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Developing a Conceptual Framework of Nurse–Family Communication in the ICU: a Narrative Review

Fitria Nola Rezkiki, Hamidah Binti Othman, Imelda Rahmayunia Kartika, Neila Sulung

UNIVERSITAS FORT DE KOCK BUKITTINGGI

Nursing Study Program
Universitas Fort de Kock Bukittinggi, Indonesia

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[1]Fitria Nola Rezkiki, [2]Hamidah Binti Othman, [3]Imelda Rahmayunia Kartika, [4]Neila Sulung

ABSTRACT

***Background**: Communication between nurses and family members is a fundamental component of family-centered care in intensive care units (ICUs). While previous studies have examined communication practices, barriers, and interventions, limited attention has been given to understanding how family experiences of nurse communication may contribute to theoretical development in critical care nursing. Aim: This review aimed to synthesize evidence on family experiences of communication with nurses in adult ICUs and to identify conceptual dimensions that may inform the development of a theory of nurse-family communication in critical care. **Methods**: A theory-informed narrative review was conducted using systematic search procedures guided by SANRA recommendations and reported in accordance with relevant PRISMA principles. Literature published between 2015 and 2025 was searched across major healthcare databases. Studies were included if they explored communication between nurses and family members in adult ICU settings. Findings from qualitative, quantitative, and mixed-methods studies were synthesized using thematic narrative analysis to identify recurring concepts and higher-order themes. **Results**: The synthesis revealed five interconnected dimensions of nurse-family communication: (1) information exchange, (2) emotional presence, (3) trust building, (4) family empowerment, and (5) shared decision-making. Families consistently valued communication that was timely, honest, compassionate, and inclusive. The sequence of these dimensions was derived inductively from recurring patterns across the reviewed studies and represents an interpretive progression from foundational communication processes toward increasingly participatory family involvement. Information exchange provided the basis for understanding; emotional presence addressed families' relational and emotional needs; these experiences contributed to trust, which facilitated family empowerment and, ultimately, meaningful participation in shared decision-making. The dimensions were considered interconnected and potentially reciprocal rather than strictly linear. **Conclusion**: Nurse-family communication in critical care extends beyond information delivery and functions as a dynamic relational process that shapes family experiences and outcomes. The proposed conceptual framework provides a foundation for future theory development, empirical testing, and the design of communication-focused interventions aimed at strengthening family-centered critical care nursing.*

Keywords:
family experience; intensive care unit; nurse-family communication; theory development.

Corresponding author:
Fitria Nola Rezkiki

Email:
fitrianola.rezkiki@fdk.ac.id

[1,3] Doctoral of Philosophy Programe, Faculty of Medicine UNISZA
[2]Lecture of Doctoral of Philosophy Programe, Faculty of Medicine UNISZA
[4]Professor of Health Science, Universitas Fort De Kock Bukittinggi

Introduction

Family members of critically ill patients admitted to intensive care units (ICUs) frequently experience profound psychological distress characterized by uncertainty, anxiety, fear, and emotional exhaustion (Abdul Halain et al., 2022). The highly technological environment of the ICU, combined with the unpredictable trajectory of critical illness, often places families in situations where they must rapidly process complex information while simultaneously coping with emotional burden (Blok et al., 2023). Recent evidence indicates that family members commonly report unmet informational and emotional needs throughout the ICU stay, which may contribute to long-term psychological consequences, including anxiety, depression, and post-traumatic stress symptoms (Bala et al., 2025). Consequently, contemporary critical care practice increasingly recognizes family engagement as a fundamental component of high-quality care (Asadi & Salmani, 2024).

