Question III.1:

CDC/NIOSH defines workplace violence as ‘‘violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty’’ (CDC/NIOSH, 2002). Is this the most appropriate definition for OSHA to use if the Agency proceeds with a regulation?

Question III.3:

Though OSHA has no intention of including violence that is solely verbal in a potential regulation, what approach might the Agency take regarding those threats, which may include verbal, threatening body language, and written, that could reasonably be expected to result in violent acts?

RESPONSE QIII.1 and QIII.3: We recommend that OSHA expand its definition of workplace violence beyond “physical assault and threat of assault” to include WPV subcategories typically used by hospitals to define patient and visitor perpetrated violence,[22] including: 1) physical assault, 2) physical threat, and 3) verbal abuse. Findings from a systematic review that included 17 hospital-based studies that focused on type II violence found consistency across studies with the use of these three categories (ref). Findings from this review were used to inform the development of specific definitions of these subcategories, which were then pilot tested among a multi-disciplinary group of hospital workers at three hospitals (reference) including:

physical assault which included *aggressive physical contact such as hitting, biting, scratching, pushing, shoving, spitting and/or sexual assault where a physical injury may or may not occur*.

physical threat included *threatening or aggressive physical behavior or physical force that makes the victim feel that they may be harmed such as shaking fists, throwing furniture, destroying property, having an aggressive stance, physically moving towards you, moving into your physical space*.

verbal abuse included *aggressive or inappropriate language that makes one feel threatened, scared and/or uncomfortable such as yelling, name calling, rude language, and verbal bullying*. In each case, violence was perpetrated by patients or visitors towards the worker.

- We recommend the expansion of OSHA’s definition based on an important study finding in which 30% of hospital worker participants that reported being verbally abused only,[23] also reported that the event made them feel scared about their personal safety at work. OSHA’s proposed definition is anchored in “assault” only, inferring that physical assault is more serious than other forms of type II violence. In many cases, it may be – but this is not absolute. Verbal abuse has been associated with decrease in job satisfaction, depression, anxiety, and leaving the profession.[5,9,10,13,17,19,27,29] The negative impact of these types of events are worthy of inclusion in the definition (and capturing on the OSHA Log or other surveillance method).
- Studies have also found wide variation in how healthcare workers themselves defined type II violence. Unlike a physical injury (e.g., needle stick, back pain) workplace violence is inherently subjective given that it is based, in part, on the workers’ perception of the event.
- In summary, we recommend that OSHA allow flexibility in their definition of workplace violence; while at the same time providing employers and workers, alike, with precise language and examples of their WPV definition. This will provide key personnel with appropriate guidance about the types of events that must be reported, rather than leaving this definition open to interpretation.

Question III.4:

Employers covered by OSHA's recordkeeping regulation must record each fatality, injury or illness that is work-related, that is a new case and not a continuation of an old case, and meets one or more of the general recording criteria in section 1904.7 or the additional criteria for specific cases found in section 1904.8 through 1904.11. A case meets the general recording criteria in section 1904.7 if it results in death, loss of consciousness, days away from work or restricted work or job transfer, or medical treatment beyond first aid. What types of injuries have occurred from workplace violence incidents? Do these types of injuries typically meet the OSHA criteria for recording the injury on the 300 Log?

Question V.59:

Would the OSHA 300 Log alone serve as a valuable or sufficient tool for evaluating workplace violence prevention programs? Why or why not?

RESPONSE to Q III.4 and QV.59:

In a study examining six years of first report of injury, OSHA log, and workers' compensation data in 3 of 6 study hospitals, 484 type II violent events were captured.[22] This averaged 81 events per year in 3 hospitals. In contrast, 5,400 workers surveyed in these same hospitals reported 1,200 physical assaults, 2,200 physical threats, and 5,700 verbal abuse events in a 12-month time period.[23] These findings highlight the difference between events captured by the OSHA log versus what is captured through a self-report type survey.

