

A PUBLIC HEALTH CRISIS: THE GUN VIOLENCE EPIDEMIC IN AMERICA

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED SIXTEENTH CONGRESS FIRST SESSION

OCTOBER 3, 2019

Serial No. 116-68



Printed for the use of the Committee on Energy and Commerce
govinfo.gov/committee/house-energy
energycommerce.house.gov

U.S. GOVERNMENT PUBLISHING OFFICE

43-411 PDF

WASHINGTON : 2022

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²The report has been retained in committee files and also is available at <https://docs.house.gov/meetings/IF/IF14/20191003/110968/HHRG-116-IF14-20191003-SD008.pdf>.

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THURSDAY, OCTOBER 3, 2019

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to call, at 9:35 a.m., in the Great Hall at Kennedy-King College, 6301 South Halsted Street, Chicago, IL, Hon. Anna G. Eshoo (chairwoman of the subcommittee), presiding.

Members present: Representatives Eshoo, Rush, Schakowsky, Butterfield, Clarke, Kelly, and Kinzinger.

Also present: Representatives Danny K. Davis and Jesús G. “Chuy” García.

Staff present: Stephen Holland, Health Counsel; John Marshall, Policy Coordinator; Aisling McDonough, Policy Coordinator; Rebecca Tomilchik, Staff Assistant; CJ Young, Press Secretary; Lauren Citron, Legislative Assistant, Rep. Rush; Jeremy Edwards, Communications Director, Rep. Rush; Nishith Pandya, Legislative Director, Rep. Rush; Yardly Pollas, Chief of Staff, Rep. Rush; Robyn Wheeler-Grange, District Director, Rep. Rush; Michael Brady, Press Assistant, Rep. Eshoo; Osaremen Okolo, Health Policy Advisor, Rep. Schakowsky; Kristen Shatynski, Minority Professional Staff Member; Paul Laurie, Minority Legislative Assistant, Rep. Kinzinger; Austin Weatherford, Minority Chief of Staff, Rep. Kinzinger; and Lanette Garcia, Legislative Assistant, Rep. García.

Ms. ESHOO. Good morning, everyone.

The Subcommittee on Health will now come to order. Before we begin, per an agreement between the majority and the minority, I would like to ask for unanimous consent for the House Members who are with us today who are not members of the committee, that they be recognized for 3 minutes to ask questions after committee members have asked theirs.

And note, only committee members will be allowed to make opening statements. Hearing no objections, so ordered.

The Chair now recognizes herself for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

First of all, thank you, everyone, for being here this morning. It is an honor for those of us that are not from Chicago to be here.

I am Anna Eshoo. I have the honor of chairing this subcommittee, and I have many relatives in Chicago. So this is the Midwestern part of my family, and it is an honor to be here with my colleagues on a very serious issue.

This is the very first Energy and Commerce Committee hearing on the gun violence epidemic in our country as a public health issue, and this subcommittee has jurisdiction over public health issues in our country.

I want to recognize first the members of the committee who represent parts of Chicago and the region, starting with Congressman Bobby Rush, whose district we are in.

Thank you, Bobby, very much for inviting us—asking the subcommittee to come here.

Congresswoman Robin Kelly, who is here to my left; Congresswoman Jan Schakowsky from the Chicago region; and to Representative Adam Kinzinger, who is also a representative here from the State of Illinois, a little farther away—I think next door to Robin.

Mr. KINZINGER. Yes. Yes.

Ms. ESHOO. And Mr. Kinzinger makes this hearing a bipartisan hearing, and we are grateful to him for being here today for his leadership and the leadership of each Member that is here today.

We are also grateful to have with us, and we welcome our congressional colleagues who are guests of the committee today, Representative Danny Davis, whom I always say is the voice of God when you—

[Laughter.]

Mr. RUSH. Yes.

Ms. ESHOO [continuing]. Hear that magnificent voice of his, and Chuy García, who is here; the vice chair of the Energy and Commerce Committee, Congresswoman Yvette Clarke; and I already mentioned Congresswoman Jan Schakowsky.

Now, on this—on the subject matter that is before us today, it is important to note that 100 Americans are killed by a gun and hundreds more are shot and injured every day in our country. Millions of Americans have watched in horror to see the shootings and the massacres that have taken place in our country.

They have watched families bury their loved ones, and there are too many that live in fear of what could happen next, and some are here with us today.

They are in the audience, they are at the witness table, and they are on the dais as Members of Congress. Congressman Rush buried his son as a result of gun violence.

I think this collective heartbreak will move us to work with real purpose. We are here to treat American gun violence for what it is: an epidemic.

And to treat an epidemic, we have to study it, we have to understand what works to prevent it, and we need to learn how to treat the trauma that is caused by it.

We know that a public health approach can work. Consider antismoking efforts, or preventing injuries from car crashes. We have achieved lifesaving results through funding data analysis, encouraging research, and adopting commonsense product improvements with these epidemics.

Another simple yet profound and proven method is listening to people from the communities most affected by an epidemic and the public health it represents.

We are here in Chicago's South Side, where so many have lived with the epidemic of gun violence and for decades. Thank you, again, Congressman Rush, for inviting our committee to hold this hearing in your district and for your years of work to address gun violence.

Gun homicide is the leading cause of death for African-American boys and men ages 15 to 34, and it is the second-leading cause of death for Hispanic boys and men ages 15 to 34 as well.

African-American men make up 52 percent of all gun homicide victims despite only being 7 percent of the population of our country.

Compared to the rate of gun homicides for white boys and men of the same ages, the rate for African Americans is 21 times greater, and the rate for Hispanic men is nearly four times greater.

Notably, the communities most impacted by gun violence are the most knowledgeable about how to treat it and prevent it.

It is why our witnesses include Mr. Spencer Leak, Sr., owner of a family-run funeral home in the Chatham neighborhood, who has comforted hundreds if not thousands of families whose loved ones have been killed by a gun.

It is why we are listening to Pastor Brenda Mitchell and Mr. Norman Kerr, who have taken their experiences with gun violence and used them to promote commonsense, evidence-based policies.

And it is why we are hearing from the physicians who work every day to heal the physical, mental, and generational trauma from shootings and who see the bodies that are ravaged by gun violence.

Today's hearing will not be enough to stop the daily violence. But we can broaden our understanding of how best to treat this epidemic and provide resources for public health research.

I am proud that the House voted to provide \$50 million for gun violence research at the CDC and the NIH, and the Senate needs to do the same.

I want to thank Congresswoman Robin Kelly, a leader on the issue of gun violence and for introducing—

[Applause.]

Ms. ESHOO. Sure, you can applaud. Every Member welcomes that. It is a validation of our work.

I want to thank her for introducing H.R. 1114, and this is legislation that requires the U.S. Surgeon General to provide an annual report to Congress on the public health impacts and the—you can applaud—and the costs of gun violence in America.

And I hope that our hearing today helps that bill come closer to become law. So thank you, Congresswoman Robin Kelly.

Again, I thank each of my congressional colleagues. It is a special honor to join with you here today in Chicago. I want to thank each one of our witnesses for your professionalism and your willingness to be here with us today, and everyone else that has joined us. Those that are in the audience, thank you for being here today.

Collectively, I think your presence and your testimony is going to fuel our action.

[The prepared statement of Ms. Eshoo follows:]

PREPARED STATEMENT OF HON. ANNA G. ESHOO

Welcome to the very first Energy and Commerce hearing on gun violence as a public health issue.

First, I'd like to recognize the members of the committee who represent the Chicago region: Representative Bobby Rush whose district we are in, Congresswomen Robin Kelly and Jan Schakowsky, and our Republican colleague, Representative Adam Kinzinger, thank you for your leadership and for participating in this hearing today.

We're grateful to and welcome our Congressional colleagues who represent the Chicago region and are guests of the Committee today: Representatives Danny Davis, Sean Casten, and Chuy Garcia.

One hundred Americans are killed with a gun and hundreds more are shot and injured every day. Millions of Americans have seen a shooting, buried a loved one, or live in fear of what could happen next, and some are here with us today.

They are in the audience, they are at our witness table, and they are on the dais as Members of Congress.

Your heartbreak moves us to work with purpose.

We're here to treat American gun violence for what it is—an epidemic, and to treat an epidemic, we must study it, understand what works to prevent it, and learn how to treat the trauma caused by it.

We know that a public health approach can work. Consider antismoking efforts or preventing injuries from car crashes. We've achieved life-saving results through funding data analysis, encouraging research, and adopting commonsense product improvements with these epidemics.