Within this context, communication has emerged as one of the most important determinants of family experience in critical care settings. Effective communication enables families to understand the patient's condition, participate in decision-making, develop trust in the healthcare team, and maintain emotional resilience during periods of uncertainty . The experiences of families regarding nurse–family communication are multifaceted and extend beyond the simple transmission of clinical information. Families consistently value communication that demonstrates empathy, compassion, honesty, accessibility, and emotional presence (Engel et al., 2023). Conversely, fragmented communication, inconsistent messages, limited opportunities for dialogue, and insufficient emotional support can exacerbate distress and undermine trust in healthcare providers. Qualitative studies have shown that families often interpret communication encounters as indicators of the quality of care their loved ones receive, highlighting the relational and therapeutic dimensions of nurse–family interactions (Asadi & Salmani, 2024). These findings suggest that communication should be conceptualized not merely as an exchange of information but as a dynamic relational process that shapes family experiences throughout critical illness (Adams et al., 2017).

Despite the expanding body of evidence, the literature remains fragmented. Existing reviews primarily focus on communication strategies, intervention effectiveness, barriers to communication, or healthcare professionals' perspectives. While these studies provide valuable insights, they offer limited theoretical understanding of how families experience nurse communication and how these experiences contribute to the development of meaningful relationships, trust, emotional adaptation, and participation in care (Tadros et al., 2025). Furthermore, emerging evidence continues to identify cultural, organizational, and systemic barriers that shape communication experiences, suggesting that current conceptualizations may not adequately capture the complexity of nurse–family interactions in contemporary critical care environments (Saifan et al., 2025).

Although family-centered care has become a dominant paradigm in critical care practice, existing frameworks provide limited explanations regarding the mechanisms through which nurse-

family communication influences family experiences and outcomes (Kentish-Barnes et al., 2024). Current models primarily emphasize family participation, information sharing, and collaborative decision-making, yet they often conceptualize communication as a component of care rather than as a dynamic relational process (Ahmadi & Shahboulaghi, 2025). The complexity of communication in ICU settings extends beyond information exchange and involves emotional attunement, trust development, uncertainty management, advocacy, cultural responsiveness, and relationship building. These dimensions evolve throughout the trajectory of critical illness and may differ according to family needs, contextual factors, and organizational environments. Consequently, existing frameworks offer insufficient guidance for understanding how communication processes unfold from the family perspective and how these processes contribute to adaptation during critical illness (Sun et al., 2026).

Several theoretical perspectives may partially explain communication phenomena in critical care, including Family Systems Theory, Relational Communication Theory, and Family-Centered Care Frameworks. Family Systems Theory proposes that illness affecting one family member influences the entire family system, highlighting the interconnectedness of emotional responses and coping processes (Gunnlaugsdóttir et al., 2024). Relational Communication Theory emphasizes the development of trust, mutual understanding, and relational meaning through ongoing interactions Meanwhile, Family-Centered Care Frameworks advocate partnership and collaboration between healthcare providers and families (Kokorelias et al., 2019). However, these theories were not specifically developed to explain communication experiences between nurses and families within the unique context of critical care, where uncertainty, high technology, life-threatening conditions, and time-sensitive decision-making coexist. As a result, there remains no integrated theoretical framework that comprehensively captures how families experience nurse communication in intensive care settings (Saifan et al., 2025).

Developing a theory informed directly by family experiences may provide a more nuanced understanding of communication processes in critical care (Ndile et al., 2025). Such a theory could identify core communication dimensions, explain relationships among communication behaviors and family outcomes, and guide the development of evidence-based interventions aimed at improving family support. Moreover, a theoretically informed understanding of nurse–family communication may contribute to nursing science by strengthening conceptual clarity in an area that remains largely practice-driven (Mendes et al., 2025). Therefore, this narrative review seeks not only to summarize existing evidence but also to synthesize family experiences in a manner that informs the development of a middle-range theory of nurse–family communication in critical care.

Methods

Review Design

This study employed a narrative review design informed by the Scale for the Assessment of Narrative Review Articles (SANRA) and guided by transparent and systematic literature search procedures. A narrative review was considered the most appropriate approach because the objective was not only to summarize existing evidence but also to synthesize diverse findings and identify conceptual

dimensions that could inform the development of a theoretical framework of nurse–family communication in critical care (Sukhera, 2022). Unlike traditional systematic reviews that focus primarily on intervention effectiveness, narrative reviews facilitate theory development by integrating evidence from qualitative, quantitative, and mixed-methods studies (Brignardello-Petersen et al., 2025).