- The OSHA Log alone does not serve as a sufficient tool for evaluating workplace violence prevention programs. It significantly under-captures events, including important contextual details of the events that are needed to inform WPV Prevention efforts. Expanding the definition of workplace violence (see QIII.3 response), and broadening inclusion criteria of the OSHA log would improve its utility with capturing these types of events. The bulk of the events reported in our study would not meet the OSHA log reporting criteria.
- We recommend that OSHA have additional reporting requirements, like those for needle stick, 1904.8, to allow for an appropriate capture of type II violent events and/or that OSHA require that employers keep a separate, stand alone, workplace violence reporting system that captures events aligned (at a minimum) with their definition of type II violence

Question III.5:

Currently, a mental illness sustained as a result of an assault in the workplace, e.g., posttraumatic Stress Disorder (PTSD), is not required to be recorded on the OSHA 300 Log "unless the employee voluntarily provides the employer with an opinion from a physician or other licensed healthcare professional with appropriate training and experience (psychiatrist, psychologist, psychiatric nurse practitioner, etc.) stating that the employee has a mental illness that is work-related (1904.5(b)(2)(ix))." Although protecting the confidentiality of the victim is important, an unintended consequence of omitting these incidents from the 300 Log is that the extent of the problem is likely underestimated. In a workplace violence prevention standard, should this exclusion be maintained or be removed? Is there a way to capture the information about cases, while still protecting confidentiality?

Question IV.3:

The only comparative quantitative data provided by BLS is for lost workday injuries. OSHA is particularly interested in data that could help to quantitatively estimate the extent of all kinds of workplace violence problems and not just those caused by lost workday injuries. For that reason, OSHA requests information and data on both workplace violence incidents that resulted in days away from work needed to recover from the injury as well as those that did not require days away from work, but may have required only first aid treatment.

RESPONSE to QIII.5 and QIV.3: It is unclear why OSHA is limiting "mental illness" sustained as a result of an "assault" to this potential standard. The proposed scope is narrow with respect to the type of outcome(s) considered (PTSD), and the subtype of type II violence (assault). Emotional and physiological responses reported by nursing staff who were victims of physical or verbal threats include feelings of anger, anxiety, fear, fatigue, headache, sadness, and difficulty concentrating.[9,10,13,17,19,29] It is noteworthy that in one study, verbal threats experienced by nurses resulted in a higher proportion feeling frustrated (61%), angry (60%) and fearful or anxious (40%) compared to those who experienced physical violence (46%, 33%, and 23%, respectively).[10] Emotional consequences experienced by physicians have also been reported, with a large proportion (89%) of ED physicians reporting they felt occasionally fearful while at work.[17] These findings concur with reports emphasizing the effects of feeling fear about future violence being associated with intentions to leave an organization.[5,27] In one study, a nurse indicated she "felt undermined and it resulted in depression" from being verbally assaulted by hospital visitors.[21] In this same study, 62% of nurses indicated that verbal abuse from visitors made them want to leave their job.

Additional Types of Data to Inform WPV in Healthcare: In a study by Dement et al.[6] in which researchers used existing first report of injury, workers compensation, OSHA log, and general safety reporting system data linked with private health insurance (in-patient and out-patient) and pharmacy claims (2004-2009) to examine associations between type II violent events with psychological health outcomes and related medication use was examined. Workers that experienced type II violence events were significantly more likely to use anti-depressant and anxiolytics relative to workers that did not report experiencing a violent event. No associations were found with experiencing type II violence and seeking mental health services; however, this null association could be due, in part, to workers having free access to Employee Assistance Program (EAP) services for a number of visits before they are charged or the visits appear in the medical claims data. Further, studies have suggested that a large number of individuals taking medications for anxiety and depression do not concurrently receive professional counseling or therapy. Analyses of medication usage during one-month prior to the event compared to post-event revealed an elevated usage of antidepressants and anxiolytics during the post-event period.

We recommend that the definition of WPV be expanded to include the three subtypes described above (see QIII.3 Response), and include additional mental health outcomes that may precede or lead to PTSD including depression, anxiety, fear of being at work, and fatigue.

Question IV.1:

Rates of workplace violence vary widely within the healthcare and social assistance sector, ranging from extremely high to below private industry averages. How would you suggest OSHA approach the issue of whom should be included in a possible standard? For example, should the criteria for consideration under the standard be certain occupations (e.g., nurses), regardless of where they work? Or is it more appropriate to include all healthcare and social assistance workers who work in certain types of facilities (e.g., in-patient hospitals and long-term care facilities)? Another approach could be to extend coverage to include all employees who provide direct patient care, without regard to occupation or type of facility. If OSHA were to take this approach, should home healthcare be covered?

Question IV.2:

If OSHA issues a standard on workplace violence in healthcare, should it include all or portions of the Social Assistance subsector? Are the appropriate preventive measures in this subsector

sufficiently similar to those appropriate to healthcare for a single standard addressing both to make sense?