Another simple yet profound and proven method is listening to people from the communities most affected by the public health threat.

We're here in Chicago's South Side where so many have lived with the epidemic of gun violence for decades. I thank Congressman Bobby Rush for inviting our committee to hold this hearing in Chicago and for his years of work to address gun violence.

Gun homicide is the leading cause of death for Africa-American boys and men ages 15 to 34, and the second-leading cause of death for Hispanic boys and men ages 15 to 34.

African-American men make up 52% of all gun homicide victims, despite only being seven percent of the U.S. population.

Compared to the rate of gun homicides for white boys and men of the same ages, the rate for African Americans is 21 times greater, and the rate for Hispanic men is nearly four times greater.

Notably, the communities most impacted by gun violence are the most knowledgeable about how to treat and prevent it.

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And it's why we're hearing from the physicians who work every day to heal the physical, mental, and generational trauma from shootings and see the human beings whose bodies are ravaged by gun violence.

Today's hearing will not be enough to stop the daily violence. We need to provide money for public health research.

I'm proud the House voted to provide \$50 million for gun violence research at the CDC and NIH. The Senate needs to do the same.

I want to thank Congresswoman Robin Kelly for introducing H.R. 1114, legislation that requires the U.S. Surgeon General to provide an annual report to Congress on the public health impacts and the costs of gun violence in America. I hope our hearing today helps that bill come closer to being law.

Again, I thank each Member of Congress, our witnesses, and our audience for joining us today. Your presence and testimony will fuel our action.

Ms. ESHOO. I now have the privilege of recognizing the gentleman from Illinois, Mr. Rush, for his opening statement.

OPENING STATEMENT OF HON. BOBBY L. RUSH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. RUSH. I want to thank you, Madam Chairman, and my friend from the great state of California. You and I were sworn in together in Congress back in January of 1993, and we have enjoyed each other and had our—our friendship has flowed all the way to this day and including this day.

I want to thank you for convening this important hearing and discussion right here in my district in the Kennedy-King College.

Kennedy-King College is, in some sense, apropos for a discussion on nonviolence in that both John F. Kennedy and Robert F. Kennedy and Dr. Martin Luther King, Jr., were killed by gun violence.

Gun violence, Madam Chairman, is indeed a national epidemic. Gun violence undermines the public health and the public safety of all of our communities.

This epidemic has had painful consequences for far too many families here in Chicago, including my own family. Far too many families in my district and similarly situated districts all across the country have felt these painful consequences.

Madam Chairman, you mentioned my son, whose name was Huey. Huey's murder was 10 years ago this very month. The anniversary of his murder was October 31st.

So we are—10 years later, we are still fighting, still wanting to try to resolve this matter of—this epidemic of gun violence in our Nation.

Madam Chair, way back in 2017 I started calling more hearings such as this to take place here in my district. Important conversations are going on in Washington, DC.

But just as important if not more so is that we are having these conversations right here in a community that for too long has felt the pain of this epidemic.

It is for this very reason that I am pleased that we are finally convening today this hearing to discuss this public health crisis, this epidemic of gun violence.

And I want to thank all of my colleagues on both sides of the aisle for being here today, and I want to thank the witnesses who have come out at their own expense, sacrificing their own time and resources, to bear testimony at this hearing.

And, Madam Chairman, I am confident that during today's hearing we will be able to shine a light on the public health impacts of gun violence, and I am optimistic that we will walk away and conclude this hearing with tangible ideas and solutions that will protect our communities in the future from this widespread and totally unrecognized epidemic.

This epidemic gun violence is not just a law enforcement issue, Madam Chairman. It is a healthcare crisis in our Nation, and as you stated earlier, it is an epidemic that we must address as an epidemic in our Federal Government.

Madam Chairman, I look forward—Madame Chairwoman, I look forward to hearing from today's witnesses, and with that said, I ask for unanimous consent to insert in the record the testimony of an individual who appeared at a hearing that I had in Washington.

That was an unofficial hearing, but I had a hearing at the Library of Congress almost 2 years ago where Dr. Megan Ranney, an

emergency physician, a violence prevention leader, and the chief research officer of affirmed research in the country's only nonprofit institution dedicated to solving gun violence through the public health approach.

Madam Chairman, I want to submit with unanimous consent her testimony for the record.

Ms. ESHOO. So ordered.

[The information appears at the conclusion of the hearing.]

Mr. RUSH. And, Madam Chairman, with that I yield back the balance of my time, and again, thank you for your participation and your leadership on this and on the issue in our Congress.

Ms. ESHOO. The gentleman yields back.

Let me just say on behalf of my colleagues we are all very, very grateful to the faculty, to the entire team here at Kennedy-King, for your hospitality, for your warm welcome, for the coffee when we came through the door and had this morning.

Let me just say that the two words, Kennedy and King, will always be a source of inspiration to each one of us, and how fitting it is that we are having this hearing in an institution of learning.

It is now my pleasure to recognize the gentleman from Illinois, Adam Kinzinger, for his 5 minutes and his opening statement.

OPENING STATEMENT OF HON. ADAM KINZINGER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. KINZINGER. Well, good morning, everybody, and for our witnesses, thank you very much for being here. Chairwoman Eshoo, thank you for making the trip, and to all my colleagues, I really appreciate you all being here.

I may be outnumbered today, but I assure you there is a 100 percent turnout of Republicans from northern Illinois.

[Laughter.]

Mr. KINZINGER. So yes. Let me—

[Applause.]

Mr. KINZINGER. One of the other things I want to make very clear, because you don't get to see this a lot when you watch TV and stuff, most of us here—I think all of us get along really well. We actually respect each other.

Unfortunately, you just see the times we argue and debate, and you assume that it is like that all the time. We actually like each other, and if I don't like somebody it is not because of their politics. It is maybe because they are a jerk. But nobody here fits that bill.

But I think that is important for me because I want to say this. You know, I think when we get into these debates, whether it is guns or gun violence, a lot of the times both sides just retreat to their corner and mistrust each other in a conversation and they assume the worst of what folks are saying, and in some cases people may mean the worst when they make a position.

But I think this is—while we are never going to agree at whatever the end result is in the near future, I think there are a lot of areas we can agree, and I think if we can begin to talk to each other again and respect each other again and listen to each other again, I think we will be able to make some progress, and that is why I am here.

I am actually here not to debate my points and not to argue. I am here to listen. I am here to listen to the people of this community, to learn more about what is working and what more we can do at the Federal level to help remedy some of these issues.

You know, whether it is a small town or a big city across the Nation, Americans are terrified by the mass shootings they have seen that have, sadly, become a regular occurrence.

Too often, though, our attention to gun-related violence focuses more on the mass shootings, and hardly any goes to the steady, devastating strings of violence and daily killings that happen here in Chicago and elsewhere, and frankly, I am horrified each week when I see the number of people shot or killed over the weekend in Chicago or when I get a notification on my phone about an active shooter. This is our community, and we need to work together to stop this violence.

As a Congressman, I feel the heat on all ends of this debate, as all my colleagues do here, and I see the validity of both sides of the conversation.

We, clearly, have a gun violence epidemic here in America, and I want to work with my colleagues on both sides of the aisle to find solutions that will reduce suicides, drug-related violence, gang violence, and mass shootings.

While the larger gun debate continues, I believe there are many areas we can find agreement, and it is our duty to do so. And today I look forward to hearing from our distinguished panel of witnesses about what more we can do to address this problem.

During this hearing, I am interested in discussing the community aspect of the gun violence crisis. I believe this component is at the heart of a lot of issues we face.

I know there have been community initiatives in Chicago, including job training, youth-based programs and support groups, which have made a significant impact.

These programs that are often formed by the community and for the community have shown how critical of a role communities can play in addressing this crisis.

We really need to make sure we are paying attention to these programs and replicate them when they are successful. I am also interested in the mental health aspect of gun violence and what we can do in Congress to ensure we provide the tools necessary to address this component of the problem, such as improving access to community health centers and those needing medical help.

But we can't legislate a heart, and that is where community and religious organizations come into play. They can help guide and give people hope for a better future.

If you don't have hope and you don't have any reason to follow a moral code or fear the results of your action, tragedy, in many cases, follows.

Desperation can be a dangerous trigger, and to the extent we can work on helping and healing those who are struggling and end the stigma of discussing and facing mental illness in this country, I fear things may only get worse.

