Sanya Virani:

Hi, I'm Sanya Virani. I welcome you to Finding Our Voice: Fresh Perspectives in Psychiatry, a podcast series hosted by me.

This podcast has been developed with the goal to address current issues as they pertain to psychiatry, with a special focus on including the viewpoints and opinions of younger groups, resident fellow members and early career psychiatrists.

Thank you for joining me as we continue our discussions on this segment of the podcast series about structural racism that affects patients and psychiatrists from minority and underrepresented ethnic groups.

Today's episode will be focused on international medical graduates. We have two esteemed guests in our midst, Dr. Vishal Madaan from the University of Virginia and Dr. Manal Khan from the University of California.

But let's start out with a few lines that my very talented friend and colleague, Dr. Sarah El Halabi from the American University of Beirut in Lebanon has written up.

Sarah recently graduated from the master's program in narrative medicine, from Columbia University and works there as faculty associate.

Ladies and gentlemen, this is coming to you straight from the heart of an IMG who is in the throes of the interview season, waiting for the nail-biting finish that March 2021 is likely to be. Sarah, welcome. We are so excited to hear what you have for us.

Dr. Sarah El Halabi:

Thank you, Sanya, for having me. I'm happy to be here. I don't usually preface, but let me start by saying that the poem is called Life Lessons, Bro, Life Lessons. That is a line that Sanya actually texted me. So, this poem is an inspiration from there.

Sanya Virani:

Thank you, Sarah. Take it away.

Dr. Sarah El Halabi:

Thanks, Sanya. Life lessons, bro, life lessons. I stand by this camaraderie and its many blessings. Look the path straight in the eye. Sometimes I'm frightened, counting the days as they go by, but I've found my people. Here I stand, enlightened.

To be or not to be, questions of an IMG. What does it mean to travel here from overseas? My friend Sanya asks me to write a poem about us all, and so I celebrate the serene epiphany that I'm not alone. Life lessons, bro, life lessons.

The path's been rough, but the path is the lesson. Walk into every space with intention, carrying new perspectives, creating new dimensions, asking critical questions, being gifted the space of reflection.

Our identity is rich and many. We work hard. It's all love. This revelation is virtual ascension. Life lessons, bro, life lessons. Life lessons, bro, life lessons.

Sanya Virani:

Thank you so much, Sarah. How very touching, thoughtful and insightful. This is a great way to get us started on the discussion about IMGs as a minority and underrepresented group.

I got to know Dr. Khan and Dr. Madaan at the American Association for Directors of Psychiatric Residency Training, the AADPRT's annual meeting in Dallas last year, where they were paired up as mentee and mentor as part of the Nyapati Rao and Francis Lu IMG Award.

Dr. Manal Khan is a first-year child and adolescent psychiatry fellow at the University of California in Los Angeles. She graduated from the Adult Psychiatry Residency Program at the University of Washington in Seattle. Welcome Manal, to the podcast.

Dr. Manal Khan:

Thank you so much.

Sanya Virani:

And Dr. Vishal Madaan is a tenured professor, associate professor in psychiatry and child psychiatry at the University of Virginia in Charlottesville. He is the founding director for the Center for Psychopharmacology Research in Youth at UVA and serves as training director for the Child and Adolescent Psychiatry Fellowship Program there.

Dr. Madaan also serves as president-elect of the APA's IMG Caucus and is the chair of AADPRT's IMG Caucus. Welcome, Dr. Vishal Madaan, to our podcast.

Dr. Vishal Madaan:

Thank you so much, Sanya, for having me. It's wonderful to be here. What a start by Sarah. Very much appreciate it. Thank you again.

Dr. Sarah El Halabi:

Thank you so much.

Sanya Virani:

Thank you. Thank you. It is so nice to be connecting with the both of you after Dallas. How life has changed, no?

I had no idea that Dallas would be the very last trip I would be taking for at least a year or two, and even that seemed to have happened a very long time ago.

Anyway, let's all get started. All three of us are international medical graduates, but we come from very different cultural backgrounds.

Despite the wonderful melting pot that America is, all of us have had a fair number of personal stories about physician and patient discrimination, in both overt and covert ways.

Manal, it's recruitment season again. I can never help but reminisce about what I was doing in the winter of 2015, 2016, in the midst of a nerve-wracking interview season. Do you remember? I think we both matched in 2016. No?

