

BOSTON UNIVERSITY
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ANNUAL SHINE LECTURE
THE STOP SHACKLING PROJECT:
MAKING AN IMPACT FOR PATIENT RIGHTS
1:00 PM ET

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>> DEAN HYDER: Good afternoon. My name is Adnan Hyder, and I have the privilege of serving as Dean of the Boston University School of Public Health. On behalf of our school, welcome to the Annual Shine Lecture. Thank you to the many who helped make this event possible and thank you to our very own Center for Health Law, Ethics & Human Rights for hosting today's event.

I would like to start by recognizing the late Professor George Annas, whose memory and contributions are very much alive and well with us. He was a great scholar, dedicated teacher, and beloved member of the SPH and BU Community. I only met him once, but I had the pleasure of learning from his many papers on Bioethics, and subjects we will talk about today, ethics, law and policy, all topics he was an expert on.

This lecture also honors the memory of Cathy Shine, and her dedication of the rights of patients and the rights of the underserved. So, we want to acknowledge that today, as well.

Now, the lecture today is on a very, very important issue. That aspect of The Stop Shackling Project: Making an Impact for Patient Rights. This is an issue that comes from a number of different topics, from ethics, the modeling perspective, from the dignity of care of patients, from the perspective of autonomy and patient's rights. That is why it is so appropriate that a Center for Health Law, Ethics & Human Rights is hosting this. I am so delighted with the panel we collated together.

My colleague will introduce the panel, but suffice it to say, that Professors in academics, nursing colleagues, and many

other colleagues are all contributing together to this dialogue.

(Recording in progress)

That is important today, because we want to bring at the school particularly an interdisciplinary perspective to everything we do at the School of Public Health.

My role is to welcome you. Eventually I will bid farewell to you at the end, but I am very excited to introduce the Moderator for today, Elizabeth McCuskey, who serves as Director of the BUSPH Center for Health Law, Ethics, and Human Rights and Professor of Health Law, Policy, & Management. Professor McCuskey's research focuses on regulatory reforms for health equity and courts' roles in securing those reforms. She has nationally-recognized expertise in state-level health reforms and the role of employer-sponsored insurance in universal access plans, especially ERISA preemptions issues. She advises state legislative task forces on preemption issues in the design of health reforms.

Liz is a dynamic leader of this center. Thank you for hosting this, Liz, and over to you for today. Thank you.

>> LIZ McCUSKEY: Thank you, Dean Hyder for that introduction. And, thank you, again, for joining us today. The Stop Shackling Project exemplifies what we at BU talk about as convergent research, which is not just interdisciplinary, but super interdisciplinary. It translates, Human Rights, Institutional Management into practice, by enacting and implementing policy change, on behalf of a particularly vulnerable population, incarcerated patients.

The Stop Shackling Patients Coalition makes an especially fitting and poignant topic for the Cathy Shine Memorial Lecture, because we are honoring Cathy Shine, whose experience being inappropriately and involuntarily restrained in hospital care had tragic consequences, and prompted her family to endow this lecture in the hopes that no other patient should suffer the same fate.

So, this year's lectures also exemplify what it takes to make a difference in patients' rights. The roles that education, mentorship, institutional leadership play, in promoting real change, and real impact, and I now have the privilege of introducing today's speakers, the main event, why you are all here!

So, Neil Singh Bedi is the Founder & Director of the Stop Shackling Patients Coalition. He is currently a fourth-year medical student at the Boston University School of Medicine and his work lies at the intersection of public health and clinical care - with a vision to make health systems more sustainable,

effective, and equitable, and, who just matched with his first-choice residency at MGH.

(Applause)

Super! Congratulations!

We are also joined by Sondra Crosby, who is a medical doctor and Professor of Medicine at Boston University, specializing in internal medicine. She is also a faculty member of the Health Law, Bioethics, and Human Rights department at the Boston University School of Public Health. Dr. Crosby is notable for being one of the first doctors allowed to travel to Guantanamo to independently examine Guantanamo captives. a role that she still inhabits today.

And we are also joined by Nancy Gaden, a distinguished leader in nursing, serving as Senior Vice President and Chief Nursing Officer at Boston Medical Center (BMC) since 2014. She played a key role in the clinical planning and execution of merging two campuses and led BMC to its first Magnet designation in December 2021.

So, we are delighted to be joined by all three of you today.

To start, I will turn it over to Neil Singh Bedi so he can share an overview of the Stop Shackling Patients Coalition and their current work. So, please join me in welcoming to the stage Neil Singh.

>> NEIL SINGH BEDI: Good afternoon! Thank you for the calm response. I always appreciate that. My name is Neil Singh Bedi. I want to welcome all the folks here and folks on Zoom to join the The Stop Shackling Project: Making an Impact for Patient Rights. Before I begin, I want to take a moment to acknowledge the work we will be discussing today was built from an entire community of incredible people, people you will get to meet today, including Dr. Crosby and Dr. Gaden, and two of my colleagues and friends, Resident Physicians in New York. I am incredibly grateful to this entire team of awesome people, and so many others that made this work possible.

I also want to take a moment to acknowledge our friend and my mentor, Professor George Annas. I got to meet George five years ago when I took the class that he and Dr. Crosby co-taught here at the BU School of Public Health. It is in his memory and legacy we continue to do this work. I am inspired by him and am grateful to know him.

With that, no lecture of the modern day is complete without appropriate pop culture reference, so we will play a couple clips from The Pitt, a show most you have at least seen or heard of, to set the stage for what we are really going to be talking

about today.

(Playing The Pitt Clip)

>> NEIL SINGH BEDI: Thank you, Matt. We will use some of the scenes and discuss them later on today, but I wanted to set the stage a little bit with some of the themes early-on. A lot of you might be thinking, this is just a TV show. This is not what it really looks like and not reality of what happens in our Health Care System.

Some of you who are clinicians know that this is actually a very common scene of what happens in our emergency rooms and inpatient units every single day.

And early on in my med school journey, I am a 4th year med student now. When I was a first year, we go through what is called a Clinical Skills Development Course that we call doctoring. In that course we are paired with a 4th year med student. We go into the hospital and learn how to take care of patients. We learn how to put on a stethoscope, how to do a physical exam, and interview patients and ask about their medical history.

One of the first patients I got to see through doctoring was a patient who was incarcerated. She was an older woman, barely 100 pounds, and had a terrible cancer diagnosis.