Review Question

The review was guided by the following research question:

How do family members experience communication with nurses in adult intensive care units, and what conceptual dimensions emerging from these experiences can inform the development of a theory of nurse–family communication in critical care?

Literature Search Strategy

A comprehensive literature search was conducted across five electronic databases: PubMed/MEDLINE, Scopus, CINAHL Complete, Web of Science, and PsycINFO. These databases were selected because they index a broad range of nursing, critical care, health communication, and interdisciplinary healthcare literature.

The search was limited to studies published between January 2015 and December 2025 to ensure the inclusion of contemporary evidence reflecting current critical care practices. Only articles published in English and available in full text were considered. Search terms were developed based on the Population–Concept–Context (PCC) framework and combined using Boolean operators. Key search terms included: ("family" OR "family member*" OR "relative*" OR "caregiver*") AND ("nurse-family communication" OR "communication" OR "therapeutic communication" OR "family communication") AND ("intensive care unit" OR "critical care" OR "ICU") AND ("experience*" OR "perception*" OR "perspective*" OR "satisfaction"). Database-specific adaptations of keywords and controlled vocabulary terms (e.g., MeSH terms in PubMed) were applied when appropriate.

Eligibility Criteria

To guarantee consistency and relevance to the review goal, studies were chosen based on predetermined eligibility criteria. This study had a number of inclusion criteria, therefore they were included if they: (1) Focused on communication between nurses and family members; (2) Conducted in adult intensive care units or critical care settings; (3) Reported family members' experiences, perceptions, expectations, or evaluations of communication; (4) Used qualitative, quantitative, or mixed-methods designs; (5) Published in peer-reviewed journals between 2015 and 2025; and (6) Available in English.

Studies were then disqualified based on the exclusion criteria if they: (1) Focused exclusively on physician-family communication; (2) Were conducted in pediatric or neonatal intensive care units; (3) Addressed communication solely among healthcare professionalS; (4) Were conference abstracts, editorials, commentaries, dissertations, protocols, or grey literature; and (5) Did not separately report findings related to nurses.

Study Selection

A total of 1,920 records were identified through database searching, including PubMed (n = 477), ScienceDirect (n = 312), Web of Science (n = 639), Embase (n = 283), and CINAHL (n = 209). After removal of 241 duplicate records, 1,679 records remained for title and abstract screening. Of these, 1,620 records were

excluded based on the predefined eligibility criteria. The remaining 59 reports were sought for retrieval, and all 59 reports (100%) were successfully retrieved and assessed for full-text eligibility. Following full-text assessment, 47 reports were excluded for the following reasons: the population did not comprise family members (n = 15), the study was not conducted in an adult ICU (n = 6), the communication examined was not nurse–family communication (n = 10), the study was not empirical (n = 7), the article was a review (n = 6), the publication was an editorial/commentary (n = 2), and the publication was a protocol or conference abstract (n = 1). Ultimately, 12 studies met all eligibility criteria and were included in the qualitative synthesis. The study selection process is presented in the PRISMA flow diagram (figure 1)

Data Extraction

Data were extracted using a standardized extraction form developed by the review team. Information collected included: Author(s) and year of publication, Country of study, Study aim, Design and methodology, Sample characteristics, ICU setting, Communication-related findings, Family-reported experiences, Key conclusions. Additional notes were recorded

Data Synthesis

Data were analyzed using thematic narrative synthesis. The synthesis process involved three stages: (1) Familiarization with study findings through repeated reading of included articles; (2) Identification of recurring concepts and communication-related experiences reported by family members; (3) Development of higher-order themes and conceptual categories through constant comparison across studies.

