Health, Spirituality and Medical Ethics Journal
Qom University of Medical Sciences
September 2023. Volume 10. Number 3

Research Paper

Investigating Patient Advocacy Among Muslim Nurses: A Qualitative Study

Atye Babaii[1, 2], Mohammad Abbasinia[1, 2*], Bahman Aghaie[1, 2], Fatemeh Dehghani[2], Abbas Moghadam[3, 4]

1. Department of Internal Surgical Nursing, School of Nursing, Qom University of Medical Sciences, Qom, Iran.
2. Spiritual Health Research Center, Qom University of Medical Sciences, Qom, Iran.
3. Cellular and Molecular Research Center, Qom University of Medical Sciences, Qom, Iran.
4. Neuroscience Research Center, Qom University of Medical Sciences, Qom, Iran.

Use your device to scan and read the article online

Please cite this article as Babaii A, Abbasinia M, Aghaie B, Dehghani F, Moghadam A. Investigating Patient Advocacy Among Muslim Nurses: A Qualitative Study. Health Spiritual Med Ethics. 2023; 10(3):137-144. http://dx.doi.org/10.32598/hsmej.10.3.85.11

http://dx.doi.org/10.32598/hsmej.10.3.85.11

Article info:
Received: 28 Apr 2023
Accepted: 09 Jul 2023
Publish: 01 Sep 2023

Keywords:
Qualitative research, Nursing, Patient advocacy, Patient rights, Islam

ABSTRACT

Background and Objectives: Providing a clear and practical definition of advocacy would help nurse increase their involvement in advocacy and preserving the patients' rights. This study deepens the understanding of the features of advocacy among Muslim nurses.

Methods: This study was conducted using the qualitative content analysis approach. The data were gathered through conducting in-depth semi-structured interviews with a purposeful sample of 18 nurses and they were analyzed using the thematic analysis approach.

Results: The main characteristics of patient advocacy include protecting the religious aspect of care (avoiding treatments that are contrary to the religious beliefs of patients, and paying attention to religious issues in the care of unconscious patients), providing dignified care (being non-judgmental, providing patient comfort using methods appropriate to their religion, maintaining patients' privacy, and respecting patient's cultural and religious values), and giving hope to the patient (reminding patient's sources of strength and hope, and paying attention to the patient's concerns).

Conclusion: In this study, the main characteristics of patient advocacy from the point of view of Muslim nurses have been determined. The results of this study will help Muslim nurses to understand more deeply what they should do to help their patients.

*** Corresponding Author:**
Mohammad Abbasinia, Associate Professor.
Address: *Department of Internal Surgical Nursing, School of Nursing, Qom University of Medical Sciences, Qom, Iran.*
Phone: *+98 (903) 7393208*
E-mail: *abbasinia64@gmail.com*

Introduction

A disease is a condition in which all or part of the body's function is impaired [1]. Patients are vulnerable and the degree of vulnerability varies depending on the severity and nature of their illness [2]. Patients are considered vulnerable when they cannot fully express and protect their rights and needs. Therefore, they need people to advocate for them [3]. Patient advocacy is a core component of the nurses' professional identity and cannot be separated from it [4, 5]. Patient advocacy has positive outcomes for both nurses and patients. The patient-related outcomes include enhancing patients' autonomy, and self-regulation, and empowering them to decide about their healthcare [6] and protecting their values and rights [7]. For nurses, patient advocacy might not only enhance their job satisfaction, self-confidence, and self-esteem, but it will also improve the public image of nursing [8], and increase the efficiency and independence of the profession [9].

Several studies have been conducted in different countries with different religions on the concept of patient advocacy. Bu and Jezewski defined patient advocacy as preserving patient autonomy, acting as the patient's representative, and championing social justice in the provision of healthcare [8]. This concept is also defined as being the patient's voice, creating a sense of trust in the patient, and safeguarding the patient [10]. Negarandeh et al. defined patient advocacy from the perspectives of Iranian nurses as the provision of training, respecting, valuing, supporting, and protecting patients as well as trying for continual improvement of patient care [11].

