

Episode: Ethics Talk Podcast Transcript – Force, Authority, and Harm Minimization

Guests: Arya Shah, MD; Carmen Black Parker, MD; Ambrose H. Wong, MD, MSED

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Tim Hoff (Host): Welcome to Ethics Talk, the *American Medical Association Journal of Ethics* podcast on ethics and health and health care. I'm your host Tim Hoff. The April issue of the journal, *Compassionate Uses of Force*, explores important questions we should ask about the goals, motivations, and protocols according to which force is implemented in health care. Using force in the course of a patient's care is generally regarded as the last resort. There are cases however in which force is needed to care well for a patient. When force is necessary, clinicians are obligated to minimize harm to the patient. But what if instead of talking about this rise-to-the-minimum standard of harm minimization we instead talk about compassion?

The April issue explores this idea. When using force is the most compassionate thing you can do to care well for a patient, how should it be done?

Health professionals beginning their careers are often surprised at the power they have in patient-clinician relationships. While students might learn about when and whether it's appropriate to use various means of force, being endowed with the authority to actually carry out an act of force against a patient can be overwhelming.

DR ARYA SHAH: I think the thing I was least prepared for in starting residency was the amount of authority I had and the amount of decision-making capacity that I had, specifically with regards to forcing treatment on patients without their consent. And so, over the course of the past couple of years as a resident, I have noticed a visceral feeling in my gut during different situations in which force implemented in a way that I feel is appropriate or inappropriate. And, in talking about it I realized there was no right answer to how we were doing things. Discussions were often vague without any strict guidelines, and I realized one way to channel some of that uncertainty was through exploring what has been done to think about the use of force in medicine. Not just in psychiatry but in all aspects of medical care. It's ubiquitous.

HOFF: That was Dr Arya Shah, a third-year psychiatric resident at Brigham and Women's Hospital in Boston, Massachusetts and the journal's editor fellow who worked with us to assemble this issue. Over the course of her work with us she found that the conversations about appropriate uses of force in healthcare are far from settled.

SHAH: Essentially, the fact that I didn't know much was the reason I started to do the research and I realized that the truth is nobody has a right answer, and that did surprise me that there are no universal guidelines. It varies state to state, country to county,

between institutions, and between different medical specialties in the same hospital there might be very different approaches to when it's considered appropriate to force treatment and when it's considered not appropriate to do that. I think that's been incredibly surprising but also validating for me in terms of having made the decision to make this the topic of my issue.

HOFF: Despite a lack of standardized policies and protocols for force, Dr Shah does have recommendations for what clinicians should think about when considering how to preserve compassionate intention when using force.

SHAH: The first and most important is that if and when we do execute force all decisions should be made in the best interests of the patient and just remembering to keep that in mind in whatever decision is made. Two, that it's also important to recognize how your own biases influence your decisions and remembering to keep those in check before jumping to a decision. These situations can often be traumatic to both the patient but also to all the providers that are involved. So remembering to debrief with all stakeholders, debrief with the patient, and reflect on the experience to make sure that if things need to be done better next time that it can be discussed and done.

HOFF: With us next are Dr Ambrose Wong and Dr Carmen Black-Parker. Dr Wong is an assistant professor of emergency medicine at the Yale University School of Medicine in New Haven, Connecticut. Dr Parker is an assistant professor of psychiatry at the Yale University School of Medicine with a primary clinical appointment at the Connecticut Mental Health Center in New Haven, Connecticut. They joined us to discuss their research about patient experiences of restraints, behavioral or emergency response teams, and how simulations help prepare trainees not just to minimize harm in use of force but to demonstrate compassion.

Drs Parker and Wong thank you so much for joining me.

DR CARMEN PARKER: Thank you.

DR AMBROSE WONG: Thanks for having us.

HOFF: I think a good place to start for our listeners who are unfamiliar with you both and your work, can you take a moment to introduce yourselves and the kind of research that you do around behavioral or emergency response?

PARKER: Dr Wong, I'll let you go first.

WONG: Absolutely. As we mentioned I am an emergency physician by clinical training, I work in the emergency department, and my primary research is looking at trying to create patient-centered health and health care practices in the emergency department. Often times behavioral health is challenging to deliver in the acute-care setting and a lot of patients feel somewhat neglected. I think health care workers also feel like they may

not have adequate training or preparation for dealing with behavioral health. So, looking to try find that intersection between patient-centered approaches and creating better practices for patients while trying to help staff members feel safe and secure and deliver best practices care as much as we can. So, overlap between workplace violence and safety for staff as well as patient-centered approaches in behavioral health.