Dr. Manal Khan:

Thank you so much for having me here. It's an honor to share a platform with you, Sarah and Dr. Madaan.

Yes, that was some experience. I really like how you highlighted that even though we are all IMGs, we have our own unique stories.

It is important to acknowledge that although there are some common factors, IMGs are a heterogeneous group of physicians who can be very different from one another, depending upon a variety of factors, such as their country of origin, visa status, material and relationship resources in the US.

Therefore, I can only speak for myself. During my MET cycle, I applied to 88 programs. When I share this with my AMG colleagues, they tell me that I was being too cautious and should have applied to fewer programs.

When I share this number with my IMG colleagues, they tell me that I was not being cautious enough and that I should have applied to more programs. Their reaction does highlight the difference in our journeys.

Now that you have asked me to reflect upon mine, with an eye towards discrimination, I cannot help but recall some interesting comments and questions. I will share one with you.

During my interview trail, an attending commented that my father, who's a military psychiatrist in Pakistan, must have been a megalomaniac. I guess he was trying to do some sort of stress in occupation testing, but now looking back on it, the comment sounds very inappropriate.

Then the whole process of traveling back to your country of origin, securing a visa, ensuring that credentialing is done on time, especially in the context of the infrastructure of low, middle-resource countries and then hoping to return to the US in time, it's a lot.

Ours was also a unique year. Soon after we started our training, there was a travel ban. I haven't returned to Pakistan since 2016.

Dr. Vishal Madaan:

Yeah. Your discussion, Manal and Sanya, certainly jogs several memories from my training more than 15, 16 years ago.

I think I applied to maybe 60-ish programs and got interview calls from 20. So, it's been obviously an interesting journey going all along.

But I can recall one of my first experiences in the US was at a very prestigious institute, where some of the staff wondered whether snake charmers and elephants were still the norm on the streets of India.

This was even after the time of Y2K bug, if you remember that, and how the Indian engineers had really stolen the limelight working in Silicon Valley.

But anyway, I realized from that, that while I had come a long way in my attempts at understanding aspects of the American culture, people in small-town America had really not had the opportunity to look beyond their daily life, from their small towns and look at maybe broader, more global horizons.

I also remember my first residency interview, where everything was really going beautifully, remarkably well till the last session with the training director, who made some unwanted, unsavory remarks, which actually led me to not consider that program at all.

The battle in your mind, between doing residency in a top tier university program on a J-1 Visa, with its post-residency challenges versus doing that in a mid-level program on an H-1 visa was pretty engrossing in those days.

Then, I would say early on in residency, there were times when I felt like I was treated with some indifference by some nursing staff. Yet, over time, when they realized that I was contributing well to the team, they would come around.

I also interestingly recall a resident colleague who became a very good friend over time, who actually questioned my work ethic very early on, because my Social Security number had not arrived and I could not log on to the VA computers.

It took them some time, actually up to three years maybe, to realize that it was just a procedural hurdle that I couldn't really do much about in my first 10, 12 days of work.

Sanya Virani:

Snake charmers and elephants, really, Dr. Madaan? And megalomaniac father being an army psychiatrist, Manal? Wow. This is indeed just testament to the fact that IMGs have to undergo some very uniquely stressful situations in order to secure a spot and start residency training in the US.

Not everything is so in your face and as aberrant always, though, as you described, Manal.

So we matched, we entered into residency. How was that experience? I'm asking in particular if you found yourself experiencing micro and macroaggressions on account of you being an IMG.

Dr. Manal Khan:

Oh boy, micro and macroaggressions. The micro ones are so hard to process and deconstruct. With them, you are left one train. Did that really happen? Am I blowing this out of proportion? Maybe they did not mean it the way it came out.

This happens in the middle of a workday, and you're left with the task of processing, compartmentalizing and moving on.

This shows that even though racism exists out there between people, but it also exists intra-psychically, in the minds of those who are discriminated and those who discriminate.

These microaggressions and macroaggressions can be directed towards you from patients, peers, staff and faculty. I remember many such conversations.

I have been asked about my opinion regarding 9/11, by an attending. I have been congratulated on The Squad's victory by an attending who commented that my people won. Maybe she was referred to Ilhan Omar or Rashida Tlaib. I don't know.

