

The Exploration of Culturally Sensitive Nursing Care in Pediatric Setting: a Qualitative Study

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Abstract

Background: One of the essential aspects of the provision of care is cultural issues. Cultural sensitivity is the key for cultural care. The aim of this study was to explore culturally sensitive care in pediatric nursing care in Iran.

Materials and Methods: This study was a conventional content analysis. Participants were consisted of 25 nurses and 9 parents selected through purposive sampling from three pediatric referral centers in Tabriz and Tehran, Iran. Data was collected using semi-structured interviews and field notes and were concurrently analyzed by using Graneheim and Lundman (2004) method. Data was transcribed verbatim, words, sentences, and phrases were considered meaning units, abstracted, labeled and compared for developing categories.

Results: Culturally sensitive care of a sick child was consisted of three themes: 'cultural exposure', 'intercultural communication' and 'the reconciliation of cultural conflict in families/care'. During the 'cultural exposure' nurses were informed of the cultural manifestations, strived to identify and understand patients/families with cultural diversities and respect their cultural beliefs. The nurse used the native language in 'intercultural communication' or a combination of verbal and nonverbal communication methods to reach a common understanding. Finally, a nurse in the conflict between the culture of child/family and care took actions for making decisions to develop a compliance between care and the family culture and amended parents' harmful desires through negotiation and appropriate care.

Conclusion: Understanding the concept of culturally sensitive care, can help with resolving the problems of cultural exchanges in Pediatric wards. Providing cultural facilities and interpreters to communicate with patients/family increase their satisfaction.

Key Words: Child, Cultural diversity, Culturally sensitive care, Nurses, Qualitative research.

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1-INTRODUCTION

Cultural diversity is defined as variations and differences between and within groups in life, language, values, norms and other cultural aspects (1). Iran is a country with diverse religions and different ethnic groups, each with its own customs, language and identity. The presence of different religions and ethnicities highlights the importance of culture (2).

Cultural sensitivity is the most comprehensive concept for being aware of knowledge related to ethnicities and religions, which is used for describing and understanding individual's characteristics and his/her responses (3). It is also defined as the individual's interest for understanding others' sub-cultures (4). In the process of care and treatment of patients, the ignorance of cultural diversity leads to inequality, discrimination, misunderstanding and stereotypes (1). On the other hand, care proportional to the culture reduces inequality and its consequences, prevents discrimination, misunderstanding, ignorance and stereotypes and provides conditions for equal patient care. For this reason, the provision of culturally sensitive care to patients with a diversity of culture and ethnicity is of special importance (5).

In the provision of culturally sensitive care, a healthcare provider needs to understand cultural differences and consider the needs and expectations of patients, gain their trust and plan for appropriate patient care. Those patients who trust their health caregivers are honest and provide them with more information about their culture (6, 7). Culturally sensitive care also leads to effective communication, effective intervention, patient satisfaction (8), a change in the lifestyle and adherence to the diet and treatment regime. This requires an understanding of patients' views on the meaning of their illness. Healthcare

workers need to strengthen cultural awareness, cultural sensitivity and responsibility for providing healthcare services (9). Tucker et al., introduced patient-centered care included culturally sensitiveness. They emphasized behaviors and attitudes specific to the patient (such as making the patient to feel comfortable, respecting the patient and attracting his/her trust to the caregiver); also highlighted the need for the collaborative patient-centered relationship between the patient and healthcare provider with a focus on empowering the patient as the main feature of culturally sensitive care (10).

Cultural sensitive care of a sick child should be able to respond to the attitudes, feelings and conditions of those with specific attributes of identity. Such care coincides with the patient/family values and beliefs and makes them feel comfortable, respected and trusted to healthcare providers (7). Culturally sensitive care is sensitive to the needs of each patient based on his/her eating habits, religious and linguistic needs of the patient/family and is designed for each patient (3). Knowledge, attention, respect, understanding and the appropriate care plan are the characteristics of culturally sensitive care (8).

