecution rates. A novel, hybrid professional jurisdiction was established by a form of medical action that combined the right to health care with the right to justice for victims of violence (Morse, 2019). Forensic nurses working with victims of elder abuse faced the same challenges: evaluating injuries, establishing cause, and interpreting results, while maintaining a patient-centered focus. Support came not only in changes to state Nurse Practice Acts but also in the growth of professional nursing organizations offering structure, education, and certifications for specializations across the life span, for example, the American Nurses Association and International Association of Forensic Nurses' (2017) publication of the *Forensic Nursing: Scope and Standards of Practice*, published in 2009 and revised in 2017, and the availability of certifying examinations in gerontology for advanced practice nurses (Murphy et al., 2014).

Research advances in violence across the life span led to the development and implementation of screening tools that informed work with elder victims of violence, for example, the Danger Assessment Tool (Campbell, 1986; Storey & Hart, 2014), Abuse Assessment Screen (Nursing Research Consortium on Violence and Assessment; D'Avolio et al., 2001), and Hurt/Insult/Threaten/Scream (Iverson et al., 2013).

Schofield (2017) stated tools and screening assessments can be grouped into three sections: measures that screen at a population level, in healthcare settings, and to assess neglect and self-neglect. The Conflict Tactics Scale and the Conflict Tactics Scale-2, which are not specific to elder abuse, and the Vulnerability to Elder Abuse Scale, which is specific to elder maltreatment, are examples of population-level tools. Assessments used in healthcare settings include the Brief Abuse Screen for the Elderly, the Elder Abuse Suspicion Index, and the Indicators of Abuse Screen. There are many validated measures for screening older adults for neglect, such as the Caregiver Neglect tool and the Elder Self-Neglect Assessment. Knowing how and when to apply these tools is essential (Schofield, 2017). The elder abuse forensic nurse specialist fills this gap with the knowledge of pertinent tools and assessments, assisting fellow clinicians with interventions in abuse and improving elder patient outcomes.

Elder Abuse Education for Forensic Nurses in an Aging America

Nurse specialization has been essential to advancing the profession. Research conducted in new areas of interest has yielded positive results such as improved patient outcomes and quality of healthcare, increased patient satisfaction, and reduced healthcare costs. Curricula were developed to educate nurses in the newly specialized fields (Cotton, 1997). Those working with older adults are in a prime position to identify abuse, regardless of the type of abuse or whether they are required to report it. However, for those working in elder care, identification of elder maltreatment has not been part of their training; unless educationally prepared, healthcare professionals are unlikely to identify abuse in all but the most extreme cases (Starr, 2010). This becomes particularly important when establishing the need for a new role or specialization in nursing, such as the forensic nurse specializing in elder maltreatment, as this segment of the population has unique needs that require specific nursing knowledge for successful intervention.

Starr (2010) identified the basics of a formal nursing educational course in elder abuse would increase knowledge and understanding of elder abuse; develop skills in forensic aspects of maltreatment; expand knowledge of healthcare law, including the criminal justice system and how it functions; connect students with elder care service providers; and enlist students in raising awareness of elder mistreatment through creative assessment. Skills-based competencies are an important tool for forensic nurse examiners responding to elder abuse in a hospital-based context. Normal aging versus abuse was taken up by researchers in 2016 to develop skills-based competencies for forensic nurse examiners providing care in elder abuse (Du Mont et al., 2016). Program leaders of 30 hospital-based forensic-nursing-led sexual assault and domestic violence treatment centers helped construct 101 Elder Abuse Nurse Examiner components of care. These were translated into 47 competencies to form an Elder Abuse Nurse Examiner curriculum consisting of six content domains: older adults and abuse; documentation, legal, and legislative issues; interview with older adult, caregiver, and other relevant contacts; assessment; medical and forensic examination; and case summary,

discharge plan, and follow-up care (Du Mont et al., 2017). A pilot study, involving 18 SANEs responding to the complex care needs of a diverse group of abused older adults, found the curricula was efficacious in improving their perceived competence and self-reported knowledge in delivering elder abuse care (Du Mont et al., 2017).

A research study for the International Association of Forensic Nurses in 2018 identified research priorities and gaps in forensic nursing. Thematic analysis of members' postings in the online member community yielded eight descriptive categories, one of which was vulnerable populations. Questions in the group ranged across areas, including age, gender, ethnicity, and cognitive or mental health status. Comments focused particularly on needed skills, knowledge, and attitudes (competencies) related to providing safe, culturally competent care. It was stated that forensic nursing is advancing as a discipline and as a specialty within nursing, and the capacity for professional growth continues to evolve (Drake et al., 2018). This is where the forensic nurse working with victims of elder abuse fills a practice gap.