These studies have described patient advocacy in different settings, statuses, and stakeholders in various forms and meanings. Different results of these studies can be due to the different religions of the participants in these studies. Nurses' religion can have an impact on their understanding of medical ethics issues and how to apply these issues in patient care [12]. Limited studies have focused on the aspects of patient advocacy among Muslim nurses. Since we do not know how Muslim nurses perceive and establish advocacy in the clinical context, this study clarifies the meaning of advocacy according to their experiences. This study clarifies the meaning of advocacy among Muslim nurses.

Methods

This study was conducted using the qualitative content analysis approach suggested by Graneheim and Lundman [13]. This design is appropriate for reaching a deeper understanding of the participants' experiences of patient advocacy [14].

Study setting and participants

The study setting included the teaching hospitals of Qom University of Medical Sciences. The participants were selected using the purposeful sampling method [15]. The inclusion criteria were having a bachelor's degree and higher education in nursing, being Muslim, having at least three years of work experience, and willingness to participate in the study. The participants who refused to participate in the study at any stage of the study and the participants who could not express their experiences were excluded from the study.

Data collection

Two individual interviews were conducted with 18 nurses. The first interview was exploratory and involved open questions [16], and the second interview was used to verify the meanings shared in the first round. The interviews were conducted in the Persian language. Each interview lasted for 30 to 50 min. The interview guide included general questions as follows: 1) "According to your experiences, please explain the situations that will help me understand what advocacy means to you?"; 2) "What do you do as an advocate in the clinical settings?"; 3) "Can you explain an experience you have had with a patient to advocate your patients?"

Other questions were asked based on the nurses' responses. For example, "What do you do to protect the physical privacy of patients?" was asked of a participant after they commented about the importance of protecting patient privacy. In addition, probing questions, such as, "Why do you think that is?" were asked to elicit further details or seek clarification during the interviews [17]. Data saturation was achieved with 16 participants. This was the point in coding at which no new conceptual code emerged from the interviews [18].

Data analysis

All interviews were recorded with the permission of the participants. After each interview, the content was transcribed with the Microsoft Office Word software, version 2016 and analyzed by the Graneheim and Lundman method [13]. In the first step, each interview was transcribed word by word. In the second step, each interview's text was read several times word by word, sentence-to-sentence, and paragraph-to-paragraph to obtain

a sense of the whole. In the third step, the meaning units of each interview transcript were identified and coded. The first author analyzed the total data, while the second and third authors analyzed half of the textual data. Three authors then compared the codes and revised minor disagreements after discussion. In the fourth step, codes were grouped into subcategories according to their conceptual similarities and differences. In the fifth step, subcategories are compared with each other, and the latent data content is identified and presented as the main categories. The final three categories were examined by all authors to ensure a clear difference between the main categories and subcategories and to fit the data within each category. Also, all the codes, subcategories, and main categories were given to one of the faculty members outside the research team. They separately reviewed and confirmed the appropriateness of data analysis. Parts of the audiotape were translated from Persian into English by an independent translator blind to the study to check for consistent translation.

Data trustworthiness

The credibility was established by allocating enough time for each interview and member check. Also, two research supervisors checked the quality of interviews, coding, and categories to reach a consensus. Dependability was accomplished by long-term engagement with participants and the constant comparative method. In this way, the initial codes were examined and compared several times, and the repeated codes were analyzed and categorized. For dependability, all stages of the study were reported in detail. For confirmability, codes and categories were reviewed and approved by a faculty member outside the research team. The contextual and demographic features of the participants were provided to help readers decide on the transferability of the findings.

Results

As shown in Table 1, a total of 18 nurses from diverse backgrounds were invited to participate in the study. The participants were different in terms of gender (male or female), education levels (from bachelor to PhD), job positions (nurses, head nurse, supervisor, and manager), workplaces (internal ward, surgical wards, intensive care units, cardiac care units, emergency departments, and operation rooms), and their practice experiences ranged from three to 23 years.

As shown in Table 2, the main characteristics of advocacy for the patients include protecting the religious aspect of care (avoiding treatments that are contrary to the religious beliefs of patients and paying attention to religious issues in the care of the unconscious patients), provision of dignified care (being non-judgmental, providing patient comfort using methods appropriate to their religion, maintaining patients' privacy, and respecting patient's cultural and religious values), and giving hope to the patient (reminding patient's sources of strength and hope, and paying attention to the patient's concerns).