RESPONSE to QIV.1 and QIV.2:
We recommend that the Standard be more inclusive rather than exclusive with respect to including all healthcare workers inside and outside the Healthcare and Social Assistance Sector – including home health workers. Our recommendation is based on the limited epidemiological data indicating the WPV prevalence and risk factors among these workers. The absence of research evidence should not infer an absence of risk. For example, studies have examined WPV incurred by school teachers, yet little is known about type II violence (perpetrated by students and/or parents) towards school nurses. These healthcare workers provide direct patient care outside the healthcare sector and should be provided with the same benefits and protection of this proposed standard as other healthcare workers within the Healthcare and Social Assistance sector. Similarly, occupational health nurses (OHNs) work in numerous industries and settings providing health care and should be covered, as well. With respect to home healthcare workers, we also recommend that these workers be included. With the formation of the Affordable Care Act, and the formation of Accountable Care Organizations (ACOs), home healthcare has increased significantly. Hospitals are broadening their reach to their surrounding communities through outpatient clinics and home health services. Workers in home health most likely face unique challenges with respect to WPV risk factors, and their coverage with this standard is recommended. Broader inclusion will insure that all healthcare workers facing the risk of WPV on the job are protected.

Question IV.4:
OSHA requests information on which occupations are at a higher risk of workplace violence at your facility and what about these occupations cause them to be at higher risk. Please provide the job titles and duties of these occupations. Please provide estimates on how many of your workers are providing direct patient care and the proportion of your workforce this represents.

Question V.27:
What do you know or perceive to be risk factors for violence in the facilities you are familiar with?

RESPONSE QIV.4 and QV.27: There is consistency across numerous studies regarding occupations at risk for WPV and factors that place them at risk. Below is a summary of these findings. However, we have also included information about occupations not typically identified as being at risk, and associated risk factors with respect to their job responsibilities. The salient issue of this summary is that there is no single profile of potentially violent patient/visitor. Similarly, a large number of workgroups can be at risk. This emphasizes the importance of ALL workers being trained and prepared for potentially violent situations while at work.

Occupational Groups and Worker characteristics have been examined as possible risk factors for workplace violence with mixed and somewhat inconclusive findings. Studies have reported a higher proportion of white female workers experiencing workplace violence,[10] but given the higher concentration of female and white workers in healthcare, this is not surprising. Arnetz et al. (2000)[1] observed in a sample of "mostly nurses" that males were at greater risk of violence, especially at night; while Kowalenko (2005)[17] observed that female ED physicians were more likely to experience physical violence while no differences in gender were reported for risk of verbal threats. Some studies indicate that younger workers,[28] and those with fewer years' experience[3] are at greater risk for workplace violence. However, among a large sample of

nurses surveyed no association for years working as a registered nurse, or years working in a department were associated with an elevated risk.[11] In analyses of workers' compensation claims, job tenure was not associated with a 12-month prevalence of assault, but a higher risk of ever experiencing a severe injury due to assault was observed among those who had worked in health care longer. These findings suggest that time at risk incurred over workers' careers results in an increase in the likelihood of an eventual work-related assault.[4] Some[29] have attributed findings of older workers being at a decreased risk, in part, to older workers being less likely to report workplace violence incidents.

Perpetrator Characteristics and Circumstances: Based on the various types of situations with which workplace violence occurs in the hospital setting, there is obviously no single profile of the potentially violent patient or visitor. Reports from emergency department workers indicate that a large proportion of patients who initiated violence were intoxicated or mentally ill.[17] In contrast, the characteristics on an inpatient unit found that patients who initiated violence were more likely to be female, older, with events more likely to happen during the day, and in isolation from other workers.[30] Psychiatric patients who were violent reported that factors about their environment ranging from being confined in a locked environment, having staff treat them disrespectfully, and policies that limited their "privileges" to leave the hospital led them to behaving violently.[14] In a separate study, patients who were cognitively impaired were found to initiate violence when they were receiving "aversive" care (e.g., when staff behavior is experienced as unpleasant by the patient).[30] The authors theorized that these patients may be less able to communicate and warn staff that they are not willing to participate in a procedure, becoming aggressive more quickly. A delay in services or treatment (e.g., pain medicine) has also been identified as a trigger for both patients and family members.

