Are medical societies developing a standard for gun injury prevention?

M M Longjohn, K K Christoffel


Context: Following heightened gun violence in the 1990s, many medical societies in the United States adopted policies on the topic.

Objective: Identify points of firearm violence policy agreement among large medical organizations.

Design: Fourteen national medical societies—clinical focus, demonstrated interest in gun injury prevention, 2000 members—were selected for policy review in 2002. Policies were categorized on areas covered and items within these. Consensus areas were addressed by ≥7/14 societies. Consensus items were included by ≥7/14 societies, shared items by 5–6.

Results: There were five consensus areas: access prevention, gun commerce, research, public education, and clinical counseling. There were four consensus items: restricting gun access by enforcing existing laws, restricting access to all guns at the point of sale, restricting access to handguns at the point of sale, and creating a national database on gun injury and death. Shared items promote violence prevention, clinical education on risks of guns in the home, treating guns as consumer products, restricting gun access to children, bans on automatic weapons, and promoting trigger locks.

Conclusions: Large medical societies in the United States agree on key approaches for reducing gun injury mortality and morbidity. Future research will be needed to track the evolution of this emerging standard for physician action, which now includes the consensus areas and items. It promises to be, in effect, a medical standard of care for gun injury prevention. The United States experience may be useful to others working on gun injury prevention.

In the early 1990s the epidemic of gun violence in the United States reached unprecedented levels. In 1993, the number of Americans injured by firearms peaked with 39,595 deaths and another 104,390 non-fatal injuries. Older white males (75+ years) and young African-American males (aged 15–24) were found to be at particularly high risk (from gun suicide and gun homicide, respectively). The economic costs of this gun violence have been estimated to be as high as $100 billion a year, and the commitment of scarce resources to the treatment of gun injury placed significant stresses on the healthcare system.

Mobilization of the health sector to prevent gun injuries became a priority. As early as 1985, organized medicine and allied health agencies had begun to treat violence as a public health problem, and this included a focus on gun violence. Utilizing the public health paradigm, policies and programs were crafted to reduce the risks and rates of firearm morbidity and mortality. In 1992, the American Academy of Pediatrics took strong policy stances on gun injury prevention, and began a series of physician and parent education initiatives.

During the 1990s, other medical societies drafted position statements in support of various gun injury prevention strategies.

The HELP Network was founded in 1993 to develop and inform a national network of medical and health organizations promoting messages and strategies for gun injury prevention. In recent years, HELP has been joined by another network of medical organizations, Doctors Against Handgun Injury (DAHI). The organizations have overlapping goals and membership; HELP focuses more on education and information dissemination, while DAHI emphasizes national legislative issues.

Along with these developments, there emerged a more developed literature, increasing awareness by physicians of the health consequences of the epidemic, and related policy advocacy within medical societies. Policy statements designed to confront the epidemic of gun violence became common among medical societies. Such policy statements are developed by clinical societies to document organizational positions on clinical and public policy topics. They are published in medical journals and organizational newsletters, and provide a basis for member education and policy activity (such as lobbying on state or national legislation). The policy statements on gun injuries—like those on many other topics—inevitably vary across societies in details, reflecting the organizations’ constituencies, agendas, and internal protocols for policy development.

Over the last few years, the international community has focused increasing attention on the toll of small arms and the need to reduce this. Health approaches are emerging as part of the growing world effort (see www.iansa.org). The United States experience with health based approaches to gun injury reduction may be helpful to that work.

At this time it is relevant to ask what similarities exist in medical society policies despite the differences. These might constitute an emerging national standard for gun injury prevention in the medical profession. This paper addresses this question by describing an inventory of the policy statements of 14 HELP and DAHI members.

METHODS

In the summer and fall of 2002, national medical societies with a clinical focus, demonstrated interest in gun injury prevention, and more than 2000 members were selected for policy review. Fourteen medical societies from among the 127 HELP and 12 DAHI members met these selection criteria, representing 765,600 physicians (not excluding duplicate memberships). The organizations selected for review are presented in table 1.