Protecting the religious aspect of care

The nurses frequently expressed that they are responsible for providing religious care for patients. The nurses stated that they explained all the treatments to the conscious patients and performed them if the treatments were not contrary to their religious beliefs. In the case of unconscious patients, the nurses, by taking an accurate history from the patient's family, became aware of their beliefs and tried to carry out treatments according to the patient's religious beliefs.

Avoiding treatments that are contrary to the religious beliefs of patients

Most nurses stated that before performing any treatment for the patient, they explained how to do it to the patient or her family and avoided it if it was contrary to the patient's religious beliefs.

A female nurse commented, "I was doing preoperative care for the patient, he refused to shave her beard. I covered the patient's face with a surgical drape so that the surgical area would not be infected" (Participant (P) 3).

Paying attention to religious issues in the care of the unconscious patients

Unconscious patients are vulnerable and unable to defend their rights. Nurses, as patient advocates, strive to ensure that all treatment of unconscious patients is ethical.

A female nurse maintained, "He was in a coma. I put him toward the Qibla and put the Quran next to his head" (P6).

Provision of a dignified care

The nurses frequently articulated that they try to protect the patient's dignity by having non-judgmental justice, providing patient comfort using methods appropriate to their religion, maintaining patients' privacy, and respecting patient's cultural and religious values.

Table 1. Characteristics of study participants

Characteristics	Category	No.
Gender	Male	9
	Female	9
Educational level	Bachelor	12
	Master	4
	PhD	2
Job position	Nurses	11
	Head nurse	3
	Supervisor	3
	Manager	1
Workplaces	Internal ward	3
	Surgical ward	4
	Intensive care unit	4
	Cardiac care unit	3
	Emergency department	2
	Operation room	2
Work experiences (y)	<10	6
	10-20	8
	>20	4

Health, Spirituality and Medical Ethics Journal
Qom University of Medical Sciences

Having non-judgmental justice

The nurses emphasized that they listened carefully to the patient and used verbal and non-verbal skills to show that they understood the patient. They also stated that they were open-minded and understood religious and cultural differences.

A male nurse said, "Sometimes we had patients who were brought from prison for treatment. We did not consider them as bad people, we did our best to take care of these patients in the best way" (P11).

Providing patient comfort using methods appropriate to their religion

Most nurses argued that when taking a patient history, they were asked questions about subjects that would calm their minds. According to the patient's beliefs, using different methods, such as playing the sound of the Quran or the sound of nature and using different scents, they brought the patient peace of mind.

A female nurse commented, "The patient was very upset. I knew she liked the sound of the Quran. I played the sound of the Quran and the patient calmed down" (P17).

Maintaining patients' privacy

The participants were committed to maintaining the patient's privacy by observance of their physical privacy, choosing a nurse with the same patient's gender, and maintaining the confidentiality of medical records. Regarding the importance of patient privacy, a female chief nurse maintained, "If possible, I assign male nurses to male patients and female nurses to female patients. I told the nurses that women's services should not be used by male patients and vice versa" (P1).

Table 2. Characteristics of patient advocacy

Categories	Subcategories
Protecting the religious aspect of care	Avoiding treatments that are contrary to the religious beliefs of patients Paying attention to religious issues in the care of unconscious patients
Provision of dignified care	Being non-judgmental Providing patient comfort using methods appropriate to their religion Maintaining patients' privacy Respecting patient's cultural and religious values
Giving hope to the patient	Reminding the patient's sources of strength and hope Paying attention to the patient's concerns

Health, Spirituality and Medical Ethics Journal
Qom University of Medical Sciences

Respecting patient's cultural and religious values

The nurses respected their patients' personalities by incorporating the patients' culture and religious beliefs as well as by respectful conduct in their interactions with patients. One of the female nurses commented in this regard, "It was time for prayer, I asked the patient 'Do you want to pray?' He said, 'Can I pray in these circumstances?' I brought a stone for him to perform tayammum, I turned his bed towards the Qibla and helped him to pray while sitting" (P13).

Giving hope to the patient

Most nurses stated that they performed their religious advocacy role in frustrated patients by reminding patients of sources of strength and hope and paying attention to the patient's concerns.

Reminding patient's sources of strength and hope

The participants stated that they identified sources of hope and strength in the patient, such as praying and asking for help from the prophets and imams, and encouraged them to use these sources to be hopeful.