In discussing the desperation and hopelessness, we come to the issue of suicide. In 2017, 60 percent of gun-related deaths were suicides, and here in Illinois 1 person dies by suicide every 6 hours.

In the age of technology and instant gratification, more and more people are feeling less connected. They feel isolated and hopeless, and it is an issue we need to resolve as a society.

Kids today feel that their self-worth depends on the number of likes or comments or snaps they get in a given day, and that is a concern to me.

So, as we get into these different issues surrounding gun violence, I want to reiterate it is a complex problem that requires a comprehensive, holistic approach.

I am grateful to our subcommittee for holding this hearing today and especially to our panelists for being here to share their experience, their expertise, and insight as we look at the root cause of this violence and work together to find real solutions to address the gun violence epidemic.

With that, I yield back.

[The prepared statement of Mr. Kinzinger follows:]

PREPARED STATEMENT OF HON. ADAM KINZINGER

Good morning, everyone. I'd like to thank the chairman and staff for organizing today's hearing in Chicago, and the witnesses for taking the time to discuss some of the outside factors at play in the public health aspect of the gun violence crisis we face as nation.

I'm here to listen to our witnesses and the people of this community to learn more about what's working and what more we can do at the Federal level to help remedy some of these issues.

Across the country, from small towns to big cities, Americans have been terrified by the mass shootings that have sadly become a regular occurrence.

Too often, our attention to gun-related violence focuses more on the mass shootings and hardly any goes to the steady, devastating strings of violence and daily killings that happen here in Chicago, just north of my hometown.

Frankly, I am horrified each week when I see the number of people shot and/or killed over the weekend in Chicago or when I get a notification on my phone about an active shooter in our area. This is our community and we need to work together to stop this violence.

As a Congressman, I feel the heat on all ends of this debate, and I see the validity of both sides of the conversation.

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These programs that are often formed by the community and for the community, and have shown how critical of a role communities play in addressing the crisis.

We really need to make sure we're paying attention to these programs and replicate them when they are successful.

I'm also interested in the mental health aspect of gun violence, and what we can do in Congress to ensure we are providing the tools necessary to address this component of the problem, such as improving access to Community Health Centers for those needing medical help.

But we cannot legislate the heart. And that's where the community and religious organizations come into play. They can help guide and give people hope for a better tomorrow.

If you don't have hope, you don't have any reason to follow a moral code or fear the results of your actions.

Desperation can be a dangerous trigger, and to the extent we can work on helping and healing those who are struggling, and end the stigma of discussing and facing mental illness in this country, I fear things may only get worse.

In discussing this desperation and hopelessness, we come to the issue of suicide.

- In 2017, 60% of gun-related deaths in the U.S. were suicides.
- And here in Illinois, one person dies by suicide every six hours.

In the age of technology and instant gratification, more and more people are feeling less connected—they feel isolated and hopeless, and it's an issue we need to resolve as a society. Kids today feel their self-worth depends on the number of likes or comments or snaps they get in a given day, and that's a real concern to me.

As we get into the different issues surrounding gun violence today, I want to reiterate that this is a complex problem that requires a comprehensive, holistic approach.

I'm grateful to our subcommittee for holding this hearing today and especially to our panelists for being here to share their expertise, experience, and insight as we try to look at the root causes of this violence and work together to find real solutions to address the gun violence epidemic.

Ms. ESHOO. The gentleman yields back.

It is now—the Chair would like to recognize Mr. Butterfield, the vice chairman of the full committee, for his 5 minutes for an opening statement. A pleasure to recognize you.

OPENING STATEMENT OF HON. G. K. BUTTERFIELD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH CAROLINA

Mr. BUTTERFIELD. Thank you very much, Madam Chair. I know Ms. Clarke may not take too kindly to that. She is the vice chair of the full committee. I am vice chair of the subcommittee. Thank you.

Ms. ESHOO. You just got a raise.

Mr. BUTTERFIELD. I know. Thank you.

[Laughter.]

Mr. BUTTERFIELD. But let me join Congressman Rush and Congressman Kinzinger for—join with them in thanking you for your incredible work on this subcommittee.

You promised us months ago that you would have this field hearing, and you have fulfilled that commitment, and so we thank you very much.

It is good to be with my colleagues, particularly those from Illinois, and my good friend, Bobby Rush, who sits to my right, and I understand that we are physically in your congressional district. So thank you for your work.

Madam Chair, the gun violence epidemic in America can no longer be ignored. We must treat this epidemic for what it is. It is a public health crisis, and that is why we are here today.

Democrats in the House recognize this crisis, and we are determined—yes, we are—we are determined to take some action.

With that said, Madam Chair, I would like to yield 2 minutes to my friend from Illinois, Congresswoman Kelly.

Ms. ESHOO. Are you yielding?

Mr. BUTTERFIELD. I was going to yield Congresswoman Kelly some time if she is not on the schedule to do an opening statement. She is on the schedule? Reclaiming my time.

[Laughter.]

Ms. ESHOO. Now, don't lose the time.

Mr. BUTTERFIELD. I just didn't want to—I just didn't want to leave my friend out—Ms. Kelly—because she works so hard.

But for too long, Madam Chair, we have handcuffed the Federal Government from researching the affliction of gun violence in America and its impacts on public health.

We need to marshal the resources of the Department of Health and Human Services and the CDC to know the impact—the huge impact—that gun violence is having on kids right here in Chicago and our neighbors all across the country.

We need to know how they will be impacted throughout their lives after they witness their loved ones get gunned down in the streets or committing suicide with the assistance of a firearm.

We need to know why the homicide rate in America is more than 25 times the average of other developed nations. We are going to face the gun violence epidemic head on, and today's hearing will help us in that fight.

I now want to yield time to Ms. Schakowsky, since she is on the second tier. But she is nonetheless a very strong and forceful leader in this area.

Ms. Schakowsky?

Ms. SCHAKOWSKY. I thank the gentleman for yielding.

So we heard that number—an average of a hundred people a day. That adds up. If you multiply it by 365, 36,500 people a year dying from guns. In Chicago, as of Sunday 2,101 people shot and 382 killed.

This is a crisis. It demands a sense of urgency right now. We are raising the profile right now today, but we need action.

So, you know, in Chicago and in Illinois we have good laws on guns. But 60 percent of the guns that come into our State come from other States across the border.

You can go to Indiana on a weekend and go to a gun show, open up your trunk, and load up that car with any kind of gun that you want, and drive across the border. We don't stop people.

I want to thank not only our panel, but I see people in the audience with red shirts, moms against gun violence. Moms—thank you so much.

[Applause.]

Ms. SCHAKOWSKY. I see people that are here that want to help us. They deserve our help. And on the panel, let me just thank Pastor Mitchell, especially because of the feeling of a mom, not only as an expert now, on this to bring that.

And I want to—Mr. Leak, a friend of mine—when we are talking about the number of people killed, I said, “Think about if it were a virus, what would we be doing? We would be searching for that.” And he said, “Well, what about if it were terrorism?” He said, “We would be at war.”

This is a war that we have to win. Children are hiding in bathtubs in their homes to seek refuge from bullets that may come through.

So this is an opportunity and an obligation today to actually move ahead.

Thank you. I yield back. I thank the gentleman for yielding to me.

Mr. BUTTERFIELD. Thank you. Madam Chair, I yield back.

[Applause.]

Ms. ESHOO. The gentleman yields back.

I now would like to recognize the gentlewoman from Illinois, Congresswoman Robin Kelly, for her statement, and with thanks for your work as well.

OPENING STATEMENT OF HON. ROBIN L. KELLY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Ms. KELLY. Thank you, Chairwoman Eshoo, and thank you for your leadership in this area, and I want to welcome all of my colleagues to Chicago and thank all of the witnesses for taking their time to be here.

But thank you for holding this important hearing on gun violence as a public health crisis. Thank you to all of my colleagues. As I said, really appreciate you being here. By being here you are showing your commitment to solutions that will end our Nation's gun violence epidemic.

Congresswoman Schakowsky talked about the statistics—over 35,000 people, and the number of people in the Chicagoland area. Like nationwide statistics, a disproportionate number of these victims are young African-American men. Specific to the public health threat posed by gun violence, I have introduced, as you have heard, H.R. 1114, legislation to require the Surgeon General, our Nation's doctor, to submit an annual report on the impacts of gun violence on public health.

In 1964, the Surgeon General issued this report, "Smoking and Health." That report sparked a revolution in thinking about tobacco use, smoking, and public health.