I remember sitting next to her. Every time she would try to talk, she would try to sit up in her bed, and the shackle on her ankle would drag her right back down in the hospital bed.

This is a scene all over the country every day.

Later on that month when I got to see my first patient incarcerated, I went back to Dr. Crosby. Dr. Crosby taught a class I took the year before I started medical school. I happened to strike a conversation with her about this patient that I saw, and she was actually the attending overseeing my fourth-year preceptor at the time.

Dr. Crosby shared this article written by one of our internal residents at the time. In this piece, the authors about the process of taking care of one of his patients in the ICU who happened to be incarcerated. The patient went into cardiac arrest in.

This piece Tyler walks through the process of running the code for the patient, trying to get their heart beating again. With every compression that Tyler did, he could hear the sound of the shackle against the hospital bed.

The patient eventually died. And the title of Tyler's piece was no patient should have to die in shackles.

Now, a lot of you might be thinking, we still do this? Here in America? Yes! We do.

And the more I was able to dig into this, and the more I learned about the practice of caring for patients who are incarcerated, I came to learn that up until the last decade, it was common practice for us to shackle people who are pregnant while they were giving birth.

I don't feel like I have to go through this, but for the sake of completion, shackling is horrific for many reasons. It causes physical and emotional harm to the very patients we are trying to take care of. It interferes with our capacity to care for them, do things like a physical exam, transfer in from a gurney, to ambulance to hospital bed. Get them down to surgery quickly, to imaging they need, and it cause as significant degree of Moral Injury to us, as members of the Health Care Team, especially our nurses at the bedside, 24 hours-a-day, 7 days-a-week, taking care of the patients and seeing the condition they are in. But more than all that, it is a horrific violation of these patients' basic Human Rights and a fundamental affront to their human dignity.

Early on in this process, when we started to dig into the problem of shackling, I had the opportunity to speak with some people formerly and currently incarcerated and I asked them about their experiences with the Health Care System.

I will never forget one of the quotes from one of the gentlemen I got to speak with. He said, I hate going to the hospital, but I really hated the shackles, because they took away my humanity.

And I don't think there is a better quote to describe that scenario.

The purpose of our lecture here today, and the reason we are all gathered, is to talk about the importance of patient's rights. I am here to argue that it is our responsibility as members of the care team, our responsibility as a community, protecting Public Health, to protect the basic rights, the basic Human Rights, of the patients we take care of, because everything that happens to them, especially while they are in our care, is our responsibility.

Patient's rights are Human Rights.

As any Human Rights person would do, we go back to the Fundamental Human Rights Doctrine. Didn't know these existed before I start medical school, but I came early on to be introduced to Nelson Mandela rules and the United Nations has a Best Practices document for how you make sure the rights of people incarcerated ready protected.

This is not to say we don't violate a lot of these Human Rights on so many scales, especially now, but I cited many of

these rules in the past couple years when talking to people. The rule I cite most often is rule 47 which says the use of chains, irons or other instruments that are inherently degrading or painful, should be prohibiting. I have never met anyone that said the use of shackles is inherently degrading and painful.

So, I shared with you that case I had early on in Medical School, and a group of us got together under the mentorship of Dr. Crosby and Professor George Annas, asking how we can fix this problem, looking at what we can do to take action on. As many groups of medical students do, we wrote a petition in a very noisy, boisterous way and sent it to Nancy's Inbox and said Boston Medical School, you should do better. We need to improve the care for incarcerated patients, do something so no patient ever dies in shackles again at our Health Care System.

We really didn't know what would come with this, but the policy we wanted to implement got a lot of traction and helped us build momentum to get resolutions passed, the American Mental Health Association and more to increase the state of the dialogue around the country, not just about the use of shackles, but about how we care for people incarcerated, and how we care for people who are vulnerable.

More than that, we were able to actually join with the leadership of Boston Medical Center, much in part thanks to Nancy, who you will hear from later today, and actually redesign our policy for care for patients who are incarcerated.

Before this policy existed, we could advocate for shackles to be removed if we needed to go down for an MRI, or surgery or an exam, but this policy list as set of special circumstances. If a patient is sedated, intubated, if they had a stroke and quite literally can't move their limbs, or if they are materially ill with a cancer diagnosis and can't get off their bed, we can advocate for their shackles to be removed simply because it is the right thing to do.

At the time this was the first kind of policy in the country allowing for passionate shackle removing and since then other systems in the Boston area and other states have started to adopt similar policies and more than that, interrogate the overall policies of care for patients that are incarcerated.

Early on as I was sharing my first-year med student experience, I got to have a lot of conversations about why I felt our system needed to address this issue. I often got a lot of pushback, especially from attendees and Deans that said this is great, but should a med student be the one that cares about this? You should wait until you are an attending, you should wait until you have real backing from your institution to

address challenges like this.

I hated when people said that. I wholeheartedly disagree. We as trainees in the institution should be the lead of change for our systems. 20-years from now when I am an attending, we will be the ones responsible for how our systems function. They are our systems to inherit, so, yes, we should design the system of the future, because the patients are ours to take care of.

So, over the course of the afternoon today, we will go through two sort of broad questions. We will discuss what we have been able to learn over the last couple of years, and also take a little time to think about where we go from here. We welcome your participation both here in the room and on Zoom to think about how we keep pushing this momentum, to bring change to other Health Care System, as well.

To introduce us now, not only helping other Health Care Systems adopt policies for their individual hospitals, but we are also supporting work in California to actually help legislate this at the State level and we were able to support recently a non-profit group in California bring a bill to the California State Legislature taking a generalizable version of the policy we passed here, trying to make it state law for the entire State of California.

For that, I will pause here, and we will join together.

>> ELIZABETH McCUSKEY: Now I would like to invite Dr. Crosby and Dr. Gaden to join us. If you have questions, I would ask you to submit them on Zoom through the Q&A button at the bottom of your screen.

So, coming off of Neil's presentation, Dr. Crosby, I will start with you.

When the students first approached you about this full-threaded petition and bold idea what, were your initial thoughts and reactions?

>> SONDRRA CROSBY: Great question. Well, you know, first of all, I have been an attending at Boston Medical Center longer than Nancy has been here. Like, 30 years. I have witnessed scores of incarcerated patients who were shackled with metal shackles while critically ill, intubated, at the end-of-life, dying, and I have even seen dead bodies in shackles who haven't been removed.