In 2020, Berishaj et al. proposed the advanced role of the forensic nurse hospitalist (FNH). Describing forensic nursing as an evolving specialty designed to meet the unique needs of victims, suspects, and perpetrators of trauma, this new role warranted a new term. FNH qualification would include education and licensure to practice specifically in the hospital setting. The Nationwide Emergency Department Sample in 2012 found that more than 29 million persons aged 60 years or older were seen in U.S. EDs, with 7,154 receiving a diagnosis of elder abuse. Citing these numbers, Berishaj et al. (2020) proposed that the FNH would be instrumental in addressing the multifaceted needs of patients across the life span, as well as contribute to ongoing educational initiatives in the healthcare system.

These advances in education support the forensic nurse's evolving role in the trauma of elder mistreatment. The prevalence of elder abuse and increase in the aging population worldwide indicate a need for more comprehensive health service involvement, which includes a forensic nurse examiner specializing in interventions in multiple aspects of elder care and abuse (Du Mont et al., 2015).

The Evolution of the Forensic Nurse Role in Elder Maltreatment

Understanding the nature and scope of elder abuse has progressed exponentially in the last 20 years, because of research that has led to the growth in identification, intervention, and prevention. Once thought to take place only in older adults' private homes, research shows they are often maltreated in assisted living facilities, skilled nursing, and nursing homes under the umbrella of "long-term care facilities." Abuse is inflicted not only by caretakers and staff but also by resident-to-resident aggression, defined as "negative, aggressive and intrusive verbal, physical, sexual, and material interactions between long-term care residents that in a community setting would likely be unwelcome and potentially cause physical or psychological distress or harm to the recipient" (Daly, 2017, p. 77). Neglect and self-neglect also receive more attention in the literature. Usually by a caregiver, "neglect" is characterized as failure to act by someone with a duty to do so on behalf of an older person requiring care or other assistance. "Self-neglect" can be harder to identify and to intervene on behalf of an older adult. Self-neglect is an adult's inability, because of physical or mental impairment or diminished capacity, to perform essential self-care tasks and may include hoarding, obsessive–compulsive disorder, or living in squalor. Much of the discussion on self-neglect centers on decision-making capacity. Older adults with decision-making capacity are allowed to make their own decisions, even if those choices seem unwise to others (Heisler, 2017).

Strangulation and suffocation are forms of elder abuse, leading to neurologic sequelae and death. Strangulation is difficult to detect in elder populations, partially because of underlying medical conditions and advanced age. Historically, elder death investigations have not been a priority for medical examiners and coroners. However, strangulation as a cause of death increases with a victim's age and gender: Women over 65 years old are more likely to die from strangulation than men of the same age (Heisler, 2017).

The forensic nurse specialist in elder abuse is increasingly becoming the expert in these areas because of knowledge, training, and experience. This role has evolved with both an identified need and recognition of the forensic nurse as a valuable member among elder abuse experts. Research in elder abuse has produced opportunities for new areas of inclusion in forensic nursing education. Phelan (2018) highlighted the need for nurses to provide integrated care as older persons transition through different care settings. The literature shows the forensic nurse is effective in addressing elder abuse and maltreatment and has the ability to provide integrated care to an older victim of violence (Berishaj et al., 2020; Doyle, 2013; Du Mont et al., 2017). This role for forensic nurses, as it continues to evolve with an ever-aging society, will add to both older adults' safety and the wider body of knowledge in forensic nursing science.

Summary

Forensic nurses specializing in the field of elder abuse have been crucial to the evolution of elder care. The aging population growth carries multiple implications for forensic nursing: A larger nursing workforce will be needed to care for this group; nurses specialized in working with older adults will be required to intervene more broadly with elder victims of violence. As certain types of crime (e.g., financial abuse and cybercrime) continue to advance in elder maltreatment,

forensic nurses working with abused and neglected older adults will need to keep pace with these changes to interact efficiently for quality patient outcomes. With older persons adopting technology more widely, forensic nurses will need to evaluate which modalities for intervention work best in elder abuse. The elder abuse forensic nurse will have to keep abreast of new research to assess which methods work across diverse populations. Using forensic nursing science, the elder abuse forensic nurse will influence practice outcomes, thereby increasing safety for older adults and the wider population.

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