A male nurse maintained, "The patient had just found out that he had cancer, and he was very upset and disappointed. I brought him a prayer book and asked him to keep himself hopeful by praying. I told him that if he had hope and followed the treatments, he could cope with his illness" (P15).

Paying attention to the patient's concerns

Some patients think that their disease is the result of their sins. The nurses gave hope to them by explaining that sometimes God tests people with hardships and calamities, and in this test, only those who are patient are victorious and successful. Nurses also said that using a religious counselor can help eliminate sources of concern and increase patients' hopes.

A female nurse said, "My patient was sad. He said I do not know what sin I did that God gave me this disease. I explained to him that God wants to test us with the disease and if you have patience and hope for God's mercy, you will get better very soon" (P8).

Discussion

This study clarified the meaning of advocacy among Muslim nurses. According to the results of this study, protecting the religious aspect of care, providing dignified care, and giving hope to the patient are the main characteristics of advocacy. Hospitalized patients are vulnerable and unable to preserve their rights [8]. Nurses in this study considered themselves responsible for protecting the religious aspect of their care. They avoided treatments that were contrary to the religious beliefs of patients and paid attention to religious issues in the care of the unconscious patients.

Choi et al. (2014), found that nurses tried to ensure patient safety by managing the sudden changes in patient's health conditions and offering guidance to and correcting the mistakes of their colleagues [19]. Vaartio et al. [20] have also reported that nurses try to protect their patients by monitoring the process of care provision and identifying measures that can protect the patient against harm. These studies emphasize the physical aspects of patient protection, and the protection of the religious beliefs of the patients has been neglected. According to the results of this study, avoiding treatments that are contrary to the religious beliefs of patients, and paying attention to religious issues in the care of unconscious patients are introduced as other aspects of patient protection.

According to the participants, the provision of dignified care is the second main feature of advocacy. The participating nurses were committed to providing dignified care for their patients. Nurses frequently commented that they try to be non-judgmental. They also tried to provide patient comfort using methods appropriate to their religion. Non-judgmental justice is one of the basic human needs [21]. To this end, nurses have to ration their time between the patients due to the lack of resources, especially human resources [22]. The role of nurses in providing justice in health care is not limited to hospital settings. Rather, nurses as patient advocates should strive to ensure equity and social justice in resource allocation and access to relevant health care at all levels including the community level [5]. Boyle (2005) has also investigated the perceptions of perioperative nurses about patient advocacy and reported that nurses usually try to give their patients a sense of comfort by being physically present, holding patients' hands, and providing them with warm blankets [23]. Nurses who participated in another study also tried to provide comfort to their patients by decreasing noise and negative effects of the high-tech setting [24].

As shown, in most studies, the role of physical measures, such as being physically present, holding patients' hands, and providing them warm blankets, and environmental measures such as decreasing noise and negative effects of the high-tech setting in increasing patients' sense of comfort has been emphasized. The results of the current study showed that measures related to patients' beliefs, such as playing the Quran or the sound of nature and using different scents, can increase patients' comfort.

According to the results of this study, maintaining patient privacy is an important aspect of patient advocacy. Confidentiality or information privacy, choosing a nurse with the same patient's gender, and observance of their physical privacy were among the strategies that nurses used to advocate for patients and preserve their privacy. Respecting patient privacy is one of the basic patients' rights [25]. Schroeter [26] and Arnold [27] also emphasized the crucial role of patient privacy in effective communication between patients and healthcare workers and introduced it as the cornerstone of patient advocacy and providing dignified care. However, the latter two studies did not mention physical safeguarding and assigning nurses to the same patient's gender. The inconsistencies between the studies might be attributable to the cultural differences between the societies in which the studies were conducted. Among Muslims, respecting for patient privacy has different aspects such as physical, informational, psychosocial, and spiritual-religious privacy [28].

In addition to protecting patient privacy, respecting patients' cultural and religious values are also examples of providing dignified care. Muslim nurses frequently declare that they are respectful towards patients' cultures and take notice of their cultural and religious beliefs. Nurse scholars have frequently emphasized that nurses as patient advocates must respect patients' values [5], personality, autonomy, and self-determination [6]. They also should be assured that the patient's needs are met following their wishes [29], unless in conditions in which the patient's interests and preferences contradict their clinical safety [30].