Emergent themes were subsequently interpreted using a theory-building perspective to identify relationships among concepts and to generate preliminary propositions regarding nurse–family communication in critical care. The final synthesis aimed to move beyond descriptive aggregation by developing an explanatory conceptual framework that captures how communication processes influence family experiences, trust formation, emotional adaptation, participation in care, and decision-making within the ICU context.

Trustworthiness and Rigor

Several strategies were employed to enhance review rigor, including transparent reporting of search procedures, use of predefined eligibility criteria, systematic quality appraisal, and iterative team discussions during data synthesis (Brignardello-Petersen et al., 2025). The review process adhered to SANRA recommendations for narrative reviews and incorporated elements of PRISMA reporting standards to improve methodological transparency.

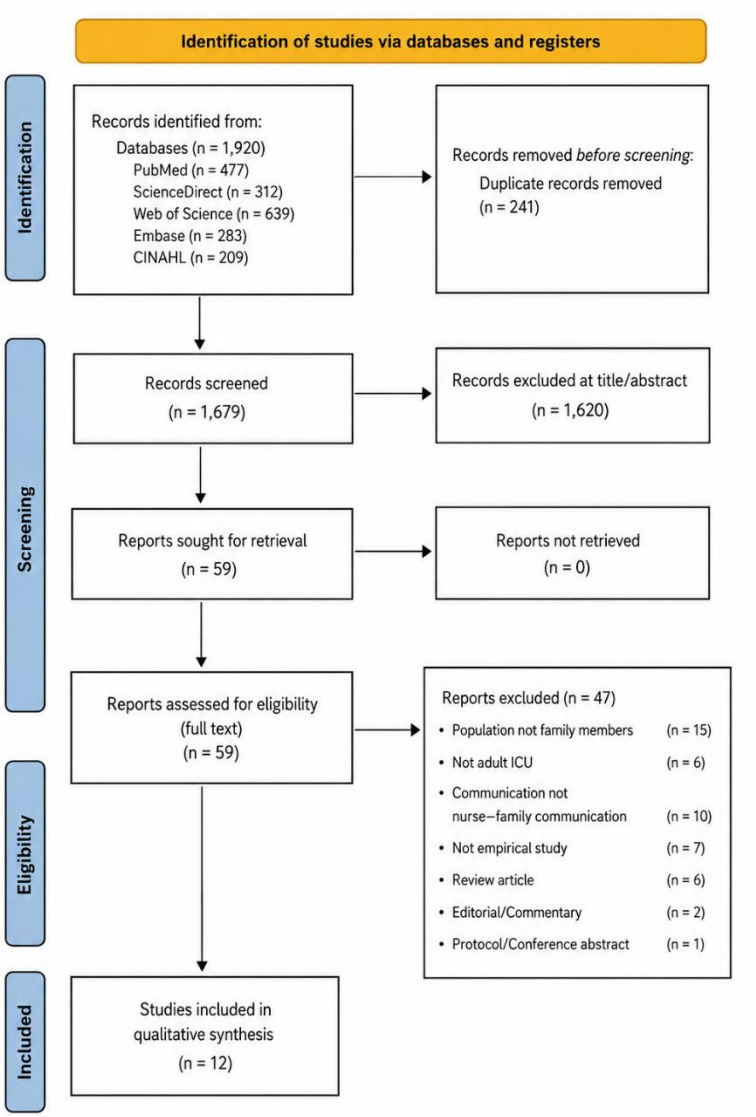

Figure 1. Prisma Flow Diagram
Nurse-Family Communication in Critical Care
A Narrative Review of Family Experience

Results

Overview of the Evidence

The reviewed literature consistently highlighted nurse–family communication as a central component of family-centered care in adult intensive care units (ICUs). Across qualitative studies, survey studies, integrative reviews, and scoping reviews, family members described communication with nurses as one of the most influential factors shaping their ICU experience. The evidence showed that families valued timely information, emotional support, honesty, accessibility, and opportunities to participate in care and decision-making. Conversely, inadequate communication was associated with uncertainty, distress, dissatisfaction, and reduced trust in healthcare providers.