So, I will tell you, it was a moment of self-reflection that I have been witnessing this, and I hadn't done anything meaningful about it. I was humbled but really excited when Tyler Lescure, who was one of my trainees, came to me and talked about this experience of doing CPR, and hearing the shackle hit the bed with every compression. Then shortly thereafter, Neil Singh

and his group of students were passionate and fiercely dedicated to making a change in this practice.

So, that was really exciting, but again, just humbling, the power of trainees and students is just really remarkable in this case, but in so many cases.

Now, did I think this was actually going to work?

(Chuckles) Professor George Annas and I discussed this. He is, like, no lawyers will never let this happen!

But Neil Singh and his group of students were very thoughtful and organized and made what I thought, Nancy will comment, a really powerful case for making a change.

I thought, if it is going to happen anywhere, it will be at Boston Medical Center, who has a longstanding commitment to taking care of vulnerable patients, including incarcerated patients. If it doesn't happen here, it won't happen anywhere.

So, Again, initially I wasn't so up in the stick, but as time went on, we had a tremendous collaboration with hospital leadership. That doesn't always happen with Human Rights projects, I can tell you.

I just think it was, you know, an amazing successful project that, thank you to so many people that participated Annas and were responsible for it.

>> LIZ McCUSKEY: So, one question has to be the amazing motivation, but working on behalf of incarcerated patients, a largely marginalized and often ignored population, Dr. Crosby, you have worked with those patients extensively even before this project. What has drawn to you work with this patient population in particular?

>> SONDRAS CROSBY: Great question. As I said, the Boston Medical Center has a longstanding commitment to vulnerable populations. I have been documenting violence in prisons for probably decades now.

Prisoners, incarcerated people, I think are amongst the most marginalized of marginalized populations.

Not even to talk about the circumstances that led them to be incarcerated in the first place. But prisons are a place of violence. They are places of medical neglect, and places where people suffer from injuries and even death, just for being in carceral settings.

Unfortunately, health professionals are part of that violence. It has been documented that misdiagnoses, delayed diagnoses, premature deaths, are partly contributed to medical neglect, stigma and fear on the part of healthcare professionals, and that actually translates to when incarcerated people are cared for in hospitals, the stigma, neglect and even

violence. This is a reality in our systems, so I have been very committed to the plight of incarcerated people. This project is like a dream come true, beyond my wildest dreams.

>> LIZ McCUSKEY: Dr. Crosby, can you reflect on some of your experience mentoring students, or the role you think of mentorship outside the classroom or even your Clinical Practice has played for you?

>> SONDRAS CROSBY: So, mentorship is so critically important. Honestly, it is one of my most favorite parts of the job, is mentoring students like Neil Singh and his group, and just watching these tremendous successes.

I think one of my favorite investigative journalists is Nicholas Christoff from the New York Times, who would say, in every classroom there are people that will change the world. You just need to let them know their across matters. That is paraphrasing. I truly believe that.

Mentoring has just been inspirational, and, you know, practically, in Human Rights work, it is also a little bit self-serving, because, you know, doing this work for so long I, speaking for myself, will often get a blind eye or develop biases. Then to have a student come along and say, wait a minute, why are we doing this? It is just so powerful. So, yes, mentoring has just been outstanding. It is really great.

>> LIZ McCUSKEY: So, when I am thinking of the role of education and mentorship and up students, we all want to do whatever we can to help you shine. Sometimes we need you to show us what we already think is important. But when we are trying to translate it into something real and affecting all kinds of other people that, is where I this I this coalition has taken steps that are really, really important.

So, as an institutional leader, Dr. Gaden, I will turn it to you, when students brought this project to you, what were your initial reactions and thoughts?

>> NANCY GADEN: You didn't have to do a petition. It is okay! (Chuckles) Yeah, it was -- a lot was sent to the President of the hospital. The CMO and I had said let's have a meeting with the people and we will be done. Mostly it is because we focus so much on employee safety and workplace violence.

So, we thought the medical students might be naive in terms of what they ask of us, which would have to be balanced against the staff safety.

I remember the first meeting. I remember where we were. This small group of students with Dr. Crosby, we met in the conference room and we brought to the first meeting the attorney, the head of Public Safety and Dr. McCuskey and I. They

did this impressive presentation about incarcerated patients.

One thing I remember, at the time, 50% of the people incarcerated, walking through our halls with shackles, are just accused, and haven't even been tried and convicted, which is just such a sobering thing to consider.

Especially, you reminded me this morning about ICE.

There are a lot of people in that system who are shackles and we make judgments about them. You know, they may not have even done anything, or did something very small, and because of their color are dragged through our systems.

Anyway, it was a really impressive meeting. I think, like you, it was time to say, I haven't even looked at the policy on shackled patients lately. I wonder what is the tone? It is separate from the patients we restrain for safety and other reasons. This is really only about the shackled patients coming from the prison system.

Yeah. I just we quickly realized we could learn a lot from this young group of students, and we should reflect on this ourselves, and that we would have opportunity to regroup on our policies. I also did not think it would go as far as it has, but we realized that in order to make real change, it would have to be a very deliberate process, with each of the steps.

And it was a great partnership.

>> ELIZABETH McCUSKEY: It always sounded to me like it really took off because there was an institutional leadership willingness to both listen and consider policy change. But also, to focus on the many things that the institution has to take care of, including employee safety, health protocols.

So, as anyone here who has ever known a nurse can tell you, being at the bedside as a nurse and having that direct role in patient care is really important, and I think lends itself to a scenario where nurses and the nursing staff are often the ones who have to advocate for patients.

Can you share a bit about how maybe your nursing perspective informed your institutional perspective about thinking about change?

>> NANCY GADEN: Yeah. I mean, I was smart enough to involve a consume of ICU leaders who ended up being really critical to the implementation of change, that was practical and make sure it with us consistent across -- I was saying earlier -- we have 1,800 nurses or something. So, when you want to make a change with that many people across years and transitions of people coming in and out. The attendings, staff and students coming in and out, you have to think about how to embed that.

I think the nurses got used to caring for patients who are

shackles and kind of were deferring to the officers that were with the shackled patients. They are their responsibility, in addition to the clinical responsibilities that the staff have.

So, but Boston Medical Center attracts nurses and physicians -- everybody who is attracted to work at BMC is really I don't know, inspired by the mission and wants to do the right thing.