In 2019, it is time for this Surgeon General to issue a report on gun violence. In addressing the public health impacts of gun violence, we cannot be limited to the immediate impacts of bullets on the human body.

We know that gun violence takes an emotional and psychological toll on communities. In some parts of my district, young people experience levels of PTSD on par with returning veterans because of regular gun violence.

Simply addressing easy access to guns will not solve all the challenges in these communities. Decades of systemic underinvestments and disinvestments in schools, transportation, businesses, and public spaces coupled with residential segregation by race has created a divided city—a divided city in which gun violence is largely concentrated in black and brown communities that are underserved, underresourced, and, for some, wary of law enforcement.

As a member of this subcommittee and chair of the Congressional Black Caucus Health Braintrust, I am dedicated to finding solutions that improve the health of all communities across the country. This includes preventing gun violence.

As I said, gun violence impacts our society in various ways, and not only does it take a toll on our healthcare system, it also negatively impacts our economics and reduces worker productivity.

A recent study on gun violence found that loss of quality of life, psychological and emotional trauma, decline in property values, and other legal and societal consequences stemming from gun violence cost an estimated \$174 billion.

Of that cost, the Government directly absorbs \$12 billion. Instead of using these funds to invest in our communities, workers, and

their families, these dollars are bled away due to gun violence and its impacts.

I always say nothing stops a bullet like an opportunity. In order to combat gun violence and help these communities rebuild, they need investment.

In this Congress I have introduced several pieces of legislation to improve economic opportunities in underserved areas, including Creating Pathways for Youth Employment Act, Heroes for At-Risk Youth, and Community College to Career Fund Act.

For the past several Congresses, I have also introduced the Urban Progress Act that would also help to fill this void in economic opportunities, strengthen police-community relations, and promote commonsense gun violence prevention policies.

I look forward to the witnesses' testimony and, again, welcome. And I yield back.

Ms. ESHOO. The gentlewoman yields back.

The Chair reminds Members that, pursuant to committee rules, all Members' written opening statements shall be made part of the record.

I now would like to introduce the witnesses for today's hearing.

To my left, Pastor Brenda Mitchell. She is the mother of Kenneth D. Mitchell, Jr. Welcome to you and thank you for being here with us today.

Dr. Selwyn Rogers, Jr., chief, section for trauma and acute care surgery, and founding director, the Trauma Center, University of Chicago Medicine. Welcome to you, and thank you for joining us here today.

Dr. Ronald Stewart, director of trauma programs, American College of Surgeons Committee on Trauma. Traveled from Texas to be with us here today.

Mr. Norman Kerr, director of violence prevention from the city of Chicago. Thank you for joining us today.

Mr. Spencer Leak, Sr., the president and CEO of Leak and Sons Funeral Home. He has a real story to tell.

And last but not least, Dr. Niva Lubin-Johnson, immediate past president of the National Medical Association. Thank you to you.

Thank you to each witness. We look forward to your testimony and now, at this time, the Chair recognizes each witness for 5 minutes.

We will begin with Pastor Brenda Mitchell. I think that you are probably familiar. Do we have the lighting system there?

Yes. Green—you know what green means. Yellow, caution. When the red light comes on, full stop.

All right. You are probably wondering why that doesn't apply to Members of Congress.

[Laughter.]

Ms. ESHOO. But anyway, so thank you again, and the Chair is pleased to recognize Pastor Brenda Mitchell for your 5 minutes of testimony.

STATEMENTS OF BRENDA K. MITCHELL, PASTOR AND MOTHER OF KENNETH D. MITCHELL, JR.; SELWYN ROGERS, JR., M.D., CHIEF OF TRAUMA AND ACUTE CARE SURGERY, UNIVERSITY OF CHICAGO MEDICINE; RONALD M. STEWART, M.D., MEDICAL DIRECTOR, COMMITTEE ON TRAUMA, AMERICAN COLLEGE OF SURGEONS; NORMAN LIVINGSTON KERR, DIRECTOR OF VIOLENCE PREVENTION, CITY OF CHICAGO; SPENCER LEAK, Sr., PRESIDENT AND CHIEF EXECUTIVE OFFICER, LEAK AND SONS FUNERAL HOME; NIVA LUBIN-JOHNSON, M.D., IMMEDIATE PAST PRESIDENT, NATIONAL MEDICAL ASSOCIATION

STATEMENT OF BRENDA K. MITCHELL

Ms. MITCHELL. Thank you.

Good morning to this esteemed body, to Everytown Survivor Network for allowing me to be here, to the moms of Mom Demand Action and Purpose Over Pain, who has also given me my voice. I also recognize Spencer Leak, Sr., who was the recipient of my son's burial service and given me a voice also on Black-on-Black love.

I am Pastor Brenda Mitchell. I live in University Park, Illinois. I have lived and worked in the Chicago area most of my life.

Today I am here as someone who has experienced two family members taken by gun violence—my brother and my son. Today I am here as a voice for my son.

I am here as a voice for my community. I am here on behalf of the hundreds of mothers who have had their children torn from their lives by gun violence.

My son, Kenneth, was the center of our family. He was the first grandchild on both sides of the family and became a role model for his younger siblings and cousins.

At the age of 31, he was a single parent of two little boys, 8 and 6, and another son who would be born 30 days after his death.

It was Super Bowl weekend. As the manager of a golf center in University Park, he was hosting a Super Bowl party on Sunday. His boys were with their mother, so he took the rare opportunity that evening to spend some time with friends at a local sports bar, playing darts and enjoying each other's company.

As Kenneth was leaving, an argument broke out between two individuals outside of the bar. Kenneth intervened, attempting to diffuse the situation and make peace, when a friend of one of the individuals went to his van, grabbed a gun, and started randomly firing into the crowd.

Kenneth was struck by a stray bullet and killed. I received a call in the middle of the night that no parent wants to receive. I was told my son, Kenneth, had been hurt in a shooting and he was lying at the scene with a sheet over him.

I could not tell my husband his son, his namesake, our first-born child, was dead. Earlier that day, I distinctly remember feeling so satisfied with my life, and I thanked God for meeting my needs and the needs of my family. I could not ask for anything.

Little did I realize that in less than 24 hours I would have to ask God for strength.

After Kenneth's death, I felt for the first time in our lives that my family was dysfunctional. My son was a crime scene. I could

not touch him. The pain was so intense that I would not wish this experience on my own worst enemy.

Even worse was trying to navigate through it with no resources. I was traumatized with nowhere to go.

Just a week before Kenneth's death, our younger son, Kevin, left for his third tour of duty in Afghanistan. This is the kind of thing that a mother worries about.

I prayed for Kevin, placed him on the altar, and in my mind he was the one who was in danger. I never would have imagined Kenneth would be the one to die from an act of gun violence right here at home in a free country.

A week later, I brought Kevin back to bury his brother in a free country. My life shows that trauma. Post-traumatic stress syndrome and grief have lasting effects in the lives of those that are touched by gun violence.

However, I learned these terms and the impact on health. Even if I didn't know what it was called, I knew how it felt and I saw the effect it had on my life and the lives of surviving family members.

My mother could not handle after losing her first grandson, to gun violence, after the death of her own son. My mother willed herself out of her pain. She died from a broken heart.

I myself had to leave a successful career because of PTSD and trauma. I lost cognitive memory. I did not know my phone number or the names of people very close to me.

I still struggle to recall the date of my son's death. This is not because the date is not significant to me, but because it is a manifestation of that trauma.

I almost died three times with extreme hypertension and narrowing of the arteries in my brain because of the level of stress I was under. I was grieving for my son, raising my grandsons left without their primary parent.

I had to look at my youngest grandson and know that he would never meet his father. I had to recreate his father for him. There are no words that communicate the depth of that loss. How many young men and women have we lost who will never have the chance to reach their full potential?

Every day there are communities being shattered by the devastation that is this crisis of gun violence. We have children in Chicago who aren't worried about growing up to be a doctor or a lawyer. They are just worried about growing up, period.

That reality is unacceptable. In my own journey—and I am almost done—I have come full circle. I identify with the devastation families experience every day in our country and in Chicago.

It has become my passion to help others understand how trauma of gun violence can affect individuals and communities. I have become an advocate for trauma-informed care, and I will do whatever I can to help others so that they don't have to experience what I have gone through.

It is so important that families like mine who have been deeply impacted by gun violence to keep telling their stories. If we keep shining the light on the impact of gun violence, then our children's deaths are no longer in vain.