However, I think the interaction that stands out most for me was with a peer. This peer and I were on a rotation together. Sometimes after completing work, we would talk about all sorts of things, including international politics.

We had a really good relationship, and I still have a lot of fondness for this peer, but they questioned my religious identity, asked me about another Muslim country's internal politics and urged me to comment on Islam's association with global terrorism.

Sanya Virani:

Don't you sometimes also find yourself wondering about how much of it is said while wearing the garb of good intention and lightheartedness? But of course we'd much rather not go there.

The point is, so much is ingrained in people's minds and unless we all become responsibly aware of what it is that we are thinking, saying or insinuating, no one will really begin to identify the problems that present and come as a consequence of microaggressions.

On that note, Manal, I know you have an interesting example to share with us about what happened during one of your didactic sessions during residency. So, why don't you go ahead and tell us about it?

Dr. Manal Khan:

Yes. That incident highlights how we need diverse voices, because all of us have a very different lived experience. Sometimes, even the most well-intentioned discussions and tools can be a source of suffering for some.

In my fourth year, we had didactics on using virtual reality for psychotherapy. Researchers from the VA brought with them a simulation program based on the Afghan war, that was being used to help OEF and OIF war veterans with PTSD.

There were some specific features. For example, you could select terrains, weather, situations, et cetera, to be as closely reminiscent of their experience. These features were supposed to help with retrieval of trauma memories.

One of those features was adding the cries of a baby. I remember at that point, I just choked up. As someone whose country was collaterally damaged in this war, I was overwhelmed with the continued pain, otherization and dehumanization.

Afghanistan is real. Those babies were real. How can we continue to put the suffering of people in the background as props? I did not have bandwidth to share this with my presenters, but my peers did.

The feedback was very well received. However, this highlights that trauma folks, trainees and patients alike, from war-affected countries, does not get talked about during our residency training.

Dr. Vishal Madaan:

Yeah, that's very interesting. I recall some of that was coming up when I was in training. So, that's very interesting how some of these newer experiences, while thought to be as useful for our patients, may come across as very distressing to us as trainees or trainers.

In fact, I remember as a trainee, I recall a junior IMG resident with a former completed psychiatry training in their home country, being kicked out of training and being told that they had no aptitude for psychiatry.

That was the written note, no aptitude for psychiatry, even after they had completed successful training in psychiatry in their home country.

Now, this colleague may have had some obvious challenges to work on, but they weren't really truly given much of a chance to acculturate in their intern year.

That particular colleague tried unsuccessfully for another position, for the next couple of years, but that label that he got, they couldn't move beyond it. They ended up switching careers.

Another very straightforward example of systemic and organizational biases is the interplay between the term diversity and IMGs.

While there's growing interest in all graduate medical education programs to enhance diversity, IMGs are often mistakenly believed, in my opinion, to not enhance diversity in numbers.

This, I find to be a very strange thought. I don't quite understand, because IMGs truly enrich the diversity of experience in training programs, from my perspective.

Sanya Virani:

Absolutely, Dr. Madaan. You bring up such an important point. First of all, Manal, thank you so much for sharing that example about the didactics experience. It is horrific to see how somebody who has probably lived that experience would've related to it in the way that you possibly did.

Dr. Madaan, I wanted to share some actual numbers that I was studying, pertaining to the match over the past decade, specific to psychiatry and specific to IMGs and how the field compares to other specialties.

As you correctly pointed out, it is very mistakenly believed that IMGs do not contribute to the diversity and inclusion concept within psychiatry, when it is the furthest thing from the truth.

Interestingly, the number of IMG physicians matching into psychiatry residency decreased considerably over the past decade.

In 2010, 24.5% of the matched PGY1 psychiatry residents were foreign trained. In 2013, the percentage of IMG physicians reached a 10-year peak of about 30%, and then steadily decreased to just 16% in 2020.

In 2020, in comparison to other large specialties, psychiatry had a greater proportion of incoming IMG resident physicians compared to OBGYN, emergency medicine and surgery, which has always been the case, but a much smaller proportion of IMG physicians compared to internal medicine, which was at 39%, family medicine at 28% and pediatrics at 20%.

But perhaps the most striking feature is the fact that when compared to seven other large specialties that I mentioned before, psychiatry saw the largest decrease in matching IMG physicians.