PARKER: I am new faculty here to Yale. I came here with a primary focus on anti-racism and anti-bias in medicine. In all things I do, I'm very vocal about being a very proud under-represented African American female psychiatrist medicine. In my cultural background informs a lot of my clinical and academic research work. As far as removing the language of bias and racism from behavioral emergencies I noticed that a lot of the implementation of force I was noticing during my formative training years was used disproportionately to those of under-represented status – those with mental health diagnoses - there is a lot of stigma bias communication errors in removing those aspects from behavioral emergencies became a primary focus for me.

HOFF: An article that you co-authored last year, Dr Wong, explores patient experiences with physical restraints in emergency departments. One interesting thing about their experiences of restraint use is that many patients' responses not only emphasized the restraints themselves but clinicians' uncaring implementation of the restraints or simply not even responding to patients' questions and concerns. What did this tell you about the potential place for so-called compassionate uses of force and how the way the force is implemented changes patients' perceptions of it?

WONG: It's a really great question. I would say, first and foremost that, I am myself learning about the process as a researcher and a clinician as I'm learning about the topic in talking with stakeholders and individuals and patients themselves. I think my perspective has changed quite a bit over the course of really learning about the topic and doing more scholarship on the topic. I really started approaching the issue of using physical restraints, but really talking about managing behavioral emergency and behavioral health from the perspective of keeping staff members safe. I actually was an educator by training I used simulation and health care simulation in my work. Nurses were coming to me talking a little bit about the injuries that they experienced managing these patients. What I learned over time and working with folks like Dr Parker and talking to patients who have been restrained is that it's not really a binary "yes-no" using restraints, but really changing the whole perspective on looking at how we interface patients and care providers at the bedside. Dr Parker and I have talked a little bit about even the use of the word "compassion" or the "compassionate use of restraint" and maybe really changing that to thinking more bit about clinical management for behavioral health and why restraints might be necessary or not and are there any alternative use to it.

I think the other thing that the article mentioned, which you hinted, at is the idea of thinking from the perspective of the patient and some new ideas around trauma-informed care. How past experiences that the individuals may have had either by being restrained in the past or behavioral issues that they've had or experiences they had in

their lifetime can really manifest and recycle trauma when they come in and see us in the emergency department. To think a little bit about decision making at the bedside that would try to minimize that kind of trauma. I think patients talk a little bit about some of the experience they've had and the socio-economic disadvantages they've had – being homeless, having been victimized because of the color of their skin or because of substance use or mental illness. Really looking for compassion and humanistic behaviors from us so that we can do that and try to minimize the amount of pain that they experience when they come and interact with us at the bedside.

HOFF: Thank you. Dr Parker, I addressed that to Dr Wong but if you have anything to add, you're welcome to.

PARKER: I fully agree, Dr Wong and I have had some many wonderful conversations, trading ideas, and expanding each other's perspective to our mutual topic of interest. Again, he hinted at how patients of color may experience health care - especially security enforcement of health care environments - very differently and drastically. And myself, a proud member of the African American community in having witnessed and personally endured discriminatory treatment, I bring this flavor with me to our work in behavioral emergencies because that is a huge contributing factor to iatrogenic exacerbation of behavioral distress.

HOFF: Both of you kind of touched on this in your response about the distrust of health care professionals and organizations that patients who come from historically marginalized communities that have been on the receiving end of medical abuses both over time and currently. What should we learn from these patients and their communities and the distrust of health care that they have?

WONG: Dr Parker, I'll let you take the lead on that one first.

PARKER: Thank you. I think one of the biggest problems inherent to health care: all of us join health care because, by nature, by heart, we want to help and we want to achieve the benchmarks that society says we should be achieving that is – do not discriminate, treat all patients fairly, don't do this don't do, racism is bad – we all hold these tenets to be truths within our personal selves. Unfortunately, the data is reiterated again and again in a thousand different ways and a thousand different fields that we as a body are failing to meet those objectives. However, we have not yet developed a language to describe incidents of failure on our end. So, the first thing I would say to answer your question is when patients distrust us sometimes they're completely justified. We turn on the TV and look what members of my communities have to go through, members of the Latin-x community have to go through. COVID brought up a lot of disparities and discrimination for our Asian-American colleagues and friends and neighbors.