I thank you for allowing me to humbly submit this testimony.

[The prepared statement of Ms. Mitchell follows:]

Testimony of Pastor Brenda K. Mitchell

**On "A Public Health Crisis:
The Gun Violence Epidemic in America"**

United States House Committee on Energy and Commerce

October 3, 2019

Good morning, Chairwoman Eshoo and members of the Committee on Energy and Commerce. It is an honor to appear before you today to tell my story and to testify on gun violence as a public health crisis.

My name is Pastor Brenda K. Mitchell and I live in University Park, Illinois. I have lived and worked in the Chicago area most of my life. Today, I am here as someone who has experienced two family members taken by gun violence: my brother and my son. Today, I am here as a voice for my son. I am here as a voice for my community. I am here on behalf of the hundreds of mothers who have had their children torn from their lives by gun violence.

My son, Kenneth, was the center of our family. He was the first grandchild on both sides of the family and became a role model for his younger siblings and cousins. At the age of 31, he was the single parent of two little boys, and another son who would be born thirty days after his death.

It was Super Bowl weekend and Kenneth was the manager at a golf center in University Park, a suburb of Chicago. He was busy that weekend getting ready for a Super Bowl party he was hosting on Sunday. His boys were with their mother, so Kenneth took the rare opportunity that evening to spend some time with friends at a local sports bar—playing darts and enjoying each other's company.

As Kenneth was leaving, an argument broke out between two individuals outside of the bar. Kenneth intervened, attempting to diffuse the situation and make peace, when a friend of one of the individuals went to his van and grabbed a gun and started randomly firing into the crowd. Kenneth was struck by a stray bullet and killed.

I got a call in the middle of the night that no parent wants to receive. I was told my son Kenneth had been hurt in a shooting and he was lying at the scene with a sheet over him. I could not tell my husband his son, his namesake—our firstborn child—was dead.

Earlier that day, I distinctly remember feeling so satisfied with my life, and I thanked God for meeting my needs and the needs of my family. I could not ask for anything. Little did I realize that in less than 24 hours our lives would never be the same and I would have to ask God for strength.

After Kenneth's death I felt for the first time in our lives that my family was dysfunctional. My son was a crime scene, I could not touch him. The pain was so intense that I would not wish this experience on my worst enemy. What was even worse was trying to navigate through it with no resources. I was traumatized with nowhere to go.

Just a week before Kenneth's death, our younger son, Kevin, left for his third tour of duty in Afghanistan. This is the kind of thing that makes a mother worry. I prayed for my other son Kevin and placed him on the altar. In my mind, he was the one who was in danger. I never would have imagined Kenneth would be the one to die from an act of gun violence, right here at home in a free country. After witnessing death firsthand, a week later I brought Kevin back to bury his brother in a free country.

My life shows that trauma, Post Traumatic Stress Disorder (PTSD) and grief have lasting effects in the lives of those who are touched by gun violence. However, I learned these terms and their impact on my health and my family over time because the concept of "trauma" had not been spoken of in my community or identified as a root cause. Even if I didn't know what it was called, I know how it felt and I saw the effect it had on my life and the lives of my surviving family members.

I mentioned earlier that my brother died by gun violence. I witnessed my mother mourn my brother who was shot and killed. She could not handle losing her first-born grandson to gun violence after the death of her own son. My mother willed herself out of her pain. She died from a broken heart.

I myself had to leave a successful career because of PTSD and trauma. I lost cognitive memory. I did not know my phone number or the names of people I am very close to. I still struggle to recall the date of my son's death. This is not because that date is not significant to me but because it is a manifestation of trauma.

I almost died three times from extreme hypertension because of the level of stress I was under. I was grieving for my son and raising my grandsons left without their primary parent. I had to look at my youngest grandson who was born 30 days after my son Kenneth's death and know that he would never meet his father. I had to recreate his father for him. There are no words that can communicate the depth of that loss.

We know that 58 percent of American adults or someone they care for have experienced gun violence in their lifetime. Every day, 100 Americans are killed with guns and hundreds more are shot and wounded. Every day there are more mothers like me who mourn for their children. Every day, there are more children, like my grandsons, who learn their parent will never be coming home to love and care for them.

How many young men and women have we lost who will never have the chance to reach their full potential? Every day, there are communities being shattered by the devastation that is this crisis of gun violence. We have children in Chicago who aren't worried about growing up to be a doctor or a lawyer—they are just worried about growing up, period. That reality is unacceptable.

In my own journey, I have come full circle. I identify with the devastation families experience every day in our country and in Chicago. It has become my passion to help others understand how the trauma of gun violence can affect individuals and communities. I have become an advocate for trauma-informed care, and I will do whatever I can to help others, so they don't have to experience what I have gone through.

It is so important for families like mine, who have been so deeply impacted by gun violence, to keep telling our stories. If we keep shining a light on the impact of gun violence, then our

children's deaths will not be in vain. They are still speaking. We are that light that shines in the midst of darkness.

The country is at a crossroads. Americans are demanding action to reduce gun violence, and Congress has an opportunity to do something about it. No one law will stop all gun violence, but there are common-sense, widely supported steps we can take NOW to make our families safer. The House of Representatives is doing its part. It passed a number of bipartisan measures to reduce gun violence--including strong background checks legislation--and I am hopeful the House will soon vote on The Disarm Hate Act, a strong red flag law proposal, and prohibiting high-capacity magazines. The Senate is still refusing to act. It's time for the Senate to do its job and pass background checks on all gun sales and strong red flag legislation and lastly let's begin the narrative around Trauma Informed Care. We are the walking wounded with sore that will never heal.

My story illustrates the price of inaction. I appreciate the opportunity to be with you today and thank you for listening to my story. I will answer any questions you may have.

Ms. ESHOO. Pastor Mitchell——

[Applause.]

Ms. ESHOO. Pastor Mitchell, thank you for the courage you have exhibited today in coming here to tell your story, which is just riddled with just tremendous grief. Thank you. We really hold you in our debt.

I now would like to recognize Dr. Selwyn Rogers, Jr., and thank you for being here today to be a witness. You have 5 minutes for your testimony.

STATEMENT OF SELWYN ROGERS, JR., M.D.

Dr. ROGERS. Good morning. Thank you very much, Chairwoman Eshoo, and the entire Subcommittee on Health. I want to thank all of you, including Bobby Rush, for all that you do to continue to keep Chicago and America safe.

We are honored to have you here in Chicago and appreciate the time you are spending to understand the devastating toll violence has on the lives of Americans, and the steps you and Congress can do to help protect our children, our families, and our country.

My name is Selwyn Rogers, and I serve as a professor of surgery and chair of trauma and acute care surgery at the University of Chicago Medicine.

In my work, I lead a dedicated staff of specialists who care for people who have been traumatically injured. In my own location in the South Side of Chicago, we sit in the epicenter of much of our city's gun violence.

When we think of gun violence in the United States, we often think of tragic events such as mass shootings in Dayton, Ohio, or El Paso, Texas.

However, in Chicago, every day we see smaller examples that are no less devastating. We see a 22-year-old man driving with his girlfriend shot and killed in a carjacking. His crime—he owned a nice car. His name was Alexis Andrade.

We see a 36-year-old mother of three shot and killed in front of her children at a cell phone store. Her name was Candice Dickerson.

We see the 11-year-old girl killed by a stray bullet in her living room while she planned her birthday party the next day. Her name was Kentayvia Blackful.

At our hospital at the University of Chicago Medicine, we work to the absolute limits of our abilities every day to save people like these.

But far too often the bullets lead to death, despite all of our efforts. When that happens, we have a moment of silence to mourn the loss.

However, we know that that moment will soon be pierced by screams of anguish and sometimes anger at a life that has been extinguished way too soon.

The loved ones plea to tell us that their daughter, their son, their significant other is not dead. They ask me, "How could this happen? Why did this happen?"

I have no answers. But answers are exactly what we need. I am here to testify today that we collectively need to find answers to

the intentional gun violence that has killed over 14,000 Americans in 2017, the data that is most recently available.

In addition, as we also noted, over 23,000 Americans were killed by gun suicides last year. In February of this year, I joined a medical summit of more than 40 professional organizations that agreed upon a united statement on the impact bullets have on the health of people.

My colleague Dr. Ron Stewart, to my left, will elaborate on these in his remarks. We must understand this violence is a public health issue and a public health crisis, and as such we should address it with the same urgency that we do for Ebola or any other disease we know we can treat.