There was a 46.3% decrease of IMG physicians from 2014 in to 2020 alone. Four other specialties, including family medicine, internal medicine, surgery and neurology, saw fewer IMG physicians matching into PGY1 positions. Back to you, Dr. Madaan, about your experiences as a resident.

Dr. Vishal Madaan:

Yeah. Thank you for sharing those numbers, Sanya. I think it's also important to extrapolate that data to subspecialty fellowships because in our subspecialty fellowships, for example in child psychiatry, you actually see a higher proportion of IMGs, compared to the total proportion of fellows that you may have.

Recent data also shows a significant dip in IMG numbers for fellowships in all subspecialties. How this would have a downstream effect is equally worse.

But yeah, rewinding back to times when I was a resident, I always had this nagging feeling, so to say, about not getting acknowledged for my efforts.

There were several times when working on a manuscript or publication, my name was pushed to third or fourth in authorship, and I had done bulk of the work.

As an attending, I've tried to make sure that, that really doesn't happen to any of the trainees that work with me.

Plus, one other thing that I've noticed, the 360 degree evaluations that you would get from staff members, those can be remarkably different for you compared to some of your other colleagues, even when you may have done a similar or better job. You know that objectively, really.

Another interesting comment that I've held onto, has been one of a senior professor's, when I was looking for my first faculty position and trying to decide between a few opportunities.

One professor who I was particularly close to and fond of, in fact, unwittingly asked me whether it was hard for me to say no to the other opportunities because of my, in quotes, colonial mindset.

So, it can be pretty challenging going through some of these comments and navigating them, as Manal was pointing out.

Sanya Virani:

Yeah, absolutely. I just keep getting more and more surprised as you're sharing more and more of these tidbits with us.

It can be very distressing indeed, after you've put in all of this effort, come here, challenging all odds and then getting to a point where you think you deserve to be, but are denied a number of opportunities for various reasons.

I'm getting a sense that we're slowly moving a little bit away from the topic of racism by itself, to talk more about discrimination in general.

So thank you, Dr. Madaan, for sharing your experiences on this issue when you were in the initial stages of your career. But I was wondering, how did things change once you became more seasoned faculty?

Dr. Vishal Madaan:

Yeah. I would say as faculty, I've had, I call it the good fortune, actually. I've had the good fortune to serve as a supervisor for several IMG residents who were in fact close to being fired from training, for largely trivial misunderstandings, which were deemed as unprofessional.

A lot of those interactions that were found overall to be problematic, when you look at them closer, often they have some cultural element to it.

It was very interesting that because of those, such trainees were truly kept on a short, very tight leash. Often, you would run into faculty that, they had made such a referral, such decisions based on a possibility of implicit bias on their part.

With appropriate support, several such trainees were easily able to move past those experiences, graduate successfully in our faculty themselves, in different academic programs.

But from what I've seen and known over the years, discrimination doesn't end with residency.

In fact, you can feel sometimes that it accentuates after residency training, because as a resident you're probably one of 40 people.

When you're looking at a faculty recruitment or other things, you're one of maybe two or three. So, it often feels that... and this is not unlike other people of minority groups, you feel that you can, at times be overlooked for opportunities for career advancement.

Often, you feel like you've hit the glass ceiling, academic glass ceiling as I call it, and you can't pierce through it.

Similar experiences can be found in public sector, private practices, where you can come across, you will come across people on visas, who get exploited or be threatened into trouble with the USCIS if they don't go along with what may be an unfair practice.

Sanya Virani:

Thank you, Dr. Madaan. You're opening my eyes to a whole different set of problems, which I don't know how I'm going to encounter once I step out of training and look for my first job. But let's see if I can use all of this advice in order to cross the bridge when I get to it.

I wanted to draw everybody's attention to one thing that's mentioned in the DSM-5's V codes, specifically the one that's 62.4, which goes by the title of Target of Perceived Adverse Discrimination or Persecution.

So, exactly what you were talking about, Dr. Madaan, is codified in DSM-5 as one of the things that can be paid attention to if such a situation comes about being, a target of perceived adverse discrimination or persecution, specifically Z60.5. So, just wanted to draw everybody's attention to it.

While it is fascinating how microaggressions and macroaggressions and incidents of becoming acutely aware of being an other, as you gave an example of your didactics, Manal, continue to be a part of our experience, there is very little discussion about it.