So, as soon as you raise something like this, like, hey, it is possible for us to do something like this differently, I think we really had broad support, but it wasn't anybody that said I don't know if we want to do it that way. Everybody was, okay, let's now figure out how to think differently in these moments.

When I was thinking earlier about the policy, you know, the simplest thing, the policy was called Care of Prisoners and we just need that one change these days to find and replace. To say it was about incarcerated patients and change the wording in the Policy Statement, put something about Compassionate Care. The tone, small things like that can make a big difference.

But yeah, nurses, I think do care about the patients. They do think of the patients' privacy, respect and dignity. This was a natural step to think about.

Then, I think the logistics were the thing that took a lot of time to figure out how to embed it in a way where everybody will be consistently evaluating a patient for that. So, yeah.

>> NEIL SINGH BEDI: If I may, the notion of having -- of being naive. We were. I will still think I am about most things in the context of how Health Care Systems operate.

And Avi is our Director for the Medical ICU Nursing Team, and a fantastic human being, and is the reason this policy was designed the way it was, and actually implemented.

I think one of the things we learn early on as med students, like, oh, you are a med student, you are ready to go to med school, you are a doctor, it will be great, you don't know anything as a first-year med student. Am I really ready for graduation? I am 49 days away. You still have this sense of there is so much to learn and so much to do. You can't tackle every single system's problem, and address every issue for every patient, all-day, every day.

But what you can do is go to smart people and say, there is this one thing that has been really bugging me, and I feel we can do something about it. You work with really smart people who give you advice, who are your mentors and say, here is one way you can approach it. Here is one person you should talk to. That build as web of knowledge that extends far beyond myself to a

group of people that might not even be the ones writing the emails and sending the Zoom Meeting invites they have gotten from me, but just who can support you and give you knowledge. That was more important than anything, I feel like.

>> NANCY GADEN: I think that is great framing for, you know, we did try to have the right people at the table. We had the senior-most person in charge of Public Safety, the senior-most attorney, the Chief Medical Officer and me. We are the ones that can squelch something or try to give it life. I think we all had the same commitment, but it really was the work that you and your students had done to frame it, you did the work too say, yes, this is the right work and we can probably figure it out together.

But again, it was a petition.

>> NEIL SINGH BEDI: Now I can just email you.

>> SONDRRA CROSBY: I got the Vice President.

>> NANCY GADEN: Oh, yes. It was fun preparing for the lecture. I looked back at the presentation and the first few emails we exchanged and it just reminded me how far we have come.

I was telling Neil it is time to revise the policies. We look at hospital policies every three years and it has been three years and we need to revamp.

>> ELIZABETH McCUSKEY: I think the Stop Shackling Patients Coalition really accurately described why you have been able to make change in policy. Why you have been able to translate the things you learn in Human Rights, the things you learn in medicine and patient care, into action at an institutional level, and healthcare in a major Health Care System.

So, Nancy, as the person in leadership, I think you are typically the one who has to bring all the parts together that would need to be involved in decision-making, but also in implementation.

Can you walk us through all the parts that really needed to be involved to really make the change at the health system level?

>> NANCY GADEN: We started with the policy and reworded the part we had to just make it reflect more of our philosophy around respectful patient care. It with us clear that the politics safety leader would have to start to work with the jail system, the prison system, and the leaders there to figure out, what would be the communication we would have to do in order to be able to request the shackles be removed, and we all learned that. We can't take them off. We have to have them take them off so that is one thing.

The attorney was there really for support. We didn't really need too much of his input.

I think probably the most important thing is, policies are one thing, but people don't normally run to the policy and read it. So, that was really the work you and your team did with Avi. We put question into the ethics system, the computer systems that the nurses use, and we are used to doing assessments every few hours for all sorts of different things. We already had questions that existed for patients that were shackled, that had to do with how well their circulation was, their bodies were aligned. We were already doing nursing assessment questions.

The thought is, okay, that is where we can add questions to evaluate whether the patient should be evaluated for taking them out of shackles, with specific questions -- you put the slide up -- about either being sedated, end-of-life, unable to mobilize. So, now when a patient is shackled, those group of questions come up for the nurse at every shift. They have to re-look at, like, is this a patient that could be referred to the Attending Physician for someone that meets the criteria for being unshackled?

So, they have to ask the questions and kick it to the Attending Physician if the patient meets the criteria. Then we have a whole lot of resources. At the end of the policy, all the phone numbers and names of all the people in charge of the different physicians and who the Attending Physician would reach out to make the request.

So, I think we tried over time to put together enough support so that the people at the bedside, in the middle of the night, would have what they needed to go through is decision tree and contact the prison system Lieutenant or -- so, yes, I think the important thing when you want to make things consistent for every nurse who has been a nurse for 20-minutes, 49 days, a doctor from 1 minute to really experienced people, you do have to embed some sorts of forcing functions in order to be consistent, so, I am proud of that work.

I think that has helped other organizations to think about how to implement.

>> ELIZABETH McCUSKEY: If I can ask you a follow-up.

Did you anticipate resistance either to the concept, or to the implementation from any particular section of your system?

>> NANCY GADEN: Well, we knew that the prison officials -- that is their number one job -- to keep the prisoner from hurting anybody, or running away, or any kind of bad thing happening to them.

So, we always assumed and were correct that they would be

the barrier, the challenging piece.

I was never worried about anybody in teams being a barrier. But I have also, you know, had plenty of examples where I tried to do something and it wasn't designed well enough to really work, so I was conscious of trying to make sure it was kind of full proof from that.

But you know, I never -- did you ever have anybody that was responding poorly?

>> NEIL SINGH BEDI: Not responding poorly. Bill Givens, who I love dearly is the Director of Public Safety. He had a little misgiving, respectfully for the protection of staff safety. He was, like, what if something bad happens so we are trying to streamline the communication between BMC and the facilities. He is now one of the largest champions of the policy. I love that we do this, people tell me it is great, people reach out to me.

I feel like you said, when you frame so clearly, I don't want someone to die in shackles, it is really hard for people to say no.

>> NANCY GADEN: Um-hmm. I don't want someone to die in shackles, but I understand you have to keep your staff safe. You take the air out of the room with the but what. It has always been those two things.

>> NEIL SINGH BEDI: Um-hmm.

>> ELIZABETH McCUSKEY: Other than the energy of naivete, what -- did you find anything surprising about working with a large health system to do something that is both Human Rights-based, and also fairly discreet in its scope? It is a one-policy change, but it comes from something so much bigger.