The results of a study by Heidari in Iran, show that culturally sensitive care is inadequate in adult wards, because nurses have not received proper education and are able to provide care only based on their own cultural intelligence and initiative thinking (11). Since family-centered care is essential for providing care to children (12), the family's involvement in childcare is important for nurses (13). Differences in parents' perceptions of treatment and care, and variations in the parents and nurses' expectations are due to the influence of culture (14). Each parent has a unique parenting style (15) and engage in healthcare based on various factors such as culture, ethnicity, language, gender and

socio-economic factors (14). The available evidence suggests that despite education and planning for the provision of culturally sensitive care, healthcare settings are far away from this concept and there is a need to research on this topic (16). Although culturally sensitive care is widely accepted, the nature of this concept has not been clearly defined (17, 18). Also, no study has been performed with regard to culturally sensitive care in pediatric nursing in Iran. The available studies mainly have focused on communication with parents and young nurses, nursing of premature infants and their parents.

In addition, Iran is a multi-ethnic society (2). On the other hand, according to recent developments in Iran, Iranian nurses are providing care to different ethnic groups within the country and provide healthcare services to the Persian Gulf states and Azerbaijan, etc. The health tourism industry in Asia and especially Iran, has expanded and 20-25 thousand tourists annually refer to Iran for receiving treatment (19). Therefore, understanding and respecting religious rituals and beliefs of the family have deepened the human aspects of the relationship between nurse and family, which is the pillars of care in children. The clarification of the concept of cultural sensitivity in the care for sick children and learning related behaviors in the nursing community through its inclusion in the curriculum and in-service nurses' education can improve the nurse-parent/child's relationship and satisfaction. Due to a lack of knowledge on culturally sensitive care and importance of qualitative research in identifying and exploring the experiences of participants, this study aimed to explore culturally sensitive nursing care in pediatric setting.

2- MATERIALS AND ETHODS

This study was conducted from July 2015 to March 2016. The study was conducted in pediatric referral centers in

North-East and Capital of Iran (Tabriz and Tehran cities).

2-1. Study Design and Population

This study completed through a conventional content analysis method. Participants were consisted of 25 nurses and 8 mothers and one father selected through purposive sampling from Pediatric wards of hospitals in three pediatric referral centers (two referral centers in Tabriz and one referral center in Tehran). The study population included the nurses and parents in pediatric wards who worked or had hospitalized child experience in pediatrics ward.

2-2. Methods

Participants were selected from Pediatric wards of hospitals. Researcher referred to these centers, found nurses and parents from different races and, explained the aim of the study for them, checked inclusion criteria and asked about their willingness to participate in study. Sampling was first performed as purposeful among the volunteers and then was continued with maximum diversity sampling (in terms of gender, age, education, race, and work experience).

2-3. Measuring tools

Data were collected using semi-structured interviews and field notes were taken during the nurse-parent's interactions in Pediatric wards and helped with data collection from ethnics' parents from Balochestan, Guilan and Arabs, which the researcher was unable to communicate with them verbally due to different languages.

The duration of the interviews were from 30 to 85 minutes. The interviews were held in quite places convenient to participants such as the nurses' rest room or the patients' rooms. The interviews were started with a general question and continued with specific questions with regard to the study phenomenon. The

questions used during the interviews were as follow:

- What is the meaning of culturally sensitive care?
- What are the characteristics of culturally sensitive care?

Also, probing questions such as ‘would you explain it more?’, ‘what does it mean?’ and ‘why?’ were asked to improve the depth of the data collection.

2-4. Inclusion criteria

Inclusion criteria for nurses were having an associate degree and the work experience of working in pediatric wards for more than two years. The inclusion criteria for parents was the history of child’s hospitalization for one week in pediatric wards.

2-5. Exclusion criteria

Exclusion criteria were: lack of participant’s willingness to continue cooperation in every stage of the study.

2-6. Ethical considerations

The Tabriz University of Medical Sciences, Tabriz, Iran ethics committee proved this study’s ethical considerations (ID code: TBZMED.REC.1394.168). The aim and process of this study were described to the participants and permission to tape-record the interviews was obtained. They had the right to withdraw from this study at any. Those who willingly agreed to participate in this study were asked to sign the written informed consent form.

2-7. Data analyses

The method suggested by Graneheim and Lundman (2004) was used for data analysis (20). The interviews were transcribed verbatim and along with field notes were read several times to get the sense of whole. Words, sentences, and phrases were considered meaning units, abstracted and labeled with codes. The codes were compared together with regard

to their similarities and differences for developing categories. The process of coding and categorizing was discussed by the researchers to resolve disagreements. The data collection was continued until data saturation was reached (20). For example three conceptual codes including "Consideration of the child/family culture", "Understanding the child/family culture" and "Valuing culture" has been emerged from this meaning unit "Nurses often considered, understood and respected the patient/family’s language, dress and nationality to understand his/her needs and met them"; and then these conceptual codes formed the sub-category "Considering and valuing the culture of the child/family".