Have you ever felt discriminated by a patient? Tell us specifically about the incident you had on the CL service and at the VA hospital.

But might I add, I work primarily at the VA for my fellowship. I can say without doubt, that just on account of being a woman of color and with an accent, I have been subjected to a lot of snide remarks and inquiries about whether I even understood the meaning of certain words that they were saying and whether I was training here in the US because I just couldn't make it past the competition in my own country.

Dr. Manal Khan:

I remember as an intern, I had a patient at the VA who used to call me a pawn in a derogatory manner. There was also some posturing involved.

I ended up requesting my attending to accompany me while seeing him. With my attending's presence and with some clinical improvement, there was eventual fizzling out of those behaviors.

As a second year trainee on the CL service, Consult-Liaison service, we were called to assess and help a patient who had undergone a skiing accident which resulted in bilateral knee amputation.

When I interviewed the patient, he was exceptionally curt and short-tempered with me, giving yes/no responses, labeling some questions as stupid and obvious.

It was a scathing interaction, and I felt defeated. However, I processed that as an interview with someone who had just lived through a tragedy and did not owe me or anyone any courtesy.

Anyway, a nurse who was in and out of the room during our interview, shared that I should not take this too personally or I should not extrapolate this to my expertise or style, because she had heard the patient make several comments about people like me, immigrants.

I was taken by surprise that day. I had not even considered that point of view or seen the patient's behavior towards me as deliberate. It was both relieving and dejecting.

Although a part of me was happy that my skills were not in question, I was reminded of my othering. That did not feel good. The fact that my skin color and my accent makes me less likable, desired or respectable is a hard thing to sit with.

I have had some other similar interactions where patients, with not wanting to engage, have asked me to write down questions for them because they cannot understand my "accent".

Dr. Vishal Madaan:

Yeah. I remember an elderly patient on my internal medicine rotation when I was a PGY1 one. That tells you, obviously structural racism was well and alive from at least 20 years to now, listening to Manal.

That gentleman asked me not to join the team rounding on them because they felt that a side effect that they had was somehow related to my presence there.

It can be pretty challenging, especially when you're trying to acculturate yourself in your first few years of residency and learning to live in a new country, which often has more of focus on individualistic

strengths and without extensive family support and especially when you're coming from more of a collectivistic culture.

Then I would say, in faculty and training director roles, I have certainly encountered several of my IMG fellows being the target of both covert and overt verbally aggressive behavior from patients and their families.

I recall a couple of teenagers who would wear Confederate flag T-shirts for their sessions with a female IMG fellow. Some others would treat the IMG fellows very differently, compared to when they would see a non-IMG fellow.

We also had the infamous Charlottesville incident right here, which obviously touched a raw nerve for several of us.

I do recall putting together a couple of debriefing sessions then, for my trainees, right after the Charlottesville incident.

I still would say now, there are several times when we get requests from families, to get their care transferred to another physician, with examples like, oh, we cannot connect. We cannot understand, even when the same trainee has had no problems with the hundreds of other patients and families.

Sanya Virani:

I just cannot stop smiling as I relate to all of these experiences. I can tell you that I've lived through so many of these. Thank you so much Manal and Dr. Madaan for sharing this.

One thing is, even as we smile ruefully at this stuff, it's truly unfortunate that we're sometimes discriminated against by the same people that we're trying so hard to take care of. It can be very demoralizing. So, how do you deal with that?

Dr. Vishal Madaan:

For me, I would say during my formative years, my early career years, talking through such experiences with immediate family and having meaningful conversations with seasoned professors were very helpful.

Never worry about these things alone. It certainly helps to talk through several such experiences that we've talked about.

But in the longer run, I feel that as an IMG, you end up either subconsciously repressing such negative experiences, maybe actively suppressing them or more likely dismissing them.

In my opinion, it's helpful to have two mentors. One, an IMG mentor who understands and validates some of your experiences. And a non-IMG mentor, who has the ability to reflect upon what may have been more of a cultural nuance versus a microaggression that you may have felt.

Similarly, reaching out to your junior colleagues within the program and nationally even, understanding their experiences and being willing to be an active listener, I believe are much more valued.