>> NEIL SINGH BEDI: Yeah. I would say two things.

One, sort of surprising, I always had hoped that something would happen. What that was, I wasn't sure, but I was so pleasantly surprised by how welcoming the leadership was. And I think I have said this to everyone here, and so many people as I have been able to talk about this.

If we had taken the same approach at another Health Care System, it not only would not have worked, but there would have been repercussions for us as students as to how we approached addressing the policy change.

I think, obviously Dr. Gaden, and Avi, who I got to work with so closely, and even our CMO, he sat down at the meeting and was willing to listen. There are very few places in the country, I would argue, where the Chief Medical Officer of a health system this big is willing to sit down and just listen, right?

I think the other thing is, as someone who now has a little

bit of a better understanding of how the Health Care System operates, we change the policy, like, May, February of 2023, something like that. Fantastic, we did it. It is done. No one is ever going to die in shackles again.

And I am a little older now, have less hair on my head and more gray hairs in my beard, and I can tell you, passing the policy itself is only Step 1 or 2 of what will be many more steps of, like, how well is it actually implemented, how much do the nurses and attendings and resident knows about the policy, how do other health systems respond, how are they incorporating it.

So, there are so many more questions. The mature of knowing you can do a little, but every time you do something, you realize another couple does open doors for action. It is fulfilling, also, which means we have more work to do, which is good.

>> NANCY GADEN: Also, I think we have a Hawthorne Effect. When the nurses are presented with these questions every single time, it does have you thinking differently and reminds you about the humanity. What you can do to make them more comfortable. Maybe not shackling, but recognizing you can handle something more differently.

It is discreet, but it isn't only that. It has brought impact.

>> SONDRAS CROSBY: Changing the culture of how we approach people who are incarcerated.

>> LIZ McCUSKEY: So, how do you think -- this is probably for Dr. Crosby and future Dr. bet Bedi. Who do you think the future of grounding in Human Rights discipline change the way you approach Human Rights and maybe even systemic change.

>> NEIL SINGH BEDI: When I first took -- so, I signed up for Dr. Crosby's and Annas' Human Rights at the Public Health school. I thought this will be cool and given me a different perspective.

For a long time, I thought Human Rights was sit in a room, read it, talk about it over a chalkboard, but there was no application. I was so wrong. For me, when you base your work, when you base your arguments, when you base your decisions on Human Rights, you are really thinking about, what is the Gold Standard? What is the best we can do for Humanitarian, as this is what Human Rights are.

But for me transitioning into a more formal role as a clinician now, I have a basis of saying we can do better. Through this it is a very, very small Proof of Concept relative to all the other Human Rights issues to be addressed, but it is

a Proof of Concept that you can use Human Rights as a valid argument for doing better for your patients.

That, to me, is my biggest lesson from all of this.

>> ELIZABETH McCUSKEY: And Dr. Crosby, what drew you to Human Rights? Because you are medicine first, and Human Rights as like your perspective? What did you initially find so attractive about Human Rights that you were going to make it your life.

>> SONDRAS CROSBY: I think looking at medicine and patient care through a Human Rights lens, which is uplifting and defending people's dignity and humanity, kind of underlies everything for me.

That is how I practice medicine. That is how I teach -- I try to live my life that way. And putting it into action, as Neil Singh and his group did, is just amazing and beautiful.

I will say that usually this work is, like, takes forever, and what I like to say, it takes griping perseverance. I say that for many projects that have been going on for 20-years.

But this, really with the collaboration of the hospital and the fact they embraced this Human Rights approach in terms of caring for people, it really happened fairly rapidly in the Human Rights field.

But again, it is uplifting, and upholding and protecting people's Human Rights and dignity in humanity, no matter who they are. All people.

>> ELIZABETH McCUSKEY: Nancy, was there anything about this project coming to you practice Human Rights perspective that made it easier or harder for you as an institutional leader to bring together the people you needed to implement?

>> NANCY GADEN: It is so foundational, isn't it? It is really hard for people to say no to a meeting if that is core --

>> ELIZABETH McCUSKEY: Thinking Human Rights.

>> NANCY GADEN: Exactly. I can't do it. I have other things.

>> SONDRAS CROSBY: She has a conflict. (Chuckles)

>> NANCY GADEN: Right! I think, it really is something embedded in people and humans. Unlike the physicians we work with who are really trying to figure out the diagnostic path, and the way to make people well, in my profession, we are helping the patient to respond to the illness, managing their systems and side effects, then working hopefully with the family, and even their community sometimes that, is kind of our bend.

It does come completely from seeing everybody as an individual, and everyone as a human being, and within that I

think really trying to protect people's dignity, especially people who are marginalized, who we marginalize, by the way, which is why they are marginalized.

>> LIZ McCUSKEY: Yes.

So, where do we go from here? Let's pick up your slide. What are your next steps? What are your hopes and dreams and how can I help you achieve it? This is for all the panelists.

>> NEIL SINGH BEDI: For me, I think the perspective now is, one, how do you get this policy to be well-implemented at just one Health Care System. We are working on that now. Even things like communicating with different correction facilities. My time task at med school is making phone call, getting to know these people on the ground at some of these facilities, hey, there is a team of us at BMC. We want to do better for the people at your facility and help care for their health. How can we work with you in building those relationships.

The second thing, hospital systems that want to bring similar policies to their facilities, and that has been an ongoing process. I met with people and they are, like, how did you answer this question? How did you tackle this? How did you respond to this in this email? That has been helpful for myself, having a meaningful contribution there.

I do think at some point in my lifetime, I want to see to it that someone dies in shackles. I think that is a feasible goal. I think the state-level policy of having hospitals really think about this so that there are policies in place everywhere for patients to be protected this way.

Even with shackling someone while they are in labor. Now, looking back, oh, well, of course, why would we shackle someone in the middle of childbirth. It fully makes sense. I think we will either reach a point either by state-by-state administration, or national legislation, we will be able to look back and say, I can't believe people were kept in shackles in our ICUs until the moment they died, and sometimes even after they died.

I don't know -- I have no answers in terms of how all that works, but that is what we are here to do. We will figure it out. Oftentimes people ask me, or even talking about other problems, I am like, we are working on it. I can't say it will all be perfect tomorrow, but we are working on it and we will continue to do so.