Policy position statements from the 14 societies were collected and evaluated for content. Published position statements made by these organizations were located by...
Table 1 National medical societies selected for policy review

<table>
<thead>
<tr>
<th>Society</th>
<th>Year founded</th>
<th>No of members</th>
<th>Affiliated gun injury prevention organization, 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Academy of Child and Adolescent Psychiatry (AACAP)</td>
<td>1953</td>
<td>6500</td>
<td>HELP</td>
</tr>
<tr>
<td>American Academy of Family Physicians (AAFP)</td>
<td>1947</td>
<td>9430</td>
<td>HELP</td>
</tr>
<tr>
<td>American Academy of Pediatrics (AAP)</td>
<td>1930</td>
<td>57000</td>
<td>DAHI, HELP</td>
</tr>
<tr>
<td>American College of Emergency Physicians (ACEP)</td>
<td>1968</td>
<td>22000</td>
<td>DAHI, HELP</td>
</tr>
<tr>
<td>American College of Physicians (ACP)</td>
<td>1915</td>
<td>115000</td>
<td>DAHI, HELP</td>
</tr>
<tr>
<td>American College of Preventive Medicine (ACPM)</td>
<td>1954</td>
<td>2000</td>
<td>DAHI</td>
</tr>
<tr>
<td>American College of Surgeons (ACS)</td>
<td>1913</td>
<td>64000</td>
<td>DAHI</td>
</tr>
<tr>
<td>American Medical Association (AMA)</td>
<td>1847</td>
<td>294000</td>
<td>HELP</td>
</tr>
<tr>
<td>American Medical Women’s Association (AMWA)</td>
<td>1915</td>
<td>10000</td>
<td>DAHI</td>
</tr>
<tr>
<td>American Psychiatric Association (APA)</td>
<td>1844</td>
<td>37000</td>
<td>HELP</td>
</tr>
<tr>
<td>National Hispanic Medical Association (NHMA)</td>
<td>1994</td>
<td>26000</td>
<td>DAHI</td>
</tr>
<tr>
<td>National Medical Association (NMAA)</td>
<td>1895</td>
<td>25000</td>
<td>DAHI</td>
</tr>
<tr>
<td>Society of Critical Care Medicine (SCCM)</td>
<td>1970</td>
<td>10,000</td>
<td>DAHI</td>
</tr>
<tr>
<td>Society of General Internal Medicine (SGIM)</td>
<td>1978</td>
<td>2800</td>
<td>HELP</td>
</tr>
</tbody>
</table>

..., [the ACS] supports educational programs about conflict management and the avoidance of violence."

Many statements addressed more than one category. Such a statement often had “basic” content in one category and “detailed” in another. An example of a statement that was deemed basic in two categories (that is, physician education and public education), and detailed in another (that is, clinical counseling), comes from an early American Academy of Child and Adolescent Psychiatry (AACAP) policy:“... [the ACS] supports educational programs about conflict management and the avoidance of violence."

Many statements addressed more than one category. Such a statement often had “basic” content in one category and “detailed” in another. An example of a statement that was deemed basic in two categories (that is, physician education and public education), and detailed in another (that is, clinical counseling), comes from an early American Academy of Child and Adolescent Psychiatry (AACAP) policy:“... [the ACS] supports educational programs about conflict management and the avoidance of violence."

Many statements addressed more than one category. Such a statement often had “basic” content in one category and “detailed” in another. An example of a statement that was deemed basic in two categories (that is, physician education and public education), and detailed in another (that is, clinical counseling), comes from an early American Academy of Child and Adolescent Psychiatry (AACAP) policy:“... [the ACS] supports educational programs about conflict management and the avoidance of violence."

... [the ACS] supports educational programs about conflict management and the avoidance of violence."

Many statements addressed more than one category. Such a statement often had “basic” content in one category and “detailed” in another. An example of a statement that was deemed basic in two categories (that is, physician education and public education), and detailed in another (that is, clinical counseling), comes from an early American Academy of Child and Adolescent Psychiatry (AACAP) policy:“... [the ACS] supports educational programs about conflict management and the avoidance of violence."

(continued...
community based (4); clinical counseling: need for safe storage (4), child access prevention (3), identifying those at high risk (3); physician education: violence prevention training (4), training to identify high risk (3), resident training in prevention (3); access prevention: restricting access to “high risk” individuals (3), holding owner liable (4); gun commerce: childproof guns (4), taxes on gun sales (3); and research: evaluation of prevention programs and policies (4).

DISCUSSION

There is broad consensus among the large national and clinically focused medical societies studied that gun injuries are a medical concern, that public policy is essential for effective gun injury prevention, and that specific prevention steps are needed in the areas of reducing gun access and research on gun injuries and their prevention.

The greatest and most detailed consensus concerns the importance of reducing access to guns. This emphasis is consistent with research findings that access to guns at the individual, household, and state level is directly related to risk of gun injury and death in the United States.

The other area that contained consensus items relates to research, reflecting the commitment of the medical profession to collecting detailed data on gun injury and death, evaluating access-reducing measures, and improving the science and effectiveness of gun injury prevention.