In the next step, the category "Cultural exposure", were formed from two sub-categories "An awareness of the cultural manifestations of the child/family’s cultural encounter" and "Considering and valuing the culture of the child/family".

Prolonged engagement with the participants, immersion in the data, peer checking, member checking, and external checking helped with the rigor of this study. A brief report of the interviews, codes and categories were sent to three nurse researchers for checking the analysis process. Also, some nurses working in the pediatric ward were asked to check findings to ensure that their perspectives were accurately reflected and finding are meaningful for them and as the same as their experience. Maximum variations in sampling, audit trail and the description of the data collection and analysis processes were considered to improve the transferability of findings. The aim and process of this study were described to the participants and permission to tape-record the interviews was obtained. They had the right to withdraw from this study at any. Those who willingly agreed to participate in this study were asked to sign the written informed consent form.

3- RESULTS

The demographic characteristics of the participants were presented in **Table.1**. The culturally sensitive care of a sick child was consisted of three themes: 'cultural exposure', 'intercultural communication' and 'the reconciliation of cultural conflict in families/care' (**Table.2**).

3-1. Cultural exposure

The nurses stated that they encountered with patients with different ethnicities and some nationalities. This theme was consisted of the following subcategories: 'an awareness of the cultural manifestations of the child/family's cultural encounter' and 'considering and valuing the culture of the child/family'.

3-1-1. An awareness of the cultural manifestations of the child/family's

The education of cultural care and culturally sensitive care are neglected in nursing and in-service education.

"During education, we are not taught about culturally sensitive care and there is no such a thing in textbooks. Also, nothing has been done in the hospital with regard to cultural care as no education is given to staffs who work with nationals and ethnicity groups" (*Nurse 4*).

The nurses stated that they had become familiar with other cultures' customs during the provision of care to patients with various cultures and religions. They were familiar with religious beliefs, physical allegories, traditional remedies and superstitions prevalent among different ethnic groups due to their work experiences as nurses.

"I have seen here remedies such as rubbing blood on the baby's body, rubbing Zamzam water and feeding the newborn with religious water" (*Nurse 10*).

Table-1: Demographic variables of nurses and parents who participated in research

Variables		Nurse (number)	Parents (number)
Gender	Female	23	8
	Male	2	1
Age (year)	25-35	9	8
	35-45	15	1
	> 45	1	-
Education	Elementary	-	2
	High school	-	1
	Diploma	-	3
	Bachelor	19	1
	Master degree	6	2
Race	Fars	5	2
	Azerbaijani(Iranian)	11	3
	Kurdish	2	2
	Luri	1	-
	Mazani	2	-
	Gilak	1	-
	Taleshi	1	-
	Arab	1	-
	Baloch	1	-
Azeri(Azerbaijan)	-	2	
Work experience (year)	2-10 year	9	-
	11-21 year	13	-
	Higher than 20 year	3	-

Table-2: Categories and subcategories developed in this study

Category	Subcategory	Codes
Cultural exposure	An awareness of the cultural manifestations of the child/family's cultural encounter Considering and valuing the culture of the child/family	Cultural knowledge Religious beliefs Traditional treatments Cultural customs Physical allegory Superstitions Consideration of the child/family culture Understanding the child/family culture Valuing culture Personalizing care
Intercultural communication	The native language/body language Reaching common understandings	Appropriate communication with the child/family Incomplete verbal communication Nonverbal communication Efforts to improve communication skills Understanding concepts
The reconciliation of cultural conflict in families/care	The domination of culture on care The domination of care on culture Adaptation	Inappeasable parents Implementation of traumatic family culture Hospital culture imposition Dealing with customs and unreasonable demands Convincing parents Preferences expressed by parents Nurse's impartiality against the beliefs of parents Adjusting harmful needs

3-1-2. Considering and valuing the culture of the child/family

The nurses declared that they paid more attention to the child/parent who had a different culture to relieve their sense of alienation and loneliness.