Other factors considered as possible risk factors for workplace violence, but need further exploration, include inadequate staffing, downsizing in security guards, lack of protective measures such as metal detectors, alarms, and video monitors, poor discharge planning, conflict with physician, conflict with family members, unrealistic expectations by visitors and family members, long waits for care, overcrowded and uncomfortable waiting rooms, racial tension, and violence from outside the institution spilling into the hospital.[8,12, 19-21, 24]

Occupational Groups Not Typically Identified as Being at Risk that warrant inclusion and protection from this proposed standard include patient sitters, nurse managers, security guards, social workers, and hospital clerks/administrative staff.[24]

Patient Sitters (or "Sitters") are commonly utilized by hospitals to provide direct/constant observation for patients cannot be left alone due to their health (e.g., dementia, suicidal, disoriented). Although sitters serve a vital role in patient care, little has been published about their occupational health and injury risk. In fact, little was provided from study hospitals about their defined roles, responsibilities, or required training before and/or after hiring. In a study by Schoenfisch et at.[28] that focused on patient sitters the following was observed:

- Focus groups were conducted among these workers, who reported seriously unsafe working conditions with respect to type II violence. Concerns about sitters' safety were expressed by nurse managers more so than sitters themselves.
- They lacked training on job responsibilities and tasks with respect to their sitter duties, as well as training on violent event de-escalation and mitigation.
- Sitters were not integrated into the work flow of a nursing unit and were often left in isolation to deal with difficult and violent patients. Their isolation seemed to place them at greater risk for becoming victims.

- Often, sitters were not given the appropriate information needed at the outset of the work shift about the patient's potential for being violent.

Nurse Managers: In this same study, Pompeii et al.[26] observed that nurse managers had a higher than expected prevalence of type II violence. Type II violent events among nurse managers (Prevalence Ratio (PR):1.5; 95% CI: 1.3, 1.8) similar to nurses (PR: 1.8; 95% CI: 1.6, 2.1). This was unexpected finding given that nurse managers typically have a lower risk of other occupational injuries (e.g., musculoskeletal injury) relative to nurses due to differences in job responsibilities. Focus group findings indicated that workers followed "informal" reporting policies in which managers instructed workers to contact them first (e.g., by phone, email, in-person) when they needed assistance with a potentially violent patient. Nurse managers preferred to intervene and "handle the event," placing them at risk for being victims of WPV. Nurse managers play a significant role in the mitigation and management of violent events. They are the go-to person for staff when assistance is needed with a violent patient and/or visitor. This workgroup seems to be shouldering a significant responsibility for managing these events with little training or support from administration. This study observed that nurse managers were frustrated and overwhelmed with managing these events.

Question IV.5:

The GAO Report relied on BLS SOII data, HHS NEISS data and DOJ NCVS data. Are there any other data sets or data sources OSHA should obtain for better estimating the extent of workplace violence?

RESPONSE to QIV.5: The GAO report also relied on NIOSH/NIH funded epidemiologic studies which have employed cross-sectional surveys for purposes of ascertaining 12-month WPV estimates. Further, in OSHA's Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers[22] they recommend the importance of employers conducting intermittent surveys for purposes of examining the prevalence of WPV. We recommend that OSHA partner with occupational health researchers and/or hospitals that conduct these types of studies for purposes of gaining greater insight and details into the contextual details surrounding WPV incurred by healthcare workers.

Question V.57:

Does your facility use a workers' compensation form, the OSHA 301 or another form to collect detailed information on injury and illness cases?

RESPONSE to QV.57: In a study that examined type II violence events captured through the OSHA Log and Workers' Compensation in three study hospitals from 2004-2009[23] findings indicated that:

- These systems captured 484 physical assault events, but did not capture physical threat or verbal type II violent events.
- These systems only captured patient-perpetrated events, with no visitor-perpetrated events captured.
- The assessment of the existing surveillance systems revealed the limited amount of information captured with respect to contextual details. Little was gleaned from the first report of injury, workers' compensation and OSHA log text descriptions.
- Therefore, we recommend that this proposed Standard that employers use supplemental surveillance methods to capture contextual details surrounding WPV events for purposes of informing WPV prevention efforts.