A curious finding is the lack of consensus on the importance of educating physicians on gun injury prevention. It is not clear how medical societies expect their policies to be implemented by their members without such education. It is possible that policy reticence on this reflects the need for research; if so, this emphasizes the societies’ consensus in that area. Another possibility is that the societies have not yet turned their attention to applying the positions that they have developed. Further study will be needed to examine how societies educate their members about their policies.

The societies’ consensus is weaker for items than for areas. This is likely due to the fact that an independent process is used to develop each statement.

Methodological issues

The organizations chosen for study include many of the most prominent ones in organized medicine. They were selected from among all members of the two extant networks that address gun injury as a health problem. Large medical groups that do not belong to these networks are thus not included in this report. The conclusions can therefore be generalized only to the groups that are publicly addressing gun injury prevention—that is, the leaders in this area. Many other medical and allied health and health advocacy organizations (that is, the American Public Health Association, the American and Eastern Associations for the Surgery of Trauma, Physicians for Social Responsibility, etc) also have related policies, and we are not aware of any large medical societies that take a markedly different approach.

Due to the way organized medical organizations work, it is unlikely that there will ever be unanimity on the details of how best to address gun injury prevention. Still, the evolution of these policies over time can be used to track the development of a medical standard of care for the profession’s approaches to the reduction of gun injury—the second
leading cause of injury death in the United States. This report does not speak to the trajectory of that evolution, which will need to be addressed by future research.

This study also did not address the effects of organizational policy statements on the behavior of clinicians, researchers, advocates, or others. There is some evidence that organizational statements do affect physician attitudes and behavior.22,23 This is an area that needs more exploration in general, and specifically regarding firearm injury prevention.

This study was limited to medical groups in the United States. Future research will need to examine how medical groups are handling this issue internationally.

CONCLUSIONS
At least 14 clinically oriented large medical societies serving national constituencies have policies supporting gun injury prevention. Among these, there is consensus on the need for access prevention and changes in gun commerce. There is also consensus on research, public education, and clinical counseling, and on specific items related to access prevention—restricting access to guns through the enforcement of existing laws, restricting access to all guns at the point of sale (that is, closing the "gun show loophole"), and restricting access to handguns at the point of sale, and creating a national database on gun injury and death.

These areas and items constitute an emerging standard for excellent physician practice.

Other nations pursuing health based approaches to gun injury reduction may find this information useful.

ACKNOWLEDGEMENTS
Thanks to medical student Sima Patel for her initial work on the gathering of policies; to Martha Witwer, MPH, MSW, Christy Young, Gail Ellis, and Theresa Merwald for editorial assistance and fact checking; and to Lavonne Hopson and Theresa Merwald for manuscript preparation.

APPENDIX

POLICY STATEMENTS REVIEWED FOR THIS REPORT

AACP

AAFP

AAP

ACEP
- Policy #400233, Firearm Injury Prevention: 2/01.
- Policy #400174, Violence Free Society: 10/00.
- Policy #400276, Injury Control/Trauma Data Banks (9/99).

ACP

ACPM
- Preventing Handgun Injury: 11/02.

ACS
- Statement on Firearm Injuries, ST-12: 2/00.

AMA

AMWA

APA

DAHI

NMA
- Policy# 340.1, Violence Prevention Curriculum in Schools.
REFERENCES


LACUNAE

An interesting judicial decision

We have often argued that responsibility for injury prevention involves many jurisdictions. In a recent court decision in Canada, the court appeared to agree. The case of a child who was rendered paraplegic following a car crash was influenced by the Walking Security Index developed by Professor Wellar, which takes account of road features, traffic volume, and driver compliance with traffic laws in rating intersections for pedestrian security. Accordingly, the $12 million award in damages was based on the jury’s conclusion that the city was 45%, the driver 35%, and the former police chief 20% responsible for the “accident” (submitted by Barry Pless).

On jaywalking...

The implication of the term “jaywalking” is that the individual is not showing sufficient “respect” for the power of motor vehicles and the frequency of lapses in attention of those piloting them.

“…it is all about the asymmetry of power on our streets (which) ... results in the law requiring pedestrians always ... to yield to motorists (and cyclists). In fact, “in many jurisdictions, it is not enough for the pedestrian to yield; crossing anywhere without an active or passive ‘control’ is simply forbidden even if there is no ‘traffic’ ... to make the crossing dangerous” (abridged from Pednet). (Submitted by Barry Pless, who notes that all of this is a pity because he remains convinced it is safer to cross mid-block than at intersections with lights or stop signs that are not adequately enforced.)