>> NANCY GADEN: I think we need an episode of The Pitt. That is a big audience. We would be so good! Tell them what to do. That would be something a little more public like that, for people to see it in action, how it could play out to unshackle

somebody near the end of their life.

>> ELIZABETH McCUSKEY: Who would play you? No -- okay, she is good. Maybe we can do that in Q&A. I don't know, where do you want to go?

>> SONDRA CROSBY: I just wanted to add, beyond the is to be shackling, we at Boston center -- another plug for Boston Medical Center -- have fabulous faculty and colleagues who are working on other areas of improving the humanity and care of incarcerated patients, and Dr. Nicole Mushero is here, Dr. Ann Beckett is -- I don't know if she is here or not, but have both been working tirelessly to improve the care by creating standards for care of incarcerated patients, increasing their right to incarcerated patients' Right to Privacy, the right to have a healthcare professional, and helping to facilitate compassionate release when people are qualified to do that.

So, it is not just shackling. Our institution is working on many fronts to improve the care and humanity of these populations.

The other thing I would like to do, Neil Singh, I would like to get rid of metal shackles entirely. Like, they really have historical roots back to slavery, and really represent control and degradation, and we just kind of keep this going.

Why can't we find some other way, like in the Nelson Mandela Rules, to keep people safe, and use the least possible form of restraint that is necessary. I would like to get rid of metal restraints totally.

>> NANCY GADEN: In the hospital we use leather for top-tiered restraints and they work just fine.

>> SONDRA CROSBY: They do work just fine. And not as harsh. Incarcerated patients always come with metal shackles. Whereas when we restrain people in the hospital temporarily for a safety or medical reason, they are never in metal shackles. They are in soft restraints.

>> NANCY GADEN: Even the most challenging and worrisome behavior restraints, we still use leather.

>> LIZ McCUSKEY: Well, because the story starts at school, with education, what role would you like to see Human Rights or the lessons of this coalition play in Medical Education, in Public Health Education, and Nursing Education, going forward? You only have 49 days left, so please go ahead.

>> NEIL SINGH BEDI: First of all, not another plug for BU but a plug for BU. I think of all the medical schools we do the best job for students to have a place of advocacy in their curriculum already.

One thing we have been able to do is have this space and

time where the work is respected and you have mentors willing to spend time with you, which is such a privilege. Most schools don't have a phenomenal Public Health school with a Health Center for Human Rights, and all these doctors I could name that are, of course, I will grab coffee with you, sit on Zoom with you and talk to you about this.

I do think to some degree, as time goes on, and the poor outcomes of our systems are only more abundant, that every Health Care System professional, whether it is a nursing student or medical student or PA student, will find something that they are, like, this is what keeps me up at night, you know?

When I sit down and get to write this, I just want trainees and Health Care Systems to be able to look at something and say I can do that. It might not be related to incarceration. It might be related to climate change or how we treat people who are immigrants. There are so many things we need to address and of course one person can't do everything, but one thing every Dean would know is to create space for your students to learn deeply about a very narrow issue, and then give them the power to do something about it. Right?

>> NANCY GADEN: I don't think it is that different for nursing. And it is not all about nursing students, but really in the hospital to hear the voice of the frontline staff, the challenges they are dealing with, and the things that keep them up at night. We have to kind of recommit and renew our vows all the time about making sure their voices are heard, and we do create the structure around them to have them be successful in a change that can make a difference to patients, all kind of patients, who we can do better with.

>> SONDRAS CROSBY: I think Human Rights should be more fully incorporated in Medical Education, both in schools and residency training, and it is not, unfortunately at this time. We have people who seek it out, but it is required and should be a part of formal training.

I love what Neil Singh said about finding something you are passionate about.

But just on a Human Rights front, in today's world, today, there are so many overwhelming Human Rights problems, that I mean, it paralyzing at times.

And just to help people, as Neil said, we can't change everything, every issue, but we might not even be able to make something right. But we can probably find a project and make something better, even in small implemental steps.

>> NEIL SINGH BEDI: Yes. Right now, I know that advocating with this group of people, having this conversation tomorrow,

one less Human Rights problem will happen because of the work we are trying to do. Is that perfect? No. Is it enough, if we keep doing it? Yes.

>> NANCY GADEN: I think it is important, what you said, a lot of people have made commitments to their own practice. I will make sure there is an Interpreter whenever I am speaking with someone who doesn't speak English for their first language. That is a very important thing.

And, even better, if you can talk about that with your colleagues, advocate, you have broader impact for your own advocacy and in your own areas.

>> ELIZABETH McCUSKEY: So, now that we know the true power of bringing other voices in, let's turn to audience Q&A and have a discussion.

I would like to ask our virtual audience members to submit your questions through the Q&A button at the bottom of your screen, and for our in-person folks, I believe we have a microphone that will be coming around so that everyone can hear you.

I would like to start be former Shine lecturer, Heidi.

>> Thank you. First of all, congratulations. That is a real win. Very impressive.

On all counts, also on behalf of the Medical Center where I trained decades ago, very proud to say you listened and were amenable to making changes. That is terrific.

A couple of questions. One is, do you think the fact that these individuals always came with minders or an officer, made a difference, as is there is somebody there who is already watching them since the idea they could escape, or harm somebody or somebody else, whether that made a difference?

And going to -- going further, do you think eventually this may translate to the general restraint orders that still do happen.

And going back to Cathy Shine, who was absolutely compos mentis, when she was physically restrained against her will, we still deal with staffing shortages, which is one of the issues where somebody can really sit there to watch this patient to make sure they don't harm themselves.

Do you foresee at least the awareness of what it means to shackle or restrain somebody, sort of translating to other questions about, do we really need to restrain this person?

I know in critical care they are starting to do -- or they have done some studies showing to restrain somebody from extubating themselves versus not restraining them, hasn't made that much of a difference, so, I wonder how you think that may

have made a difference here?

>> NANCY GADEN: You know, we saw long-term care basically go restraint-free, I would say 15-years ago, a long time ago, so the skilled nursing facilities, the nursing homes, never use restraints.

And, you know, people fall and things happen when you don't restrain, but it is known that it is a terrible practice.

At BMC, we very, very, very, very seldom restrain people.

It is much more unusual than it used to be.

We use a lot of one-to-one observers, a lot.

We also use, now, 24 cameras in patient rooms to try to keep them safe and keep them from going anywhere without physically -- we can't even put the side rails on a bed up -- that is considered a restraint nowadays, so I think the industry has come a very long way in what sounds like was a terrible thing for the woman this lecture is named after.