"When my patient is from another culture and is stranger here between us, I take care of him/her and communicate with him/her to prevent the feeling of loneliness and provide appropriate care to him/her" (*Nurse 4*).

Also, the nurses were sensitive to the cultural meanings of the behavior and appearance in care, and considered the child/parent cultural beliefs and reasonable demands, which did not led to legal consequences. "I consider the appearance, dress mode and talking of parents for understanding their culture" (*Nurse 8*).

Nurses often evaluated the patient's language, dress and nationality to understand his/her needs and met them. In most cases, the nurses did not oppose their cultural beliefs and did not impose their own culture to the patient.

"When I pay attention to the child and parent's culture, I find what they need and may ask....I do not oppose their perspectives and do not impose mine" (*Nurse 12*).

Given the importance of nurses own beliefs, they respected parents' values and accepted them.

"As I believe in something and consider them values, parents value something that should be respected....I do not have any problem with what they do as Muslims" (*Nurse 14*).

The night shift nurse reported the child's health condition to the head nurse during the work shift change and stated: "During medication, I found that the father of this child has three wives". The head nurse immediately said: 'This is true that polygamy is common among Balochi culture, but this is rather nice to not judge others at all' (*Field note 5*).

When visitors from neighboring countries or different ethnic groups have the same religious values with caregivers, parents are encouraged to implement calming customs in critical conditions as one of the conventional methods of family care.

"When the child experience seizure, I ask the mother to put her trust in God. I encourage the mother to pray to God and read religious verses to make her calm" (*Nurse 5*).

The nurses evaluated patients' values and beliefs and provided equal care to patients with the consideration of individual's culture and context.

"Those patients who have different cultures should be treated differently, because they may have different cultural needs and disease-based education" (*Nurse 3*).

3-2. Intercultural communication

From the participants' perspectives, intercultural communication is the core of nursing for caring patients with cultural diversities. This includes two subcategories of 'the native language/body language' and 'reaching common understandings'.

3-2-1. The native language/body language

Nurses try to get familiar with those patients who were familiar with the national language and culture and provide appropriate care to the child/family. Such a communication was made based on the parent's level of understanding without the use of jargons.

"I communicate to parents depending on their level of education and culture. I communicate with them and explain complex words. If I use complex words, they do not understand what I'm saying" (*Nurse 2*).

If the nurses were unfamiliar with the child/parent's language, imperfect verbal communication using learned words and with the help of other people such as colleagues, other patient family or interpreters, writing and gesture would be established.

"I use those words I know. In many cases, I have access to an interpreter or I use nonverbal communication or gestures" (*Nurse 22*).

"There are parents in our ward with various languages such as Kurdish, Lurish and Turkish, that are unable to talk in Farsi. I have some colleagues in the ward who are able to communicate with their languages. I received help from my colleagues to communicate with such parents" (*Nurse 18*).

"In the surgery ward, I observed the communication between the nurse and Arab parents. The nurse was doing post-surgery care and checked the surgery's site on the child's neck. She asked the parents to inform the nurse if any bleeding happened with some words of Arabic language. She should used gestures to educate the parents who to elevate side rails" (*Field note 3*).

Also, the nurses tried to make themselves familiar with the language and cultures of patients for improving their communication skills.

"...I requested a mother to teach me the Kurdish language" (*Nurse 6*).

"...I ask parents about their cultures and try to learn about them" (*Nurse 23*).

3-2-2. Reaching common understandings

The nurses clarified and explained concepts to make effective communication with parents for reaching a common understanding with them. Therefore, to reach a common understanding, they used strategies such as repeating, explaining with domination, and giving feedbacks.

A parent said: "If I do not understand what the nurse says, I ask her to repeat and explain it more. The nurse taught with her behaviors how to check the child's fever" (*A mother from Azerbaijan*).

3-3. The reconciliation of cultural conflict in families/care

The nurses achieved effective outcomes through a dialogue for intertwining childcare with the child/ family care. This was consisted of the following subcategories: 'the domination of culture on care', 'the domination of care on culture' and 'adaptation'.

3-3-1. The domination of culture on care

The nurses believed that families were allowed to implement their safe beliefs and values in the hospital. However, if parents hindered the provision of care by their superstitious beliefs, the nurses explained the care process and tried to convince them of the necessity of care. If parents would not be convinced, their dissatisfaction of care would be documented in the patient care.