Question V.60:

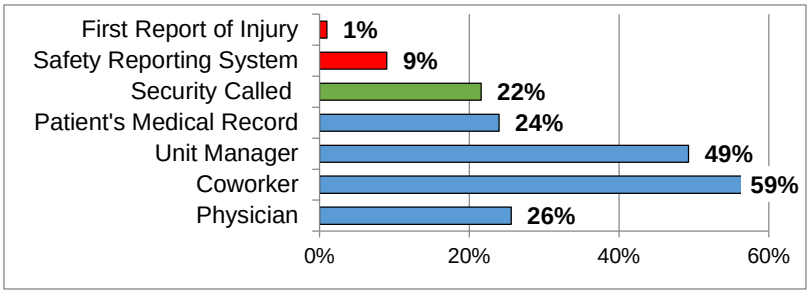
Are you aware of any issues with reporting (either underreporting or overreporting) of OSHA recordables and/or ‘‘accidents’’ or other incidents related to workplace violence in your facility and if so, what types of issues? If you have addressed them, how did you address them?

RESONSE to QV.57 and QV.60: Traditional occupational injury surveillance systems, such as the OSHA Log, are populated by reports made by workers into a first report of injury (FRI) system. The utility of these data are dependent on workers submitting a formal report into this type of system. As early as 1983, Lanza[18] highlighted the problem of under-reporting by nursing staff of type II violence events, which has continued to persist.[1-2,7] However, findings from a recent study that employed a survey and focus groups among healthcare workers[25] findings contradicted the long-held belief that workers significantly under-report type II violent events. This study observed that workers do, in fact, report, but they do so outside of the traditional occupational injury reporting systems. In this study, 2,098 of 5,385 workers that incurred at least one WPV event in the prior year, 25% (n=524) did not report; while 75% (n=1,574) indicated that they did report. As illustrated in Figure 1. workers indicated that they “reported” these events to their mangers, coworkers, and physicians about the event, or documenting it in the patient’s medical record. In contrast, **only 1% of events were reported into the First Report of Injury (FRI)** (that populates the OSHA Log), and 9% into a general workplace/patient safety system (does not populate the OSHA Log).

- If only the formal occupational injury reporting systems were examined by hospital management, these findings would suggest that type II violence rarely occurred in this 12-month time period.
- Workers’ reporting patterns were disparate, with workers reporting more to coworkers, managers, physicians, security, and into the patient’s medical record – compared to their reporting into hospital injury and safety reporting systems (i.e., first report of injury, safety reporting systems, patient safety reporting systems).
- None of the study hospitals had policy pertaining to the reporting expectations for type II violent events, which may explain the disparate nature of reporting on the part of the worker, who indicated in focus groups that they have their own “threshold” for when they report.
- Workers’ threshold for reporting varied considerably based on workers’ personal beliefs and feelings about the event, the patient/perpetrator characteristics, and their role as a healthcare professional.
- The capturing of violent events on the part of the hospitals was uncoordinated. For example, nurse managers expected workers to directly report these types of events to them, but they did not follow-through to ensure that these events were then reported into the first-report of injury.
- Hospitals did not have a coordinated method for pooling workplace violence event data across systems or groups, such as occupational health, hospital security, nursing management, human resources, and risk management.
- Factors associated with reporting type II violent events included violence sub-type of physical assault or physical threat relative to verbal abuse; feeling frightened for personal safety due to the event; incurring an injury, if a weapon was used; worker perceived that the perpetrator intended to harm them; not being alone during the event.
- Workers were significantly less likely to report a type II violent event if they were alone during the event.

- Patient satisfaction and patient satisfaction scores was a barrier to reporting. The employer's emphasis on patient satisfaction made the workers feel marginalized, and gave them the impression that worker safety was not a priority.
- Workers felt supported by their immediate supervisors with respect to reporting events, but they did not feel supported by the hospital administration. There was a lack of follow-up on the part of the hospitals.
- The lack of follow-up on the part of the employer post-event reinforced workers' feelings that type II violence is "part of the job." Workers found a way to covertly "tell their side of the study" by reporting these serious events in the patients' medical records.
- **These findings highlight the limitations of BLS WPV data, and the need for a specific WPV definition, as well as policies specific to reporting WPV events.**

Figure 1. Methods of Reporting[a] Type II Violence (n = 1,574)[25]



[a]Not Mutually Exclusive

Question V.43:

If you have a policy for reporting workplace violence incidents, what steps have you taken to assure that all incidents are reported? What requirements do you have to ensure that adequate information about the incident is shared with coworkers? Do you think these policies have been effective in improving the reporting and communication about workplace violence incidents? Why or why not?