Because when we do that, when we look at gun violence as a disease, that means it can be treated and it can be cured. If we make a true, meaningful investment in our communities, we can address some of the holistic issues that have created this gun violence epidemic.

Consider, for example, that the unemployment rate in our South Side coverage area is more than 5 times the national average, or that 43 percent of children of color here live in poverty, more than double the State average, or that South Side residents suffer significantly higher rates of chronic health conditions such as asthma and diabetes, breast cancer and HIV.

In this unhealthy environment, where day-to-day life is a constant struggle, where homelessness and hopelessness are all too common, is it any wonder that there is such a high rate of gun violence?

To address this, we need to develop evidence-based solutions and invest in research to address these root issues. Federal, State, and city dollars need to be dedicated to the study of improved prevention efforts.

Beyond that, we have to invest in remedying the social factors such as education disparities and lack of economic opportunities that are often at the root base of gun violence.

While these measures will take years to enact and take effect, there are a number of programs that can be invested in now. Violence interruption programs such as Cure Violence or the Institute for Nonviolence Chicago use community outreach workers to help prevent retaliatory violence. Hospital-based violence intervention programs such as at the University of Chicago Medicine and other medical centers throughout Chicago have been shown to reduce recidivism.

These efforts are all aimed at secondary prevention. But we must also focus on primary prevention initiatives so that people are not injured in the first place. I know that gun violence feels like an overwhelming problem. I have seen the pain with my own eyes. I have wiped the blood from my own hands.

Yet, I am still hopeful because I know that, if we take concrete actions and we do the small things that make big changes, we can change the tide of violence that has become way too common and such a devastating problem for so many in our communities and in our Nation.

Thank you for the opportunity for this testimony.
[The prepared statement of Dr. Rogers follows:]

Selwyn Rogers Speech to Congress

Good morning.

I want to start by thanking the Committee and our own Congressman Bobby Rush for the work you have done and continue to do to keep Chicago and America safe. We're honored to have you here in Chicago today and appreciate the time you are spending to understand the devastating toll gun violence is taking on the lives of Americans, and the steps you in Congress can take to help protect our children and our country.

Thank you for this opportunity to present at this congressional testimony. My name is Selwyn Rogers, Jr, and I serve as a Professor of Surgery and Chief of Trauma and Acute Care Surgery at The University of Chicago Medicine.

In my work, I lead a dedicated staff of specialists who care for people who have been traumatically injured. Given our location on the South Side of Chicago, we sit in the epicenter of much of Chicago's gun violence.

When we think of gun violence in the United States, we tend to think of the horrific recent mass shootings in places like Dayton, Ohio, or El Paso, Texas.

But in Chicago, we see smaller examples that are no less devastating.

- We see the 22-year-old man driving with his girlfriend, shot and killed in a carjacking. His crime: He owned a nice car. His name is Alexis Andrade.
- We see the 36-year-old mother of three shot and killed in front of her children in a cellphone store. Her name is Candice Dickerson.
- We see the 11-year-old girl killed by a stray bullet in her living room while she planned her birthday party the next day. Her name is Kentavia Blackful.

At my hospital, we work to the absolute limits of our abilities to save people like these. But far too often, the bullets lead to death despite all of our efforts. When that happens, we have a moment of silence to mourn the loss.

As the trauma surgeon, I know that that moment will soon be pierced by screams of anguish — and sometimes anger — at a life that has extinguished too soon. The loved ones plead to tell us that their daughter, their son, their significant other is not dead. They ask me: "how could this happen? Why did this happen?" I have no answers.

But answers are exactly what we need.

I am here to testify today that we, collectively, need to find answers to the intentional gun violence that killed over 14,000 Americans in 2017. In addition, over 23,000 gun suicides occurred that year.

In February of this year, I joined a medical summit of more than 40 professional organizations that agreed upon a united statement on the impact bullets have on the health of people. The summit recommended utilizing public health as the framework to confront, understand and treat this disease.¹

Quoted here is the summary of recommendations from this report:

- *Recognize* firearm injury as a U.S. public health crisis, and take a comprehensive public health and medical approach to address it.
- *Research* this public health crisis using a disease model, and call for research funding at federal and philanthropic levels commensurate with the burden of the disease on society.
- *Engage* firearm owners and communities at risk as stakeholders to develop firearm injury prevention programs.
- *Empower* the medical community across all health-care settings to act in the best interests of their patients in a variety of palpable ways, including counseling patients on safe firearm storage; screening patients at risk for firearm injury or death; and engaging the community in addressing the social determinants of disease, through hospitals and health-care systems.
- *Commit* professional stakeholder organizations to ensure that these statements lead to constructive actions for improving the health and well-being of our nation.

We must understand this violence as a public health crisis. And as such, we should address it with the same urgency as polio, Ebola, or any other disease we know we can beat.

Because when we do that — when we look at gun violence as a disease — that means it can be treated. And it can be cured.

If we make a true, meaningful investment in our communities, we can address some of the holistic issues that have created this gun violence epidemic.

Consider that the unemployment rate in our South Side coverage area is more than five times the national average. Or that 43% of children here live in poverty — more than double the state average. Or that South Side residents suffer significantly higher rates of chronic health conditions, such as asthma, diabetes, breast cancer, and HIV.

In this unhealthy environment, where day-to-day life is a constant struggle, where homelessness and hopelessness are all-too common, is it any wonder that we see problematic behavior?

To address this, we need to develop evidence-based solutions that address these root issues. Federal state and city dollars need to be dedicated to the study of improved prevention efforts.

Beyond that, we have to invest in remedying the social factors such as educational disparities and lack of economic opportunities that are often at the base of gun violence.

While these measures will take years to enact and take effect, there are a number of programs that can be invested in now. Violence interruption programs, such as Cure Violence or the Institute for Nonviolence Chicago, use community outreach workers to help prevent retaliatory violence. Hospital-based violence intervention programs have also been shown to reduce recidivism.

At our hospital, we have developed a program that employs people with similar lived experiences who serve as connectors to our patients and families. They help connect our patients to wraparound services including vocational training, mental health counseling, and other social services.

These efforts are aimed at secondary prevention. But we must also invest in primary prevention initiatives so that people are not injured in the first place. Because I know that gun violence feels like an overwhelming situation. I have seen the pain with my own eyes, I have cleaned the blood from my own hands.

Yet I am still hopeful. Because I know that, if we take concrete actions, if we do the small things that make big changes, we can stem the tide of violence that has become such a devastating problem in our country.

Thank you.

1. Bulger, and al. et M. Eileen. "Proceedings from the Medical Summit on Firearm Injury Prevention: A Public Health Approach to Reduce Death and Disability in the US." *Journal of the American College of Surgeons* 229, no. 4 (2019) :415 - 430.e12 .

Ms. ESHOO. Thank you, Dr. Rogers.

Now it is a pleasure to recognize Dr. Ronald Stewart for your 5 minutes of testimony, and thank you for being with us and traveling a distance to do so.

STATEMENT OF RONALD M. STEWART, M.D.

Dr. STEWART. Thank you, Chairwoman Eshoo, and members of the subcommittee. Thank you for inviting the ACS to participate. It is an honor to follow a hero and colleague of mine, Dr. Selwyn Rogers.

I would also like to thank the leadership and staff of Kennedy-King College for their terrific hospitality.

The ACS is based out of Chicago, and we are also very grateful for the invitation. For 96 years, the American College of Surgeons has worked to comprehensively improve the care of injured patients in areas such as EMS, trauma centers, disaster response systems, and this has resulted in dramatic improvements in care and outcomes for our patients.

For the past 5 years, we have focused much of our efforts on implementing a durable public health approach to reduce firearm violence and to increase the resilience of our country and the health of our patients.

The ACS represents those who care for the patients who suffer from firearm injuries. The hardest part of my work is trying to explain to the family of a child, a child who is the very embodiment of the future of that family, a child who was completely normal at breakfast, is now dead.

For those in this audience who have lost loved ones—Pastor Mitchell, Representative Rush—I know my pain pales in comparison to yours. But I want you to know that we, the American College of Surgeons, are committed to let no one die or suffer in vain.

And we know that by working together we can prevent injury and violence, and we are driven to make this goal a reality.

Over the course of the 5 years, we developed our strategy around three guiding principles.

One, address firearm violence as a public health and medical problem, not a political problem. This means focusing our attention on serving humanity and basing our actions on scientific truth as best we can determine it.