The first thing I would say is, as we look at mistrust of medical institutions, we need to remove this automatic trigger that “yes, I am completely trust worthy . . . well what do you mean I mistreated you?” That mentality makes personal agitation and patient

agitation worse. We need to find a language to openly acknowledge mistrust, openly acknowledge instances of racism [and] bias especially as we communicate to patients in a population they're already vulnerable. They're coming to the hospital because they're already sick. Whether it is for painful appendicitis, whether it is for decompensated psychosis, maybe they're co-occurring. So we have a vulnerable population doubly vulnerable because they need our help in acute-care settings. It really is the sole responsibility of providers to monitor our bias not the patient's responsibility to better respond, better cope with medical mistreatment.

HOFF: Dr Wong, did you have anything to add to that?

WONG: I think Dr Parker makes some really great points and to add to what she said, I think what is lacking is to represent the patient's voice and the voices of those who are marginalized in all aspects of the health care system but really the whole structure of society and trying to make sure they are equally represented in decision-making. For example, I think traditionally when we create health care practices or do research studies we are learning over time as our society is growing and expanding and really thinking more deeply about what we want to accomplish in terms of public health outcomes and patient outcomes that we don't have representation equally across all aspects of our society – under-represent minorities, marginalized populations. I think the ideas of for example community-based participatory research or patient engagement in all aspects of research and practice can be equally applied here in behavioral health and behavioral emergencies. So really going to the patients and going to our communities and asking what works for them, how do we better serve them, what needs might be happening, and opening the dialogue to describe and understand why distrust is there. I think the other thing that's important is making sure that we promote individuals to come into the health care sector so that there are African American physicians like Dr Parker that are taking care of African American patients so that we can have those bonds and to make sure that we have equally representation in health care.

HOFF: Force can be implemented by physical, chemical, or legal means in health care. Examples range from physical straps on a patient's bed, a drug such as a sedative that's administered without a patient's consent or against the patient's consent or an involuntary 72-hour hold. It's easy to look at these kind of restraints as unjust restrictions of patient liberties which they certainly can be. But Dr Parker help our listeners understand why force might be needed to care well for and help a patient, and if implementing force can be a compassionate thing to do, when it might be appropriate, and how it can be appropriately administered.

PARKER: I am so excited to answer this question, thank you for creating the space to discuss it. One of the fundamental differences in perspective that Dr Wong and I have is that we're not advocating this dichotomous "to restrain or not to restrain" question or even what's the most compassionate kind or method of restraining. Rather our fundamental perspective we're advocating is two-part. The first part is, what about my personal bias or behavior maybe iatrogenically exacerbating this patient's distress. That

is recognition that we are health care providers and not infallible to many forms of racial, mental health, and other forms of prejudice that our patient can be justifiably and negatively responding to. The second focus is that restraints should only be used as a vehicle to continued clinical investigation. So let the narrative not end at, "and then he was tied in 3-point restraints and had two 15-minute checks until 45 minutes at which point he was deemed adequately sedated." So again, these are a doubly vulnerable population where at baseline they might be marginalized either by a diagnosis, racial identity, sexual identity, all of the above, but now they're in an acute-care setting where they need us, and they're not at their best. So they're here for a clinical workup and often times what Dr Wong and I advocate in the literature is that emergency protocols responding to behavioral distress across the country largely are limited to security-only protocols.

In 2019 I published, in *Psychosomatics*, a review of the standardize emergency codes suggestions as endorsed by 21 different state hospital medical associations. None of the 21 state medical associations, everyone that I could find, none of them endorsed any language of a security, unarmed security threat protocol that was any different than a behavioral emergency. That is someone who is having agitated delirium, it might be a client with autism who just had a painful procedure they're not always able to say "wow, ow, it really hurts right here could I please have some help?" It often comes off as agitation. It might be future colleagues who are getting older coming at an age risk factor for delirium or poor outcomes themselves. These are security-only protocols that impact our own care as well, it's not just "other" care, it's anyone who's in hospital doors. The language in most hospitals is limited to security only for behavioral emergencies. So to further the clinical response we are advocating that in addition to security enforcement - because, yes, providers have every absolute right to a safe environment - but the clinical investigation of what precipitated it a psychiatric investigation of is there more I can do after they've been sedated to make sure that the cause of this agitation has been remedied. Also patient centered; have I talked to the patient to my best ability? If the rapport between myself and the client has broken down can I phone a friend, call a chaplain? Anything beyond restraints for containment as opposed to restraints for continued clinical and patient-centered care.