The third feature of advocacy is giving hope to the patient. Most Muslim nurses stated that they performed their advocacy role in frustrated patients by reminding patient's sources of strength and hope and paying attention to the patient's concerns.

Conclusion

Patient advocacy is a complex concept. Nurses as religious advocates should protect the religious aspect of care and provide dignified care for their patients. Protecting the religious aspect of care involves avoiding treatments that are contrary to the religious beliefs of patients, and paying attention to religious issues in the care of the unconscious patients. Provision of dignified care is also achieved through being non-judgmental, providing patients comfort using methods appropriate to their religion, maintaining patients' privacy, and respecting patient's cultural and religious values. Giving hope to the patient included reminding the patient's sources of strength and hope, and paying attention to the patient's concerns. The results of this study can be used to develop theories, guidelines, and instruments to describe, implement, and measure nurses' practice in advocacy.

Study limitations

Due to the small presence of Muslim patients from different religions in Qom, Iran, it was not possible to conduct interviews with all Islamic religions. This can affect the results of the study.

Ethical Considerations

Compliance with ethical guidelines

Approval to conduct this study was obtained from the Research Council and the Ethics Committee of Qom University of Medical Sciences (Code: IR.MUQ.REC.1399.174). Written informed consent was obtained

from all participants. All of the participants were briefed about the study objectives, and voluntariness of their participation, and were assured about the data confidentiality.

Funding

This research did not receive any grant from funding agencies in the public, commercial, or non-profit sectors.

Authors' contributions

All authors equally contributed to preparing this article.

Conflict of interest

The authors declared no conflict of interest.

Acknowledgments

The authors would like to thank all nurses who participated in the study.

References

[1] Beck MF. Theory & practice of therapeutic massage. Boston: Cengage Learning; 2016. [Link]

[2] Teunissen GJ, Visse MA, Abma TA. Struggling between strength and vulnerability, a patients' counter story. Health Care Anal. 2015; 23(3):288-305. [DOI:10.1007/s10728-013-0254-3] [PMID]

[3] Barlem JG, Lunardi VL, Barlem EL, Ramos AM, Figueira AB, Fornari NC. [Nursing beliefs and actions in exercising patient advocacy in a hospital context (Portuguese)]. Rev Esc Enferm USP. 2015; 49(5):811-8. [DOI:10.1590/S0080-623420150000500015] [PMID]

[4] Day L. Advocacy, agency, and collaboration. Am J Crit Care. 2006; 15(4):428-30. [DOI:10.4037/ajcc2006.15.4.428] [PMID]

[5] Choi PP. Patient advocacy: The role of the nurse. Nurs Stand. 2015; 29(41):52-8. [DOI:10.7748/ns.29.41.52.e9772] [PMID]

[6] Baldwin MA. Patient advocacy: A concept analysis. Nurs Stand. 2003; 17(21):33-9. [DOI:10.7748/ns2003.02.17.21.33.c3338] [PMID]

[7] David AA, Joy CA, Ominyi JN, Simon NO. Concept analysis of patients' advocacy: The nursing perspective. Int J Nurs. 2015; 5(3):1-4. [Link]

[8] Bu X, Jezewski MA. Developing a mid-range theory of patient advocacy through concept analysis. J Adv Nurs. 2007; 57(1):101-10. [DOI:10.1111/j.1365-2648.2006.04096.x] [PMID]

[9] Vaartio H, Leino-Kilpi H. Nursing advocacy-a review of the empirical research 1990--2003. Int J Nurs Stud. 2005; 42(6):705-14. [DOI:10.1016/j.ijnurstu.2004.10.005] [PMID]

[10] Munday J, Kynoch K, Hines S. Nurses' experiences of advocacy in the perioperative department: A systematic review. JBI Database System Rev Implement Rep. 2015; 13(8):146-89. [DOI:10.11124/jbisrir-2015-2141] [PMID]

[11] Negarandeh R, Oskouie SF, Ahmadi F, Nikravesh M. [Nature of patient advocacy (Persian)]. J Zanjan Univ Med Sci. 2005; 13(53):29-38. [Link]