Two, search for evidence-based violence prevention programs and best practices with the goal of implementing these programs through our network of 554 trauma centers across the U.S.

What do we mean by implementing evidence-based violence prevention programs? Is it possible to prevent or cure violence? Well, yes, it is.

For those who believe that this is really too difficult a task, to me, it is definitely not more difficult than managing a complex viral epidemic. With the will, it is possible to prevent and cure violence.

But to get this right requires the full commitment of all medicine along with partnerships at the local, State, and Federal levels. The people who are right now here, this community, communities across the United States who are working to make this a goal, to

make this goal a reality, need our full support and our full commitment.

Three, foster and provide a forum for a collegial civil dialogue centered on reducing unnecessary death and suffering related to firearm injury.

In a very interesting way, this principle has led us to realize that achieving the goals of the first two are not as difficult as we initially thought.

I told you the hardest thing about my job. I also know your job is difficult. We, the voters, send you conflicting and mixed messages. But I have learned that the message on firearm violence is not as conflicting and mixed as many would guess if we can actually talk about the problem.

We have been intentionally inclusive in our discussions. I have probably talked to more people in medicine on both sides of the political firearm debate than anyone. I presented and talked with people from Texas and from California, from Chicago and from Little Rock, Arkansas.

We have extensively surveyed ourselves and are surveying medical organizations. We have held town halls. We have put together a working group of surgeons who are also serious firearm owners.

This group produced a set of recommendations which they call the Chicago Consensus One. These recommendations are included in my written testimony, and I ask you to carefully review these recommendations to give you a real feel for what we can do when we work together.

In February, as Dr. Rogers noted, we hosted a historic medical summit on firearm injury prevention in Chicago. This summit consisted of the largest medical and public health organizations in the United States, 47 leading medical organizations.

The group identified many opportunities to collaborate in the areas of research, education, target injury prevention initiatives. These 47 all support nine consensus-based recommendations published this month in the Journal of American College of Surgeons.

Our written testimony includes this entire document, which I ask you to also carefully consider because it provides a comprehensive overview of what we mean by a public health approach.

Wrapping up, intentional violence is the most neglected health problem in America, and firearm violence is a public health crisis.

But I am optimistic. If we commit to addressing intentional violence in the same way we did with motor vehicle-related injury and death five decades ago, we can and we will make dramatic progress.

This means working together to, one, make firearm ownership as safe as reasonably possible for those who own firearms and for those who do not; two, work together to understand and address the root causes of violence.

In summary, this is the core of a public health approach to firearm injury prevention. As I said, I am optimistic. While our country currently appears paralyzed by political polarization, we hope that our recent work of building consensus among a range of diverse stakeholders and then moving to action provides a hopeful guide.

We do understand there is not a simple solution to complex problems. But we also know if we use the power of partnership, innovation, science, these complex problems are completely manageable and, yes, even curable.

We are fully committed to working with you. Thank you very much for the opportunity to present today.

[The prepared statement of Dr. Stewart follows:¹]

¹Additional material submitted by Dr. Stewart has been retained in committee files and is available at <https://docs.house.gov/meetings/IF/IF14/20191003/110968/HHRG-116-IF14-Wstate-StewartR-20191003-SD004.pdf>.



**Statement of the
American College of Surgeons**

Presented by

Ronald M. Stewart, MD, FACS

**Before the
Subcommittee on Health of the Committee on Energy and Commerce
United States House of Representatives**

RE: A Public Health Crisis: The Gun Violence Epidemic in America

October 3, 2019

Chairwoman Eshoo, Ranking Member Burgess, and Members of the Subcommittee, on behalf of the more than 82,000 members of the American College of Surgeons (ACS), I wish to thank you for inviting the ACS to participate in this hearing. The ACS is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and improve the quality of care for all surgical patients. The College is dedicated to the ethical and competent practice of surgery. Its achievements have significantly influenced the course of scientific surgery in America and have established it as an important advocate for all surgical patients. As surgeons caring for patients who have suffered traumatic injury as a result of firearm violence, we are honored to share our perspective on preventing firearm violence at this hearing on *A Public Health Crisis: The Gun Violence Epidemic in America*.

I am a trauma surgeon and serve as the Medical Director of the Committee on Trauma (COT) within ACS. For 96 years, the COT has worked to comprehensively improve the care of injured patients in areas such as EMS, trauma centers, and disaster response systems, resulting in dramatic improvements in care and outcomes. While we work on all issues related to the treatment and prevention of traumatic injury, for the past five years, we have focused much of our efforts on implementing a public health and medical approach to reduce firearm violence in order to improve the health of our patients and the resilience of our Country.

A public health crisis, firearm violence accounted for 39,773 U.S. deaths in 2017 (the latest year available) and continues to be a leading cause of death for individuals 10–24 years old.¹ The age-adjusted death rate due to firearm injury by all intents, after remaining stable for several years, increased by 17% percent since 2014.² The U.S. Centers for Disease Control and Prevention (CDC) data shows that deaths from firearm injury accounted for almost 17 percent of all injury-related deaths in 2014.³

¹ Center for Disease Control and Prevention: National Center for Health Statistics. Available at: <https://www.cdc.gov/nchs/fastats/injury.htm>

² Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018. <https://wonder.cdc.gov/controller/saved/D76/D66F943>

³ Centers for Disease Control and Prevention: National Vital Statistics Reports, Volume 65, Number 4. Deaths: Final data for 2014. Available at: www.cdc.gov/nchs/data/mvstr/mvstr65/mvstr65_04.pdf.

- Of the 39,773 people who died as a result of firearm-related injury, 23,854 people died as a result of suicide (60%).
- 14,542 people died as a result of homicide (36.6%). 553 people died as a result of legal intervention (1.4%).
- 486 people died as a result of unintentional discharge of a firearm (1.2%). 338 people died from the use of a firearm where the intent was undetermined (0.9%).

Through a public health and medical approach, significant progress has been made in reducing the incidence of death from other injuries. As an example, and in contrast to firearm related injury, motor vehicle crash death rates have decreased by more than 20% while firearm violence death rates have increased by more than 20% since 1999.⁴

In addition to the public health costs, firearm-related injuries add significant financial burdens to the U.S. health care system and result in reduced productivity of U.S. workers. According to the National Violent Death Reporting System (NVDRS), in 2010 the medical costs for the approximately 30,000 people killed by firearms were an average of \$5,891 per person and nearly \$186.6 million overall.⁵ The 38,500 injured individuals who survived firearm-related injuries but required hospitalization accrued nearly an additional \$852.9 million and more than \$3 billion in lost wages.⁵ This number is likely a significant underestimate due to the limitations in tracking this data. Another group of patients whose injuries were less severe and were discharged without inpatient admission had medical and lost wages expenses totaling an additional \$200 million.⁵

ACS Action

Given the number of firearm related injuries trauma surgeons see, the ACS has had a statement on reducing firearm injury since 1991. In light of the pervasiveness of gun violence and the dramatic increase in frequency

⁴ Stewart RM, et al. Freedom with Responsibility: A Consensus Strategy for Preventing Injury, Death, and Disability from Firearm Violence *Journal of the American College of Surgeons*. 2018; 227(2):281-283

⁵ Centers for Disease Control and Prevention. National Violent Death Reporting System. Available at: www.cdc.gov/injury/wisqars/nvdrs.html.

of mass firearm-related murders, the ACS believes a comprehensive public health solution is necessary. We did not come to this opinion based on our personal beliefs or political affiliations. We came to this recommendation following decades of study and five years of collective effort, inclusive dialogue and research regarding firearm-related injury.

Over the course of 5 years, the ACS COT developed its consensus strategy around 3 guiding principles:

1. Advocate and promote a public health approach to firearm injury prevention;
2. Implement evidence-based violence prevention programs through the network of ACS COT-verified trauma centers; and
3. Provide, foster and promote a forum for civil dialogue within our own professional organization with the goal of moving toward a consensus on programs or intervention aimed at reducing firearm injuries and deaths.⁶

Through this dialogue, we came to realize that the community of firearm owners are often approached as a part of the problem, but less commonly approached as a part of the solution. As a part of the public health model, community and stakeholder engagement strategies for public health interventions are a core step in implementation and are recommended by major international public health organizations. The degree of community engagement can make a critical difference in efficacy or lack of efficacy of a public health program. As such, in November of 2018, the American College of Surgeons Committee on Trauma Firearm Strategy Team (FAST) Workgroup released a set of 13 recommendations aimed at achieving an effective and durable strategy for reducing firearm injury, death, and disability in the United States.