HOFF: Thank you. That actually leads nicely into our next question. Both you and Dr Wong were featured in our November 2020 issue in which you argued for the widespread implementation of behavioral or emergency response teams. So for our listeners who haven't read this article which I highly encourage them to go do obviously after they finish listening to this podcast, what are behavioral emergency response teams and what's important about what they do?

Parker: Dr Wong, I will let you take it away.

WONG: Absolutely. We're really excited to have a venue with the journal to talk about what we feel passionate about which is these behavioral emergency response teams. I can talk a little bit about an example of an implementation that has happened in our

emergency department, and then I'd love to hear Dr Parker talk a little bit about her perspective in the in-patient setting and beyond. For us here at Yale New Haven Hospital we did pilot what we called an ACT alert which is an agitation code team response and these are situations where patients have become acutely agitated and potentially can be dangerous for themselves, as well as for the health care workers around them. The idea of that is to really give a venue and an opportunity to just slow down the whole process and to really uncouple what Dr Parker hinted at which is this idea of a security threat from a clinical response and to just reframe the context. Because unfortunately traditionally when you do call this type of response in most hospitals the primary response are protective services or security officers. They take the lead on keeping the situation safe. Like Dr Parker said, we do want to make sure that the situation is safe for staff and for patients. It is not acceptable for health care workers to be assaulted. That is a big systemic problem in our sector and is something that we need to fix which we'll talk about I'm sure later on in the interview as well. But I think what happens is when security officers take the lead, it's really focusing on almost a dichotomous "us versus them" relationship. "They're perpetrators of crime, we are victims," and we just have to remember that we are working and operating in the health care setting. These are patients we're caring for. These patients are medically ill and they're here in the hospital because they need our help. Thinking more about why they're medically ill and the underlining medical causes for why they may become agitated or have behavioral responses, I think is really important.

The other thing I wanted to mention is that it's really hard for health care workers. I think all of the things Dr Parker and I say are not minimizing the struggle that health care workers have when there is violence. And actually one of the articles that we have written in the past describes this idea of the patient care paradox which is that health care workers at the bedside are faced almost with the decision they have to make between keeping themselves safe and potentially using restraints, like you said, versus doing things that are really compassionate for the patient that aren't coercive. It's not really fair because at the day-to-day level there are things that are outside the control of the health care worker. They're very busy. They're pressured to respond to multiple patients at once. They have to take care of this behavioral patient and then go and take care of a very sick patient. That happens quite often in emergency department. And unfortunately, when there is high risk, high pressure, that's when bias can seep in and we know this because we've seen this in the other studies before where... There was a study actually that was done where they looked at ratings of potential implicit bias for emergency physicians before and after a shift where there's higher volume, and there's actually anti-black bias that's slightly higher when residents just went through a very high volume, high pressure shift. It's just something that's out of our control. I think what we need to do is create responses like this that really give us an opportunity to take time and respond in a slower way and make decisions that are safe for us but also important for patient care. In the ACT alert philosophy in the ED, we bring clinical staff, attending physician, resident physicians, nurses, as well as officers all together to respond. It's really important for us that the clinical lead is the one that's determining what to do and when restraints are needed to involve officers to help for that. But we think about is the clinical response first and foremost.

HOFF: Dr Parker, anything to add?

PARKER: Yes. I want to emphasize that it's not an "either/or," "compassion or safety" decision that must be made on a hairpin. Behavioral emergency response teams are a heterogeneous mixture of whatever-on-earth resources exist at an institution repurposed with the common goal of delivering patient-centered, clinically, and culturally appropriate care at the bedside. We have a formal collaboration coming out with the Province of British Columbia who has had a provincial mandated - their language is a code-white response, but it's a behavioral response team in any name shape or form - since the 2000s. And this is from downtown Vancouver with multiple resources to northern territories where we spoke with one provincial health care authority and they don't even have security in the hospital.