"Sometimes parents do not allow us to provide the required care to the child. They do not give the consent to perform invasive nursing procedures. Lastly, we document it in the patient file" (*Nurse 5*).

Sometimes, nurses were forced by parents to carry out what they wished, which were mainly harmful.

"Based on her rituals, a mother did not allow me cut the child's hair for vein catheterization from the head. I insisted, but the mother opposed my will. Therefore, I surrounded to her will,

because I did not want to bother her" (*Nurse 17*).

"If parents insist, I do what they say. For instance, the parent asked me to find a vein from another hand of the child, because one hand of the child was covered by a piece of fabric based on their rituals" (*Nurse 19*).

In spite of the education provided by the nurses, parents practiced based on their superstitions and even forced the nurses to practice based on their own will.

"...She [the mother] gave the child butter and *Sisymbrium irio* seeds without informing me. She was taught by her relatives to do so and she did" (*Nurse 7*).

3-3-2. The domination of care on culture

Sometimes, the nurses imposed the culture of the hospital to parents and asked them to follow routines. The nurses did not respond to irrational and unscientific customs of families, especially those overwhelming and traumatic ones. In such cases, the nurses ignored the parents' cultural rituals and tried to calmly and smoothly convince them to accept routine care and leave their harmful cultural rituals without any protest to nursing care.

"I say parents not to use herbal medicine during hospitalization. Perhaps, herbal medicine cause unpredicted consequences and neutralize medical regime" (*Nurse 22*).

"When parents perform treatments that may endanger the child's health, I get angry and send feedbacks to them" (*Nurse 21*).

3-3-3. Adaptation

The nurses provided ample opportunities for parents to express their desires and beliefs and provided culturally appropriate care with the consideration of their culture and context. If, parents' desires did not endanger the child health, they were allowed to follow them. Also, the nurses

negotiated with parents to adjust their desires for childcare.

"If parents do not allow me to perform the nursing intervention such as inserting the urinary catheter, I negotiate with them" (*Nurse 23*).

"I adapt with the condition and allow parents to declare their perspectives and wishes, follow their rituals, if they are not harmful to the child and do not hinder us for patient care. I incorporate their wishes and perspectives into childcare" (*Nurse 19*).

4- DISCUSSION

The aim of this study was to explore culturally sensitive care in pediatric nursing care. The finding of this study showed that cultural exposure was one of the main aspects of culturally sensitive care and the nurses were involved with the provision of care to patients with various cultures. Similarly, Jirwe et al. in a study on nursing students in Sweden believed that they were involved in cultural exposure, because they provided care to foreign patients and their families (21). Foronda also introduced cultural exposure as the background of culturally sensitive care (8). The results of this study showed that cultural exposure needed to be aware of the manifestations of different cultural and ethnic groups. Although in most countries with cultural diversities, cultural knowledge is taught during academic programs, but the education of cultural sensitivity in Iran like Turkey, Italy and Korea has no place in the nursing curriculum that increases the possibility of dealing with problems (22-24).

However, the results of this study showed that pediatric nurses had appropriate knowledge about cultural issues. Heidari's study on cultural care showed that despite educational exclusion of nurses in Iran, nurses provided cultural care by using their emotional intelligence (11).

The results of this study showed that in pediatric wards, nurses considered and compared their own culture with parents' customs, beliefs and cultural values. They tried to understand parents' cultural needs and respect them. The nurses accepted parents' faith and beliefs and use them in critical conditions to calm parents. The nurses also regardless of ethnicity or culture provided equal care to patients and tried to provide appropriate care based on their culture. Heidari similarly stated that nurses respected patients' values and provided facilities to perform their religious affairs for providing cultural care to adults. He added that nurses without asking any questions about patient's religions behaved equally with different ethnic groups (11).

The results of the study by Tavallali et al., indicated that parents in multicultural societies expected nurses in pediatric wards to be aware of different cultures and customs and adapt themselves to them. In their views, this raised nurses' abilities to respect their cultural diversities and interest to provide care to patients with different cultures (25). Cultural awareness is the background of culturally sensitive care and understanding and respecting the culture of the patient are the features of culturally sensitive care. For providing culturally sensitive care, the nurse should be able to be aware of his/her own culture to recognize its differences with other people's cultures (8).