[12] Dillard V, Moss J, Padgett N, Tan X, Kennedy AB. Attitudes, beliefs and behaviors of religiosity, spirituality, and cultural competence in the medical profession: A cross-sectional survey study. Plos One. 2021; 16(6):e0252750. [DOI:10.1371/journal.pone.0252750] [PMID]

[13] Graneheim UH, Lundman B. Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. Nurse Educ Today. 2004; 24(2):105-12. [DOI:10.1016/j.nedt.2003.10.001] [PMID]

[14] Erlingsson C, Brysiewicz P. A hands-on guide to doing content analysis. Afr J Emerg Med. 2017; 7(3):93-9. [DOI:10.1016/j.afjem.2017.08.001] [PMID]

[15] Palinkas LA, Horwitz SM, Green CA, Wisdom JP, Duan N, Hoagwood K. Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. Adm Policy Ment Health. 2015; 42(5):533-44. [DOI:10.1007/s10488-013-0528-y] [PMID]

[16] Jamshed S. Qualitative research method-interviewing and observation. J Basic Clin Pharm. 2014; 5(4):87-8. [DOI:10.4103/0976-0105.141942] [PMID]

[17] Gerrish K, Lathlean J, Cormack D. The research process in nursing. New Jersey: Wiley; 2015. [Link]

[18] Saunders B, Sim J, Kingstone T, Baker S, Waterfield J, Bartlam B, et al. Saturation in qualitative research: Exploring its conceptualization and operationalization. Qual Quant. 2018; 52(4):1893-907. [DOI:10.1007/s11135-017-0574-8] [PMID]

[19] Choi SP, Cheung K, Pang SM. A field study of the role of nurses in advocating for safe practice in hospitals. J Adv Nurs. 2014; 70(7):1584-93. [DOI:10.1111/jan.12316] [PMID]

[20] Vaartio H, Leino-Kilpi H, Salanterä S, Suominen T. Nursing advocacy: How is it defined by patients and nurses, what does it involve and how is it experienced? Scand J Caring Sci. 2006; 20(3):282-92. [DOI:10.1111/j.1471-6712.2006.00406.x] [PMID]

[21] Johnstone MJ. Nursing and justice as a basic human need. Nurs Philos. 2011; 12(1):34-44. [DOI:10.1111/j.1466-769X.2010.00459.x] [PMID]

[22] Rooddehghan Z, ParsaYekta Z, Nasrabadi AN. Equity in nursing care: A grounded theory study. Nurs Ethics. 2019; 26(2):598-610. [DOI:10.1177/0969733017712079] [PMID]

[23] Boyle HJ. Patient advocacy in the perioperative setting. AORN J. 2005; 82(2):250-62. [DOI:10.1016/S0001-2092(06)60317-7] [PMID]

[24] Lindahl B, Sandman PO. The role of advocacy in critical care nursing: A caring response to another. Intensive Crit Care Nurs. 1998; 14(4):179-86. [DOI:10.1016/S0964-3397(98)80499-0] [PMID]

[25] Adib-Hajbaghery M, Faraji M. Comparison of effect between group discussion and educational booklet on Iranian nursing students' attitude and practice toward patient privacy. J Educ Eval Health Prof. 2016; 13:29. [DOI:10.3352/jeehp.2016.13.29] [PMID]

[26] Schroeter K. Ethics in perioperative practice--patient advocacy. AORN J. 2002; 75(5):941-4, 949. [DOI:10.1016/S0001-2092(06)61458-0] [PMID]

[27] Arnold CG. Two faces of patient advocacy: The current controversy in newborn screening. J Med Ethics. 2014; 40(8):558-62. [DOI:10.1136/medethics-2012-101019] [PMID]

[28] Hasan Tehrani T, Seyed Bagher Maddah S, Fallahi-Khoshknab M, Mohammadi Shahboulaghi F, Ebadi A. [Perception hospitalized Patients from respect for Privacy (Persian)]. Iran J Nurs Res. 2018; 13(1):80-7. [DOI:10.21859/ijnr-130111]

[29] Sundqvist AS, Carlsson AA. Holding the patient's life in my hands: Swedish registered nurse anaesthetists' perspective of advocacy. Scand J Caring Sci. 2014; 28(2):281-8. [DOI:10.1111/scs.12057] [PMID]

[30] Beauchamp TL, Childress JF. Principles of biomedical ethics. Oxford: Oxford University Press; 2001. [Link]