Recent reviews have also identified multiple barriers to effective nurse–family communication, including high workload, time constraints, inconsistent information, use of technical language, cultural differences, and lack of formal

communication training for nurses (de León Oliva et al., 2025).

Characteristics of Included Evidence

The body of literature included qualitative studies exploring family experiences, cross-sectional surveys measuring family satisfaction, intervention studies evaluating communication strategies, and integrative or scoping reviews synthesizing communication practices in ICU settings. Studies were conducted in a variety of countries, including the United States, Norway, Australia, Spain, Jordan, South Korea, and several other European and Middle Eastern settings.

A recurring finding across study designs was that communication was not perceived merely as the delivery of medical information; rather, it was experienced as a relational process that influenced families' emotional adaptation and confidence in care.

Table 1. Summary of Key Evidence

Study	Design	Main Communication Finding
(Adams et al., 2017)	Literature review	Nurses viewed family communication as a core role but reported significant barriers and inadequate support systems (Adams et al., 2017).
(Frivold et al., 2018)	Cross-sectional survey	Family satisfaction with care was generally higher than satisfaction with decision-making; communication quality influenced follow-up needs (Frivold et al., 2018).
(Scott et al., 2019)	Scoping review	Information provision and communication were among the most important family needs in ICU.
(Yoo et al., 2020)	Qualitative study	ICU nurses described communication as challenging and requiring advanced interpersonal skills.
(Bernild et al., 2021)	Qualitative study	the family members need more fixed patterns for the communication, more continuity in terms of who they speak to, and that they wish that the communication be conducted in a way that is true, right, and truthful
(Kathryn et al., 2021)	A systematic review	support family-centered care practices in adult ICUs, particularly in regard to information provision, visiting practices, and supportive care.
(Dees et al., 2022)	Integrative review	Regular updates, emotional support, and assistance with decision-making strengthened relationship-centered care.

Study	Design	Main Communication Finding
(Kit & Chua, 2022)	Mixed Method Study	intensive care units to improve patient families' access to information and enhance staff communication and teamwork. Future studies should focus on refining, diversifying and innovating elements of formal and informal communication within the ICU
(Digby et al., 2023)	A Qualitative descriptive study	Families experienced significant psychological distress from being separated from their critically ill relatives. Patient care and involvement in decision-making appeared to be unchanged, but communication with staff felt to be lacking.
(Suhartini et al., 2023)	A Scoping review	that there are three categories, namely family-centered care, special aspects of communication and structured family communication guidelines. In conclusion, an effective communication approach with family members in the Intensive Care Unit provides a very important role for ritical patient-centered care in the intensive care unit
(Reifarth et al., 2024)	Mixed-methods survey study	Unanimously advocated nonverbal communication strategies included to listen attentively and to avoid interrupting as well as being approachable and honest
(de León Oliva et al., 2025)	Scoping review	Communication barriers included workload, technical language, organizational factors, and insufficient training; nurses were identified as key facilitators of humanized care.

Thematic Synthesis of Family Experiences

1. Information Exchange as a Source of Security

Families consistently reported that timely, clear, and understandable information reduced uncertainty and helped them cope with the ICU experience. Communication was perceived as most helpful when nurses proactively provided updates, explained procedures, and translated complex medical terminology into understandable language.

In contrast, delayed or inconsistent information generated feelings of confusion and helplessness. The importance of information provision was repeatedly identified as a core family need across ICU studies (Scott et al., 2019).

2. Emotional Presence and Compassionate Communication

Beyond factual information, families valued nurses who demonstrated empathy, kindness, and emotional availability. Meaningful communication encounters were described as those in which nurses listened attentively, acknowledged family emotions, and provided reassurance during periods of crisis (Gunnlaugsdóttir et al., 2024).

These findings suggest that communication functions simultaneously as an informational and therapeutic intervention, shaping families' psychological adaptation to critical illness.