Noting, understanding and respecting the culture of the patient is the building block for developing trust between the nurse and patient and facilitating patient satisfaction and adherence to treatment (26). Providing information for understanding beliefs, expectations, preferences and behaviors of different religions, considering and respecting the patient/family's needs are the best methods for patient care (27). Chen and Rankin showed that religion is the emotional aspect of people's lives and

providing facilities for religious practices is the most important tasks associated with cultural sensitive care in elderly care in South Asia (28). Inhorn et al., noted that Muslim caregivers should be sensitive to religious issues, because these issues have a direct impact on their care (29).

According to the findings of this study, the nurses used two methods for making intercultural communication with the child/parent. If they were familiar with the native language of the child/family, an appropriate cultural relationship was established. If not, they used verbal and nonverbal clues and asked from an interpreter for reaching a mutual understanding. These are supported by Heidari and Taylor et al. findings (8, 30).

Heidari stated that nurses overcome the language barriers using translators, bilingual co-workers, family members, gesturing and their own previous knowledge of the language (11). The cornerstone of the quality of care in pediatric nursing is the relationship between parents and caregivers (31). Its main elements are understanding and communicating, being influenced by the attitudes of professionals and families' desire to participate in patient care (32).

Nurses must be able to communicate with parents, develop effective relationships and mutual trust with the aim of satisfying parents in nursing practice (33). Foronda believes that effective communication is an outcome of culturally sensitive care (8). Campinha-Bacote states that during interactions with culturally diverse patients, educated interpreters are required for preventing problems in the interpretation of diseases and medical terminology (34). Clegg believes that understanding is the basis of linguistic communication, thereby achieves an understanding between the patient and nurse (17). Daily communication is an important part of nursing care (35). Communicating with sick children and

their parents is one of the most challenging tasks in pediatric nursing (36). The language plays an important role in cultural differences, because language differences between the nurse and patient hinders communication (37). In addition, differences of language, culture, gender and accent are barriers to nurse-patient communication and provision patient care (11, 38, 39). This study was performed in pediatric wards with young children and the majority of nurses were female. Most of the time, mothers were staying with their hospitalized child in wards. Therefore, gender differences between parents and nurses were undermined.

The findings of this study showed that the nurses experienced cultural conflicts in pediatric culturally sensitive care. Then they made decisions to develop a compliance between care and the family's culture. Nurses in the cultural conflicts of the family/care persuaded parents to correct their misunderstandings, made decisive actions, and focused solely on their care and treatment methods. Heidari's study also showed that nurses provided culturally sensitive care to patients rectified their poor habits through showing respectful behaviors to their values and provided necessary education to adjust them (11). Designing appropriate care plan is one aspect of cultural sensitive care for meeting individuals' needs. Healthcare workers try to change the person's perspective regarding care (8). Culturally sensitive care is more effective than general medical services (8, 40). The results of this study also is supported the Leininger theory stating that negotiation with others is required for obtaining useful results related to health care (1).

4-1. Limitations of the study

This study was based on the pediatric nurses' experiences and parents in Iran. More studies using qualitative research in this area are suggested. Since the key to improving the quality of care is

measurement (41), appropriate tools should be designed to measure cultural sensitivity with the consideration of cultural, social and cognitive factors influencing it.

5- CONCLUSION

Similarity in cultural and religious beliefs is one of reasons for health tourists in Iran by neighboring countries, especially the Arabic states of the Persian Gulf (42). Accordingly, providing cultural facilities and the use of interpreters in English and Arabic to communicate with patients increase their satisfaction with treatment and enhance health tourism. Understanding the concept of culturally sensitive care can help with resolving the problems of cultural exchanges in the pediatric ward. Nurses encounter a large number of families with diverse ethnic and cultural characteristics, but they have limited experiences in this respect originated from clinical practice.

Culturally sensitive care should be incorporated into the bachelor degree and in-service training programs for increasing the quality and effectiveness of care in pediatric wards and designing care programs with the consideration of the patient's culture and context. This is also required especially for newly nurses who do not have enough experiences for work in pediatric wards. Designing culturally sensitive care plan leads to more consistent childcare and adherence to treatment. Also, for intercultural communication, nurse managers and hospital officials need to employ interpreters in the hospital.

6- CONFLICT OF INTEREST: None.

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