If you are in an administrative role, like the medical director of a clinic or something of that sort, having clear-cut policies about biases and racism within the institution and probably even more importantly, having the will to support the IMG physician against any discriminatory behavior from patients or colleagues, is paramount.

Dr. Manal Khan:

I agree with Dr. Madaan. I think on most days, you try to compartmentalize so that it does not affect the flow of your day, but it does take a toll.

It is important to acknowledge the pain that discrimination inflicts on you, but you don't have to suffer alone.

Talk to an attending. Share your experience with a colleague. Mention these things in your process group. Vent to your therapist.

Like Mr. Rogers used to say, what can be said can be managed. So, I'm glad we are talking about this today.

For me personally, being an advocate for minorities and international medical graduates has also helped with the healing process.

Dr. Vishal Madaan:

Yeah. I would also take a second to add something which we often do not talk a whole lot about. That is the strengths, the unique strengths for IMGs, which are in our resilience and the will to move bureaucratic mountains while traveling across continents and oceans.

Like Mahatma Gandhi said, strength does not come from physical capacity. It comes from an indomitable will.

By the way, I like how we are creating a crossover here between Mr. Rogers and Mahatma Gandhi. I like that.

I also value the fact, that for every single negative experience, there are probably 10 times more positive and welcoming folks and professors who would care for you and faculty who would care for you, which obviously makes the US an incredible melting pot of talent, of cultures, opportunities, all of that in one.

Sanya Virani:

That is very valuable advice. I'm sure that those who are listening to us and struggling with similar things will find some strength in knowing that, A, they're not alone, B, their experiences are not unacknowledged and C, there are ways to commiserate and heal.

We talked about how patients can be a part of discriminatory machinery, but they can also be recipients of it. So, let's switch gears a little bit.

In your experience, have you noticed that immigrant patients are treated differently in psychiatry? Tell us about your incident with Malik, Manal.

Dr. Manal Khan:

As a first-year resident, I was on inpatient psychiatric unit. We had a young immigrant male patient on the unit for psychosis.

One afternoon, my attending and I were observing the milieu from the nursing station. My attending pointed to this patient and shared concern about the possibility that he might be responding to internal stimuli.

He was making weird body movements, standing up, bending and then prostrating. He was also turning his head from side to side.

What she saw as undertreated psychosis was a man engaged in the mass, Muslim prayer. I was able to explain this to her, but I wonder what would have happened had I not been there.

Would his prayer be pathologized? Would it be seen as a part of psychosis? Would he be treated with a higher dose of an anti-psychotic?

Therefore, in addition to cultural and structural competencies and humility, we need a diverse physician workforce. The US is diversifying, and the physician workforce needs to reflect that.

Dr. Vishal Madaan:

Yeah, I completely agree. I believe that in our specialty, in our discipline, getting to understand what a particular action or behavior means from the perspective of a patient's culture is really important.

I find that as a physician, expressing your vulnerability, acknowledging your lack of understanding about the meaning of specific behaviors for the patient and asking the patient to educate you about all of that, actually enhances rapport. It helps with better understanding, in the longer run.

To be fair, all of us have implicit biases as human beings. The sooner we utilize that information in educating ourselves, the better humans and the better physicians we become.

Sanya Virani:

Well, Dr. Madaan and Manal, this has been such a rich discussion. I don't know if a single podcast episode will cover everything, but I am glad that we have started to talk about stories of structural racism within psychiatry.

It helps us examine our specialty and be more deliberate and thoughtful in how we interact with each other and with our patients.

Thank you so much for your time and for your participation. It was such a pleasure speaking with you today, Manal, Dr. Madaan. Thank you.

Dr. Vishal Madaan:

Thank you so much for having us on board. It was a pleasure being here and discussing and sharing some of the experiences. Much appreciated.

Dr. Manal Khan:

Thank you so much. This is powerful work. I am so proud of you for doing this. And also Sarah, incredible, incredible poem at the beginning.

Sanya Virani:

Thank you. If you take away nothing from this podcast but the idea that the experiences we share with you are leading you to discovering an individual and collective identity within psychiatry and within society, I will have accomplished a great deal.

I'd like to leave you with one final thought. Life is offered to us as a means of self-expression. The highest form of this expression is through acts of kindness. I hope that we will always remember this in all our interactions with people, going forward.

I'll see you again soon, with more guests and more stories. Until then, take care and be well.

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Speaker 5:

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