3. Trust Building Through Consistency and Honesty

Trust emerged as a central outcome of effective communication. Families reported greater confidence in care when nurses communicated honestly, remained accessible, and provided consistent messages across interactions (Naef et al., 2025).

Several studies indicated that trust developed progressively through repeated nurse–family encounters and was strengthened when communication aligned with observed care practices (Dees et al., 2022).

4. Family Empowerment and Participation in Care

Families appreciated communication that encouraged questions and recognized their role in supporting the patient. Such communication increased understanding, confidence, and readiness to participate in discussions about treatment and care planning (Anderson et al., 2019).

Evidence from relationship-centered care studies suggests that active family engagement is facilitated when nurses intentionally invite family participation (McAndrew et al., 2020).

5. Communication as a Facilitator of Shared Decision-Making

Decision-making was consistently identified as a challenging aspect of the ICU experience. Families valued opportunities to discuss treatment options, clarify expectations, and understand prognosis (Scheunemann et al., 2019).

Survey findings indicated that satisfaction with decision-making was often lower than satisfaction with general care, highlighting the need for stronger communication support during critical decisions (Frivold et al., 2018).

Conceptual Integration

Across the literature, nurse–family communication appeared to function as a multidimensional relational process rather than a unidirectional exchange of information. The synthesis suggested a progressive sequence in which:

1. Information exchange reduces uncertainty.
2. Emotional presence strengthens the relational connection.
3. Trust develops through consistent and honest interactions.
4. Families become empowered to engage in care.
5. Shared decision-making becomes more collaborative.

These interconnected processes appeared to influence family adaptation, satisfaction, and engagement throughout the ICU journey (figure 1).

