Reframing Gun Violence

In western movies, the ol’ doc usually shows up toward the end, after the real men have shot it out at high noon. The doc is not a central character; he (always he) stays away from the action until it’s over, then patches people up as best he can.

The results of a survey published in this issue suggest, however, that when it comes to gun violence, most internists and surgeons are no longer comfortable in a passive, peripheral role (1). More specifically, most physicians who responded to the survey agree that gun violence is a public health problem. Most also agree that various actions, some involving regulation and legislation, some involving clinicians directly, can and should be taken to break the cycle of gun violence. Despite these perceptions, however, only a small proportion of the physicians surveyed say that they now actually counsel patients about preventing firearms-related injury and death. (Pediatricians, it should be noted, have been actively counseling families on gun violence for at least 6 years [2, 3].)

Gun violence isn’t the only form of trouble that has made the transition from nonmedical cause to medical issue. Alcoholism, narcotic abuse, domestic violence, and use of tobacco were once considered the province of the courts, the church, or society at large, not medicine. But all have been reframed to a greater or lesser extent in medical, or at least public health, terms (4). In many respects, even physical activity, food, and sex have been progressively “medicalized” in recent years.

Is this good? Some people don’t think so. Social critic Ivan Illich, for one, has raged against the medicalization of so much of human activity (5). What bothers this 20th-century Rousseau is that medicalization, in his view, destroys the natural ability of individual persons to cope with adversity and to heal themselves. Medicalization, he asserts, deadens people’s native sans culottes wisdom, infantilizes them, suppresses their autonomy, and erodes support by their community. All of this happens to satisfy the needs of huge and sinister mega-interests, both commercial (medicine as a commodity) and professional (medicine as a guild).

Others take a very different view, holding that medicalization has been important in improving a number of difficult situations. Take alcoholism:

Once a criminal offense, it has subsequently been seen as a spiritual, then a moral, then a social problem. And although these other views still cling to it, alcoholism is now considered substantially a medical problem—an actual disease—with the usual genetic, biological, chemical, and social dimensions. This mental model has profoundly affected the way in which alcoholism is handled. To be sure, effective management of alcoholism includes attention to its social and spiritual dimensions; alcohol counselors and Alcoholics Anonymous are critical participants in the best treatment programs. But thinking about alcoholism in medical terms has arguably contributed in concrete, positive ways to its understanding and control (6).

Reframing gun violence as a medical issue obviously seizes on the destructive side of gun use, but reframing does not automatically make all gun ownership and use pathological any more than considering alcoholism a disease automatically makes all alcohol use suspect. In that connection, it isn’t surprising to learn from the survey that physicians who grew up with guns in the family are less inclined to see guns as a menace (1); familiarity breeds equanimity. (Guns are, of course, specifically designed to kill; indeed, danger—that is, power—is one of their principal attractions. Gun use therefore differs from most other medicalized issues in terms of social necessity and usefulness, an issue that goes well beyond the scope of this editorial.) The problem, of course, is that gun use (like use of alcohol and sex and automobiles) so easily gets out of control, becoming a deadly risk rather than an instrument of social order and cohesion. Here is where things get complicated: enter denial, political interests, and money.

Have internists and surgeons really begun to think of gun violence as a public health problem in a meaningful way? After all, medical schools and the clinicians they produce have never been very receptive to the public health perspective. Counseling to prevent firearms violence received only a single paragraph out of nearly 1000 pages in the 1996 U.S. Preventive Services Task Force’s Guide to Clinical Preventive Services (7). It is possible, therefore, that most respondents in the survey hadn’t ever consciously considered gun violence as a public health issue, although they were apparently willing to do so when explicitly asked about it in those

This paper is also available at http://www.acponline.org.
terms. Judging from their low rate of preventive clinical practices on gun violence, respondents may not, in fact, have reframed the problem in their own minds before the survey. But even if most internists and surgeons are already convinced that firearms are a medical and public health problem, most have not yet managed to make the leap from belief to practice.

Belief–practice gaps are common, particularly in complex and difficult areas, such as smoking, risky sexual behavior, domestic violence, physical inactivity, and atherogenic diets. The gaps exist partly because medical schools and residency programs have provided little effective training in these areas (although, in fairness, this is beginning to change). Lack of training not only deprives trainees of important skills but also sends a strongly negative social message: that the care of such problems is not a part of "real" medicine. But gaps between belief and practice also exist because there are no magic bullets (so to speak) for problems like gun violence; there are no penicillins that will prevent or cure smoking, risky sexual practices, or any other behaviors gone awry. On the contrary, dealing effectively with the growing array of socially and emotionally loaded behavioral issues now dropped in physicians’ laps is hard, frustrating work. It requires sharing expertise and control with members of a multifaceted care group; it demands efficient communication, energy, and time. Pulling together the resources for such complex, integrated care has never been easy, and the dynamics of managed care may not be making the task any easier (8).

Does it matter whether physicians see gun violence as a medical or public health issue? We don’t know yet. But if the only change that comes from reframing gun violence as a medical issue is that internists and surgeons begin actively counseling their patients regularly on gun safety, the effect on firearm violence could be substantial. Our patients looked at us strangely in the 1970s when we began asking them whether they used seat belts. “What’s that got to do with my medical condition?” But clinicians kept at it, and seat-belt counseling, along with improved seat-belt technology and mandatory seat-belt laws, is now seen as part of good preventive practice (although here, too, pediatricians seem to be ahead of internists and surgeons [9]). The story is much the same with smoking, sexually transmitted diseases, and other difficult behavior-related health issues. Committed preventive clinical practice and rational public policy work, and they seem to work synergistically. As suggested by the policy paper from the American College of Physicians (10), in this issue, there is no a priori reason why this same synergy can’t be found when it comes firearms violence.

What would westerns be like if gun violence had been reframed as a medical issue 150 years ago? Instead of appearing at the end to bind up wounds and close the eyes of the dead, the ol’ doc would probably call the gunslingers into his (or her) office early in the story for some down-home but serious counseling on conflict resolution and gun safety. Medicalized westerns like that would, of course, be dead on arrival at the box office. But then, movie actors get up and go home after they are killed or wounded on the set; victims of real gun violence wind up in real physicians’ offices, real hospitals, real morgues.

What’s wrong with this all-too-real picture? Looks like it needs some reframing.

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Editor

Note: For further information and resource materials from the American Academy of Pediatrics on counseling for gun violence, readers should contact Allison Rand, Division of Child and Adolescent Health, American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, IL 60007-1098; telephone 847-981-9979; fax 847-228-5097.


References


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