And we do have a lot of -- we do have a lot of patients who we are working through their guardian, their next of kin, their Healthcare Proxy, to make sure if the patient can't speak for themselves, that we are making decisions with their chosen person.

We very seldom restrain people except for very big behavioral emergencies that we can very quickly resolve with medication management from the physicians.

We have a 24/7 behavioral response team now, with Nurse Practitioners staffing them, who help as much as we can to avoid those situations. We stat page them so they can come and deescalate before we get into that moment.

I was just looking at data yesterday. We now have a psychiatric facility that is BMC's in Brockton. It is 80 beds, and the restraint data in that psych facility is unbelievably low. It has come down amazingly in the last three years since we had the organization. They also use one-to-ones to watch patients so they don't have to put hands-on.

I am not saying it doesn't happen. We spend a lot of money on one-to-one observers, more than 100FTEs, actually, we use at BMC, so it is a very big part of my budget. It is millions and millions of dollars, but it does avoid having to tie someone down. You can watch them and hopefully keep them from hurting themselves or others, but mostly themselves, in other ways, but I think it is a great question.

We have to challenge ourselves around to mistake sure we are doing everything we can to avoid restraining somebody.

>> SONDRRA CROSBY: I agree with Nancy. I think it is, understand that medical restraints are used for a different

purpose than people coming in at incarcerated patients. So, we can't really compare those two situations.

One of the criticisms we had on the operational paper of project is, well, this doesn't go far enough.

You should admit people to the hospital, then you, the hospital, decide if they really need restraints or not.

We are not trained as law enforcement. We don't know if people are dangerous or not.

We can decide and make a medical decision about whether they need to be in restraints because they are too sick, but why can't make a prediction about whether somebody is dangerous.

So, again, I think it gets back to the least restrictive amount of restraints. I think it gets to not using metal restraints at all.

But again, it is hard to compare those two groups, because they are really completely different and restrained for different reasons.

>> NANCY GADEN: I think the other part of your question is does the presence of an officer make the staff feel not scared? I think, absolutely. I think a lot of the staff a lot of the time doesn't feel the patient needs to be restrained.

>> SONDRRA CROSBY: I would say, I am scare offend the officer sometimes. They are the only people in the hospital that have guns. Sorry! (Chuckles)

>> NANCY GADEN: No. I understand that well. Yes. I think that is part of what makes the whole thing, the staff feel safe. That is why it is right for the staff to be the advocate for the person -- the other thing, when I first came, I was taking a tour, I don't know if I started work yet. One of the ICU is taking me for a tour and she said in that room is guest of the Governor. And in another room, that patient is guest of the Governor. I thought the Governor has a lot of guests here. They were patients who were incarcerated.

And broadly, the nurses never tried to figure out what the patient did wrong to put them in that situation. They just want to care for everybody because that is the patient in front of them that, is the patient that has whatever diagnosis and that is what they are focused on, and that is the right thing. The right thing.

>> So, speaking of that difference, while you were talking and while we were watching The Pitt, I felt acutely aware that the officer was the key to the shackles. The medical staff could not do anything.

I would love to hear more if you have diplomatic dialogues for wiggle room there, to try to back off of a shackle, or

understand better how necessary it was. Because that is one thing you haven't talked much about that I would really love to hear.

>> NANCY GADEN: Yeah. When I was holding onto the policy, the old policy and new policy, in case I felt like referencing it, the last page-and-a-half is the name of each Department of Corrections, the name of the prison, the name of the warden at the time, the phone number, what kind of prison it is.

We really have focused only on the clinical situation, defining our advocacy around not shackling, and I think that anybody else can weigh into this. We never have been in a position of saying, upset, are you sure that with this crime that this person did, that we don't even know, whether or not that is the right plan for them?

If they are incarcerated in a prison, they come with a guard, because the prison is still in charge of them, kind of.

I don't know if that is the right thing or not, but we haven't gotten to that part of advocacy, if you want to think of it that way.

>> SONDRRA CROSBY: I think part of going forward is to develop better collaborations with the Department of Corrections and their medical departments, and try to individualize care. That is, again, one of the steps going down the road.

I have had very good interactions with the staff, the prison staff, where if I go in and I notice the shackles are too tight, I will ask them to loosen the shackles, and usually they are very cooperative and very responsive.

But again, in terms of removing shackles beyond one limit at a time, right now we are removing them for compassionate reasons, and, again, working our goal in the future is to work with the Department of Corrections.

Maybe to try to individualize care.

Maybe not every incarcerated person needs shackles and two guards with guns.

>> NANCY GADEN: And I think we would all agree, they are conservative. Their job, especially the guard at the bedside, he is not the head guard. He has one job, and that is to manage the safety of the milieu there.

(Speaking off microphone)

>> No, that is still part of the process right now. If we are going to request that the patient is unshackled, Public Safety is part of the group. Yeah.

(Speaking off microphone)

>> Wait for the mic.

>> This was so fantastic and inspiring. Congratulations to

all of you on really amazing work.

I am sitting here thinking about how to make this less of a microcosm and more of a nationwide policy. The questions people may ask because of the instinctive fear-based reaction to the kind of thing you are proposing.

I wonder if you know of any data that explains what the actual risk of escape or harm to others might be?

>> NEIL SINGH BEDI: So, we, and Dr. Crosby can correct me on this -- early on this was part of the conversation around who is part of that special circumstances of people who we advocate for shackles to be removed.

At BMC -- and this is data from one very specific Health Center, our patient population, we see a couple hundred people incarcerated who are inpatient at BMC.

Of those, only a subset meet criteria for shackle-removing, and of those, only a subset are unshackled successfully. Because we have to contact the corrections facility, they have to pass down approval and pass the order to the guard at the bedside.

Everything we have seen specific to this policy so far, there has been no adverse safety event because of the policy here.

Anecdotally you will see in the news patient eloped, every couple of years, and that happens, but the people who meet criteria from our clinical exam, of like a sedated patient here who is sedated and I want celebrated, is essentially the sedated and intubated patient anywhere. They are not going anywhere. They are people who have had stroke, not able to move their right body. The right leg is shackled to the hospital bed. I hate to say it, but with that clinical condition, they are not going -- that clinical condition, they are not going anywhere, you can still treat them as human beings.