In our ethics paper from the November edition of this journal, we speak to the point that first there is beneficence: deliver patient care. And in the absence of delivering patient care, we're actually violating nonmaleficence by harming patients when we call security, either psychologically or physically if they're in restraints for prolonged period and have either skin breakdown or rhabdo. There's also the concept of justice with health care. We understand the limited financial resources and as we advocate behavioral emergency response teams to hospital administration often times the knee-jerk response is we don't have enough psychiatrists for that so we're just are going to continue with the status quo. The beauty of the heterogeneity of behavioral emergency response teams is that it can literally can be anyone dedicated to a clinical and patient-first perspective. The University of Iowa went so far with their limited resources to repurpose security guards as patient care technicians and their outcomes improved. It can be a nurse, it can be a psych resident, but the biggest thing is improvement in the standard of care and adhering to our ethical tenets within medicine is not limited to utopian resources with 30 psychiatrists on staff 24/7 at all times.

HOFF: Great, thank you. Dr Wong, would you speak a little bit more about the role that simulations have in preparing trainees to implement force?

WONG: Yeah, absolutely. I am really excited and proud that simulation has had a role in training in behavioral health and specifically for behavioral health care teams. Both at Bellevue Hospital which is in New York City, as well as here at Yale New Haven Hospital, we've had the opportunity to bring an interprofessional and interdisciplinary team together in simulation to both practice training together as well as breaking down those barriers and starting a dialogue between our security staff and our clinical staff. We primarily use standardize actors, and they themselves have training in de-escalation as well as behavioral health, and they actually act out as a patient that's agitated in a variety of scenarios; someone may be just really upset because they received some bad news, they may be disassociated because of mental illness or other reasons. What we want to do is bring the clinical staff and the officers together to respond in a simulated scenario and we've done that both in the actual emergency department, and we've also done that in a simulation center in a lab. After they respond

we take the opportunity to debrief after that and just breakdown all the issues that may happen but also open the room for people to understand each other's frames of mind and what issues there may be in their safety as well as how that may potentially re-enforce bias or cause more harm for the patient and also an opportunity to do some practical things like: how do you put on a restraint safely, how do you de-escalate a patient properly, how do you deliver patient-centered care, and what are some medical and clinical issues that a patient may become agitated? We received some really great responses. I think the thing that has really helped the most is just opening an opportunity for officers and for our resident physicians to talk to each other and realize at the end of the day that they have similar goals in mind and may just come from a different perspective and that we can really come to a consensus that would both deliver patient care and keep ourselves safe.

HOFF: In response to these simulation trainings, do people find generally that they are well-equipped to deal with force implementation or are there certain things about being in the clinical environment that simulations don't really have the ability to capture?

WONG: I think it's a little bit of a mix. I would like to hear what Dr Parker thinks also about being equipped to manage these patients well and also to make the decisions properly. One thing I think that's starting to come out is the idea of "structural competency." I think it used to be called sort of "cultural sensitivity" or "cultural awareness," but now I think even the word cultural and race is antiquated, but it's really about structural issues that happen systemically would cause differences in race outcomes and other socio-economic outcomes. I think what we need to do is to train providers and health care workers to be aware of bias that themselves may not even be conscious of and to try to break down those barriers way early maybe in medical educations, in medical school, in public health training, and in clinical practice. I think one hope is that simulation can help us do that and bring up some of those issues and have those discussions. It is sometimes challenging because in the real environment you're faced with workflow and logistical issues that may not necessarily come up in simulation. But the hope is that it can reinforce some of those discussions and bring them out so that people can have a dialogue even just to start so that we can have an idea of where we need to intervene in our training.

HOFF: Sure – I'm just going to plug really quickly - if people are interested on reading more about structural competency, we do have a number of articles in the journal about that, specifically one in our September 2014 issue, I believe, by Jonathon Metzl and Dorothy Roberts. Dr Parker, did you have anything to add to that?

PARKER: I would like to echo some sentiments expressed earlier by Dr Wong about representation in the medical field and reiterate some of my concerns that medicine is not yet made it okay to knowledge shortcomings. I, as a African-American provider, represent only two to three percent of academic medicine. So as we're trying to do debriefings both in simulations and in real-world hospital settings we don't have the representation through centuries worth of systematic barriers to help facilitate these dialogues. So I want to thank Dr Wong for being an ally and encourage everyone to be

an ally to liberate ourselves to talk about what's going wrong so we can make it right – we can't fix what we can't acknowledge. And so representation and allyship is going to be a huge part to medical education to almost rewrite it from the beginning to make it okay to acknowledge bias so that we can take the next step forward in addressing it.