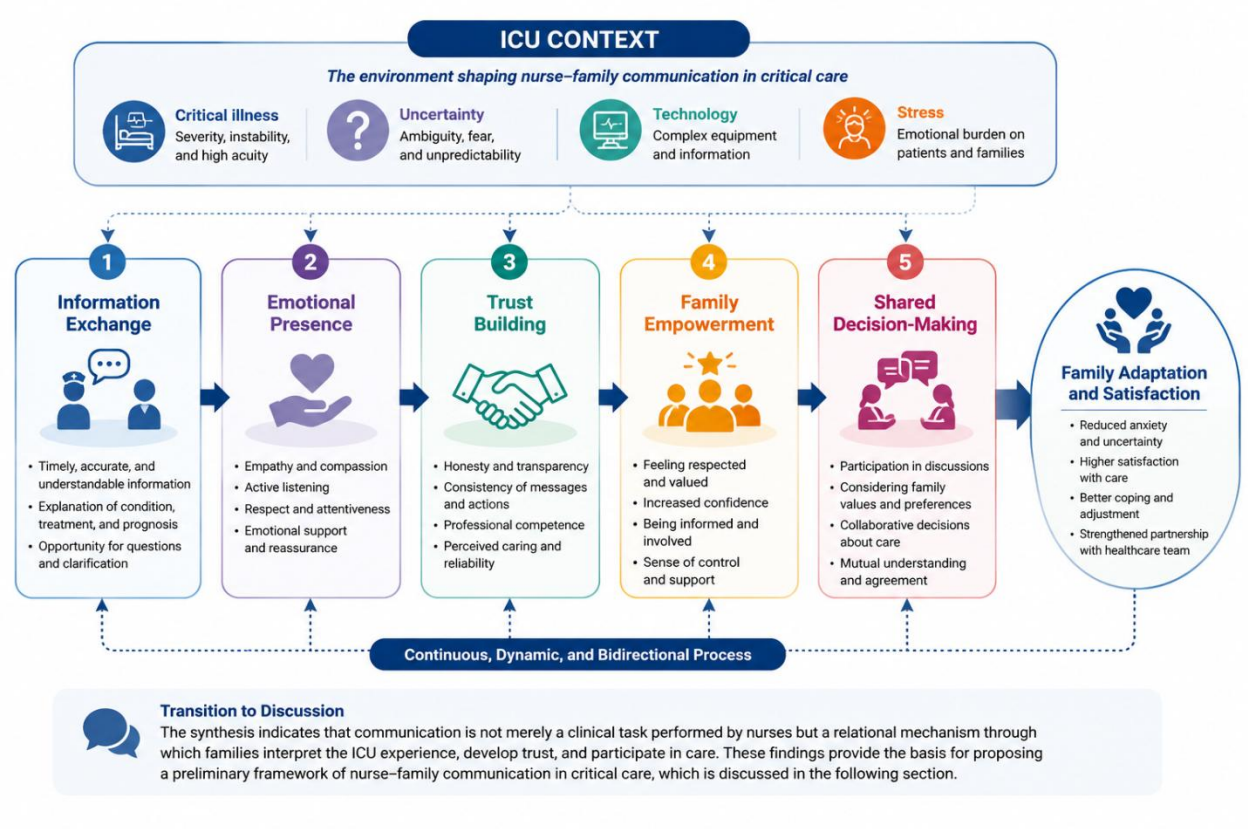

Figure 2. Proposed Conceptual Framework

Discussion

The present review highlights that nurse-family communication in intensive care units extends far beyond the transmission of clinical information and should be understood as a multidimensional relational process. Across the reviewed literature, communication emerged as a central mechanism through which family members interpret the critical illness experience, manage uncertainty, and develop confidence in the care provided (Riegel et al., 2025). The findings indicate that information exchange constitutes the foundational dimension of communication, as families consistently reported a strong need for timely, accurate, and comprehensible information regarding patient status and treatment plans. This finding aligns with previous evidence demonstrating that communication remains one of the most important determinants of family satisfaction in ICU settings (Frivold et al., 2018).Families who perceived communication as clear and accessible reported greater satisfaction with care and lower levels of uncertainty, whereas inconsistent or delayed communication often contributed to emotional distress and confusion. Recent evidence further suggests that deficiencies in communication processes may negatively influence families' perceptions of care quality and decision-making support (de Aquino et al., 2026). Beyond informational needs, the findings emphasize the therapeutic value of emotional presence in nurse–family interactions. Family members frequently

described effective communication in terms of empathy, compassion, active listening, and emotional availability. Such findings support contemporary perspectives that conceptualize communication as both a clinical and relational intervention. In highly technological ICU environments, where families often experience anxiety, fear, and uncertainty, emotionally responsive communication may function as an important protective factor that promotes psychological adaptation. This interpretation is consistent with family-centered care principles, which advocate recognition of family members not only as recipients of information but also as individuals requiring emotional support throughout the critical care trajectory. Recent family-centered intervention studies similarly demonstrate that communication strategies incorporating emotional support contribute to improved family-centered outcomes and overall ICU experiences (Li et al., 2025).

A notable contribution of this review is the identification of trust as a pivotal outcome of nurse–family communication. The synthesis suggests that trust develops progressively through repeated interactions characterized by honesty, consistency, transparency, and professional competence. Trust appeared to function as a relational bridge linking communication processes with family engagement in care and decision-making (Iunius et al., 2024). This finding is particularly important because trust has received less explicit theoretical attention within existing family-centered care frameworks. Communication difficulties identified in recent ICU studies—including workload pressures, use of technical language, insufficient communication training, and language barriers—may disrupt trust formation by limiting opportunities for meaningful interaction between nurses and family members (de León Oliva et al., 2025). Consequently, trust may represent a key mediating mechanism through which communication influences family outcomes in critical care settings.

The review also demonstrates that effective communication facilitates family empowerment and participation in shared decision-making. Families consistently valued opportunities to ask questions, express concerns, and contribute to discussions regarding treatment and care planning (Kishino et al., 2022). These findings support previous research indicating that satisfaction with decision-making is often lower than satisfaction with general care, suggesting that communication during complex clinical decisions remains a persistent challenge in ICU practice (Frivold et al., 2018). Moreover, contemporary evidence highlights that structured family-centered interventions can improve engagement and participation when communication processes are intentionally supported by healthcare professionals (Wang et al., 2023). Taken together, these findings suggest that communication functions as an enabling process through which families move from passive recipients of information to active participants in care and decision-making.