At the end of the day the responsibility of the law enforcement accompanying the patient is to ensure they are safe and the surrounding area is safe, as well.

But on the national scale, the first part of the question, I do think if we had the chance to sit down and be, like, this is the example we are talking about, the patient sedated, intubated and in cardiac arrest, they should not have to die in shackles. That is a much more clear sell, I think.

>> NANCY GADEN: I remember, you didn't even say that. You said what are the...

>> NEIL SINGH BEDI: Right. We asked Nancy.

>> NANCY GADEN: And the physicians, you tell us, where are the criteria people would agree to. If they are paralyzed or sedated, you know what I mean? So, the hospitals could have

their row criteria, it is really not nothing.

And the other thing we can run reports off of. Here is the number of patients where the assessment showed that the net criteria here. Here is the number of those where the physician was contacted here. Here is number that was requested from the prison, here is the number that was unshackled, so we can keep watching that, and if anything adverse happened, we would have a different reporting strategy for that.

>> SONDRAS CROSBY: To answer your question, there is no national data, because everybody in the United States admitted to a carceral facility is shackled and accompanied by guards, so we are the first institution to initiate this policy, even though it is now spreading around the nation.

So, I think it is too early. I certainly cannot see any danger or security risk from the patients we have shackled at Boston Medical Center. There is just not data out there.

>> NEIL SINGH BEDI: Yet.

>> NANCY GADEN: Yet.

>> ELIZABETH McCUSKEY: Yet. And we will have a question from our online audience?

>> We have a lot of questions from the online audience. I am just choosing one because I know we are at time. Someone is asking about the role for Inter-Regional collaboration on the project and whether there is a role for hospital advocacy to push toward more humane policies. Someone in the Chat said their cousin is an actor on The Pitt, so they will translate that.

>> NEIL SINGH BEDI: I will ask them to email us so we can forward a comment to The Pitt and thank them.

A group from the U-Mass System and MG System, an Emergency Medicine physician there is incredible. I think that Regional advocacy is very effective, because while we at BMC get the vast majority of patients incarcerated within the area to get care here, it does apply. All locally.

The facilities are generally the same, within the same geographic area, so I do think that is effective and something we should continue working on.

With regard to community advocacy, absolutely. I am the first to acknowledge that is an entire arena of people we should follow.

There are some folks here at BMC who have really taken root in the community of advocating. If there is anyone in the community that would like to advocate with us, I would like to learn from them. But that should be a basis and not a tangent for the work.

>> LIZ McCUSKEY: Absolutely.

>> Hi. Thank you. So, one of the things that struck me about this, and I think the first Pitt clip did a good job illustrating it, was the extent to which the prison is infiltrating the hospital.

And one of the conversations that George and I used to have it a lot. Sondra, we used to have it, too, we saw the 8th amendment and healthcare professionals in the prison setting as what should be an avenue for more dignified, Humanitarian kind of work and development.

But thanks to, you know, your work, we got chasing the opposite. Healthcare workers in these sorts of carceral settings are participating in torture, doing sort of things like -- so, I wonder -- far be it for me to say here is additional work, but can this be taken to extent and do the reverse.

Take the healthcare setting and push it into the prison setting, instead of the prison setting being pushed to the healthcare setting.

>> ELIZABETH McCUSKEY: We hear you volunteering to lead this effort. You are a writer and persuasive advocate.

>> SONDRAS CROSBY: Right. It is a really good point. As we know, prison health has regular really been taken over by private contractors and corporations. You don't even have to be Board Certified to be a prison doctor. So, so, Dr. Mishero knows a lot about this, but we do not have a great health system for prisoners.

As I said early-on, we know they are dying of neglect and dying of violence, and yeah, there is more work to do. There is a lot of work to do. We will sign you up to lead this new initiative.

>> NANCY GADEN: Boston Medical Center has a relationship with the prison system in Massachusetts. That is why we get so many patients incarcerated. It is very reasonable place for us to say we would like to partner with you a little differently and impact on the care not only in terms of Continuum of Care, but we will discharge this patient back to the prison we would like you to focus on these things, we want to be more collaborative, and do you need more support with wound care. Where are the places you feel you don't have the expertise or resources.

I don't think it is unreasonable at all. We would be the people to do it.

>> SONDRAS CROSBY: We would be. And that extends to post-release care, a very highly vulnerable time for people.

>> NANCY GADEN: Post-release.

>> SONDRAS CROSBY: Post-release. Yes.

>> NANCY GADEN: A lot of patients post-release are seen in our Primary Care Clinics, so that is another piece we should think about.

>> LIZ McCUSKEY: Thank you all so much. In the spirit of more work to do, I will bring Dean Hyder back up for concluding remarks. Thank you.

>> DEAN HYDER: Wow! First of all, what an amazing session, both intellectually stimulating, really pushing us to think about important and hard issues and also demonstrating the complexity of the Health Care System we live in.

These are very important healthcare issues. As a Global Healthcare Initiative, I was reminded, one, getting access to care for incarcerated people in itself is a problem in many countries.

In other words, folks in prison systems don't get to the hospital. In many other countries we actually have a problem right there.

But second, I am reminded of the apartheid days. I don't know if you obviously read about stuff around dual-loyalty, and this notion of dual-loyalty. Michael just raised the question of physicians working in the prison system.

Then a very, very important book that came out in the early days about ambulance of the wrong color, because white people and colored people had different ambulances. If the wrong ambulance was dispatched, it just didn't work for you.

So, such a layer of complexity to the insights that you brought. But I think what is really close to our hearts is the fact that the change begins at home.

Change begins one step at a time. And you all are demonstrating that. I know that the three of you represent the community that has been working together.

So, first, congratulations. Please join me in thanking our panelists for the tremendous work they have done.

(Applause)

I want to thank Liz and the Center for the great work that they do, and for hosting this, and, obviously, a thanks to the Shine community that comes together every year to talk about these issues.

The School of Public Health is honored and delighted to host these lectures and dialogues. This represents our convening and top leadership we would like to bring to the community.

We look forward to hosting many of these. Our Public Health conversations continue.

Our next one will be on the 29th of April, if you are interested. It will talk about Future of Public Health in United

States. This will be one component of that. Thank you. It is a very important topic. I look forward to seeing many of you there.

Thank you for joining us in-person and online. Once again, as we leave, thank you to all the panelists and our Moderator.

Thank you.

(Applause)

(Session was concluded at 2:29 PM ET)

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