HOFF: Dr Parker, I did have one other question for you. The theme issue editor of this particular issue is a resident named Arya Shah, and she expressed, when I was interviewing her for the podcast, the, sort of, surprise that she had at her own authority in dealing with patients and deciding when and whether to do anything really but especially when and whether to implement force. If you were going to give, let's say, three pieces of advice to new clinicians, specifically new psychiatrists, who are sort of almost overwhelmed by their own power in the patient-clinician relationship, how would you frame that advice?

PARKER: That's an excellent question. I think one of the first things is that power, the power dynamic, patients feel it too, which is also playing into their agitation because they know where they are on the totem pole of how the medical system is currently designed. So thank you for acknowledging our own provider authority, and now let's also take a second to step into the role of patients especially ones who are already having to deal with so much racial trauma and headache and mental health bias outside of our walls and inside of our walls. The next thing I would to say is engaging dialogue with our colleagues. So we as psychiatrists and even physicians in general, we're not typically the frontline staff hands on during emergency protocols that go wrong. So patient aids, nurses, security guards, CNAs, they're often . . . we're often behind the computer screen pressing orders - "to click or not to click" - while others are going to do our bidding. While we're also informing ourselves, educating ourselves, enlightening ourselves about different ways managing behavioral distress, it's also important to remain very, very humble that when we "click or not to click" it's not necessarily our arm most at risk of being broken, if that makes sense. A leader leads by example and through engagement. And particularly, if you're going to be that new clinician who is going to say no don't restrain go talk to them and you haven't demonstrated this or you don't have a healthy awareness that this is the frontline staff's workers comp on the line, without that perspective it's going to be hard to achieve meaningful change.

WONG: I'm nodding very *vigorously* [laughs]

HOFF: .[laughs] As am I.

WONG: I think . . . I completely agree just adding a couple points to what Dr Parker said, I think the first thing is over time what sometimes I've noticed is that you actually sort of become numb to that decision. Meaning, I think it is definitely a very powerful thing but it almost becomes routine. In emergency department unfortunately, we restrain a lot of patients, physically and chemically, and it almost just becomes something where you do and you don't think necessarily about the ramifications that actually happens at the bedside, like Dr Parker said, both for the staff member and for the patient. I think whenever we make the decision to constantly think a little bit about what that really

means for people, and that it could have lasting consequences months or years down the line, you know it could be life-changing for individuals. They may never seek health care again or come to a hospital again. Unfortunately, there may be situations where restraints are needed. I don't think neither Dr Parker and I are saying that that doesn't happen because I think Dr Parker and I both order restraints on a routine basis, unfortunately as part of job. But I think the idea is to really make sure that you're doing the right thing and really trying to make the right decision. I think the other thing that Dr Parker is saying which is great, which I totally agree, is that you need to lead by example. We talked a little bit about the fact that it has big and important implications for the patient, but we are somewhat shielded as physicians from the actual practice of putting restraints on. I think what I try to do is, when I do order the restraints, I go to the bedside and I try to go to the patient and explain why we're doing it, talk to them. And patients, even if they're getting restrained they've told us that they want to understand why, and they still want to have that engagement. Even if somebody else is putting on the restraints, I talk them through, I'll explain what's going on, I let them know that it's just temporary, we're only doing this to help you, and even if at that time they're yelling at me or saying cuss words or insulting me even, I understand that that's just something that they're responding to and that I try my best to do what's right and explain to the patient why I'm doing that even if it's hard to do.

HOFF: Drs Parker and Wong thank you so much for joining me today and hopefully we'll talk to you again soon.

PARKER: Thank you for the opportunity.

WONG: Thank you.

HOFF: That's our episode for the month. Thanks to Drs Wong and Parker for joining us for our interview and to Dr Shah for her work developing this month's issue. Music was by the Blue Dot Sessions. To read the full issue, "Compassionate Uses of Force," visit our site, JournalofEthics.org. For all of our latest news and updates, follow us on [Twitter](https://twitter.com/JournalOfEthics) and [Facebook](https://www.facebook.com/JournalOfEthics), @JournalOfEthics. And be sure to join us next month when we'll discuss equity and erasure in ending the HIV epidemic. Talk to you then.