Taken together, the findings indicate a notable conceptual gap within current ICU communication research. Existing studies largely emphasize informational and verbal aspects of communication, whereas the contribution of nonverbal communication remains underexplored despite its apparent influence on family experiences. Future research should investigate how specific nonverbal communication behaviors employed by nurses affect family trust, emotional adaptation, satisfaction, and participation in care. Such evidence may

further strengthen the emerging theoretical framework of nurse–family communication in critical care and contribute to a more comprehensive understanding of therapeutic communication within family-centered intensive care practice.

Finally, the synthesis provides preliminary support for a theoretical interpretation of nurse–family communication as a sequential and interrelated process encompassing information exchange, emotional presence, trust building, family empowerment, and shared decision-making (Bissonette et al., 2024). Existing frameworks of family-centered care acknowledge many of these elements individually; however, they do not adequately explain how these dimensions interact and evolve throughout the critical illness trajectory.

The proposed conceptual model emerging from this review suggests that effective communication (verbal and nonverbal communication) initiates a progressive relational pathway through which families adapt to uncertainty, develop trust, engage in care, and participate in decisions affecting their loved ones (Pun et al., 2023). Future empirical studies should test these relationships using qualitative and quantitative methodologies to refine and validate a middle-range theory of nurse–family communication in critical care. Furthermore, healthcare organizations should prioritize communication training, institutional communication protocols, and culturally responsive approaches to strengthen nurse–family partnerships and improve family outcomes in intensive care environments.

Strengths and Limitations

This review has several notable strengths. By synthesizing evidence from qualitative, quantitative, mixed-methods, and review studies, it provides a comprehensive understanding of nurse–family communication from the perspective of family members in adult intensive care units. Unlike previous reviews that primarily focused on communication barriers or intervention effectiveness, this review adopted a theory-informed approach to identify underlying communication processes and their relationships. The synthesis revealed five interconnected dimensions—information exchange, emotional presence, trust building, family empowerment, and shared decision-making—which informed the development of a preliminary conceptual framework of nurse–family communication in critical care. Furthermore, the focus on family experiences addresses an important gap in critical care nursing literature and offers insights that may support the advancement of family-centered care, communication training, and future theory development.

Several limitations should also be acknowledged. The included studies were conducted across diverse countries, healthcare systems, and cultural contexts, which may influence communication expectations and limit the transferability of findings to specific settings. In addition, variations in study designs, communication measures, and conceptual definitions created challenges for direct comparison across studies. As a narrative review, the study was intended to generate conceptual understanding rather than establish causal relationships between communication practices and family outcomes. Therefore, the proposed framework should be considered a preliminary theoretical synthesis that requires further empirical validation. Future research using longitudinal,

cross-cultural, and theory-testing designs is needed to examine the applicability of the proposed framework and refine its conceptual relationships across different critical care contexts.

Conclusion

This review conceptualizes nurse–family communication in adult ICUs as a dynamic, relational, and context-dependent process extending beyond information delivery. Five interconnected dimensions—information exchange, emotional presence, trust building, family empowerment, and shared decision-making—provide a preliminary conceptual framework for understanding how nursing communication may support family adaptation, engagement, and participation during critical illness.

The main theoretical contribution is the integration of these dimensions into a preliminary framework that positions communication as a relational mechanism linking nursing interactions with family experiences and outcomes. This perspective provides a foundation for strengthening family-centered critical care practice, nursing education, and communication-focused interventions. However, the proposed relationships are derived from narrative synthesis and require empirical validation. Future research should test and refine the framework across diverse ICU populations and contexts to determine its explanatory and predictive value and to support the development of a middle-range theory of nurse–family communication in critical care.

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