RESPONSE to QV.43: Based on the responses provided for QV.57 and QV.60, we recommend that the OSHA WPV Standard include a requirement that employers have a policy specific to WPV Reporting.

- Using OSHA's recently published "Guidelines for Preventing Workplace Violence in Healthcare and Social Services Workers", we re-iterate their suggestions for using the OSHA log data to track type II violent events, but we underscore that this is not enough. Study findings suggest that using only using OSHA log and workers' compensation data results in a significant under-counting of type II violent events.
- Institutions need a stand-alone workplace violence reporting systems AND a written workplace violence reporting policy that the supports the use of the reporting system.
- The workplace violence reporting policy should include an explicit definition of workplace violence including definitions of violence sub-types (e.g., physical assault, physical threat, verbal abuse, described above). This ensures that the employer, not the worker, is determining where the threshold is for reporting these events.
- The reporting policy should explicitly state where workers should "formally" report the event, in addition to "informally" reporting (e.g., if they informally report to a coworker or manager,

they must also formally report into the stand-alone reporting or the first report of injury system).

- The reporting policy should guide the manager and/or security to formally report what workers report to them (or ensure that the worker formally reports).
- Train workers on reporting procedures (formally and informally), including training upon hire, and then annually.
- As recommended by OSHA,[22] hospitals should have a mechanism in place for pooling all type II violent event data captured outside the main reporting systems (e.g., managers, security, human resources, risk management, occupational health, patient charts).
- The reporting system should be easily accessible to all workers. The intake event form should be short, avoiding time consuming reporting (e.g., having a link within the medical record system (e.g., EPIC) in which workers could access while documenting about patient care could save additional time).
- A process should be in place to evaluate the effectiveness of the reporting policy and reporting system.
- Hospitals cannot develop and evaluate the effectiveness of targeted workplace violence prevention programs without this type of surveillance system in place – which must be supported by type II violence reporting policies.

Question III. 2:

Do employers encourage reporting and evaluation of verbal threats? If so, are verbal threats reported and evaluated? If evaluated, how do employers currently evaluate verbal threats (i.e., who conducts the evaluation, how long does such an evaluation take, what criteria are used to evaluate verbal threats, are such investigations/evaluations effective)?

Question V.22:

Who provides post- assessment feedback? Is it shared with other employees and if so, how is it shared with the other employees?

Question V.61:

Do you regularly evaluate your program? If so, how often? Is there an additional assessment after a violent event or a near miss? If so, how do you measure the success of your program? How many hours does the evaluation take to complete?

Question V.62:

Who is involved in a program evaluation at your facility? Is this the same committee that conducted the workplace analysis and hazard identification?

RESPONSE QIII.2, QV.22, W.61 and QV.62: It is expected that post-assessment WPV event feedback varies tremendously by hospital, hospital unit and workgroups. Prior study findings indicate, however, that a lack of feedback on the part of hospital management and administration is a barrier to future reporting by workers,[25] In this same study, workers reported that their formal reports about being victims of WPV went "into a black hole." Some indicated that they only heard from management about a report of WPV if they had "done something wrong". We recommend that the proposed OSHA WPV Prevention Standard include requirements that employers have a process in place for conducting post-event assessments that involve the workers, as well as management, security, risk management, and occupational safety. This requirement could be anchored in OSHA's Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers (URL: OSHA WPV)[22] in which hospitals are encouraged to collect additional data (e.g., short surveys) to evaluate the effectiveness of their post-event follow-up and evaluate their WPV prevention programs.

Question V.48:

What occupations (e.g., registered nurses, nursing assistants, etc.) attend the training sessions? Are the staff members required to attend the training sessions or is attendance voluntary? Are staff paid for the time they spend in training? Who administers the training sessions? Are they in-house training staff or a contractor? How is the effectiveness of the training measured? What is the duration of the training sessions or cost of the contractor?

RESPONSE to QV.48: The literature currently provides little information on the effectiveness of specific WPV prevention training. Focus group discussion findings among healthcare workers and managers[25] suggest the following :

- In person training where workers can "role play" WPV scenarios and develop WPV mitigation skills
- WPV prevention training needs to be conducted annually
- Online computer training was perceived to be ineffective.
- Training requested with regard to what is, and is not, allowed by hospital administration with respect to how workers can intervene/mitigate violent situations.
- Training on where to report (both informally and formally) was also requested by workers and managers, alike.

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