ACS Committee on Trauma and the FAST Workgroup

The FAST Workgroup represents a diverse group of 22 surgeons, 18 of whom are passionate and expert firearm owners with a broad range of experience with firearm ownership and use. The membership makeup included hunters, sport shooters, self-defense proponents, a law enforcement professional, surgeons with previous military experience and ACS leadership from a geographically representative sample from across the country.

⁶ Stewart, R.M., Kuhls, D.A., Rotondo, M.F., and Bulger, E.M. Freedom with responsibility: a consensus strategy for preventing injury, death, and disability from firearm violence. *J Am Coll Surg*. 2018; 227: 281–283

In the *Recommendations from the American College of Surgeons Committee on Trauma's Firearm Strategy Team (FAST) Workgroup* 13 recommendations are put forth as an advisory perspective, developed by strict consensus among the FAST Workgroup. All 22 surgeons needed to agree on a recommendation before it could be included in the final set. The FAST Workgroup acknowledges that it does not represent the views of all firearm owners, or all surgeons for that matter, but it does strongly believe that action on these recommendations will increase public safety and decrease deaths without a decrease in liberty. This was the first of recommendations from this workgroup that is continuing to meet with the goal of implementing measures which would preserve freedom, while simultaneously making our Country safer, stronger and healthier.

In developing our FAST Workgroup recommendations, we did not just create new policy recommendations, we also closely considered the value of better enforcement of existing laws and strengthening current statutes and regulations, many of which are viable ways to keep firearms away from people who endanger themselves or others. We acknowledge that better enforcement requires additional resources and support across communities, and we encourage further support for existing programs.

The final article published in the Journal of the American College of Surgeons (JACS) describes the FAST Workgroup's approach and methods, and summarizes consensus recommendations for strategies and tactics to increase firearm safety, reduce the probability of mass shootings, reduce firearm-associated violence, address mental health factors, and encourage federally funded firearm injury research, while preserving the right to own and use a firearm. The article of recommendations is attached to the end of this statement and I encourage you review it.

Reaching Broader Consensus

The ACS works closely with our physician community colleagues, and like-minded organizations, who are dedicated to addressing this public health crisis. The number of professional organizations supporting addressing the crisis as a major public health initiative continues to grow. The ACS was a co-author with 8 of the largest professional organizations in the country in 2015 and contributed to a follow-on report in 2019, both published in the *Annals of Internal Medicine*. In these articles, we highlighted the rising number of firearm-related deaths each year, classified firearm-related violence as a public health crisis, and reiterated ACS' support for being part of the solution to reducing the number of firearm-related injuries and deaths.^{7,8}

The ACS partners with organizations committed to improving and advancing research related to firearm injury and firearm injury prevention. We work in concert with the Coalition for National Trauma Research (CNTR) and the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM). These organizations along with the ACS are committed to making a real difference in advancing the state of science, reducing needless firearm injury and improving the care of the victims of firearm violence.

Medical Summit on Firearm Injury Prevention

In a historic meeting on February 10th and 11th of this year, the ACS hosted 44 organizations for a Medical Summit on Firearm Injury Prevention.⁹ The attendees met to identify opportunities for the medical community to reach a consensus-based, non-political approach to firearm injury prevention. The discussions were focused on understanding and addressing the root causes of firearm violence while making firearm ownership as safe as possible.⁹ The group identified opportunities to collaborate in the areas of research, education, and targeted injury prevention initiatives. Forty-seven of the leading medical, public health and injury prevention

⁷ Weinberger SE, Hoyt DB, Lawrence HC, Levin S, Henley DE, Alden ER, et al. Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association. *Ann Intern Med.* ;162:513–516. doi: 10.7326/M15-0337

⁸ McLean RM, Harris P, Cullen J, et al. Firearm-Related Injury and Death in the United States: A Call to Action From the Nation's Leading Physician and Public Health Professional Organizations. *Ann Intern Med.* [Epub ahead of print 7 August 2019] doi: 10.7326/M19-2441

⁹ Bulger EM, Kuhls DA, Campbell BT, et al. Proceedings from the Medical Summit on Firearm Injury Prevention: a public health approach to reduce death and disability in the US. *J Am Coll Surg.* 2019. [PMID: 31108194] doi:10.1016/j.jamcollsurg.2019.05.018

organizations in the country support nine consensus-based recommendations which were published this month in the Journal of the American College of Surgeons.¹⁰

The objectives of this summit were to:

1. Identify opportunities for the medical community to reach a consensus-based, non-partisan approach to firearm injury prevention;
2. Discuss the key components of a public health approach and define interventions this group will support;
3. Develop consensus on actionable items for firearm injury prevention using the public health framework.

47 organizations support the following:

1. Firearm injury in the US is a public health crisis.
2. A comprehensive public health and medical approach is required to reduce death and disability from firearm injury.
3. Research is needed to better understand the root causes of violence, identify people at risk, and determine the most effective strategies for firearm injury prevention.
4. Federal and philanthropic research funding must be provided to match the burden of disease.
5. Engaging firearm owners and populations at risk is critical in developing programs and policies for firearm injury prevention.
6. Healthcare providers should be encouraged to counsel patients and families about firearm safety and safe storage. Educational and research efforts are needed to support appropriate culturally competent messaging.
7. Screening for the risk of depression, suicide, intimate partner violence, and interpersonal violence should be conducted across all healthcare settings and in certain high-risk populations (such as those

¹⁰ Bulger EM, Stewart RM. Opinion: A public health approach reduced deaths from car crashes. It can do the same for gun violence. SEP. 13, 2019. <https://www.latimes.com/opinion/story/2019-09-13/public-health-approach-gun-violence-deaths-firearms>

with dementia). Comprehensive resources and interventions are needed to support patients and families identified as high risk for firearm injury and who have access to a firearm.

8. Hospitals and healthcare systems must genuinely engage the community in addressing the social determinants of disease, which contribute to structural violence in underserved communities.
9. Our professional organizations commit to working together and continuing to meet to ensure these statements lead to constructive actions that improve the health and well-being of our fellow Americans.

At its core, the foundation of medicine, surgery and public health rests on two key principles: A dedication to the service of humanity, and a commitment to base our actions on objective scientific truth as best we can determine it. This approach absolutely requires addressing a public health crisis that claims the lives of 39,773 Americans as a public health problem with the resources necessary to avert this health problem. To effectively address this crisis requires a common, nonpartisan approach. This approach is facilitated by a common narrative regarding preventing firearm injury, disability and death. This common narrative acknowledges two facts that firearm ownership is a constitutionally protected right, and we have a major firearm injury and violence problem.

We can significantly reduce unnecessary death and suffering by a commitment to work together to

- 1) make firearm ownership as safe as reasonably possible (for those who own firearms and for those who do not), while 2) working to understand and address the root causes of violence in America. This is the essence of a public health approach to reduce preventable firearm deaths and injuries. The ACS knows a public health and medical approach saves lives, and strongly believes (based on both data and previous experience) the number of firearm related deaths can be reduced through federally-funded firearms research and support for non-partisan public health and medical policies, such as those advocated for by the Firearm Strategy Team of the American College of Surgeons Committee on Trauma and 47 of the leading medical, public health and injury prevention organizations in the Country. Those forty-seven medical, public health and injury prevention organizations are

continuing to work together to address this problem and are committed to working with you to make our patients and communities safer and stronger.

The ACS FAST Workgroup continues to work on strategies to make firearm ownership as safe as possible. A second, related ACS Committee on Trauma workgroup (Improving Social Determinants of Health to Attenuate Violence, I-SAVE), is working to develop strategies to better understand and meaningfully reduce violence in vulnerable communities. The I-SAVE workgroup is committed to working with vulnerable communities as a part of the solution to this public health crisis and addressing structural violence with the goal of significantly reducing harm to our patients and their communities. We will implement these strategies through our network of 554 ACS verified trauma centers across the United States, and we are committed to working with policy makers at the federal, state and local areas to reduce unnecessary death and suffering as a result of firearm related injury.

Conclusion

Firearm violence is a major public health problem in the U.S. It is a public health emergency and it requires a public health approach. The ACS represents surgeons who care for the patients who suffer, die and are survivors of firearm injuries. We understand that there is no simple solution to these problems and that the issues are complex, but we also know, if we use the power of medical science, technology, innovation and partnership, these complex problems are completely manageable and even curable. While our country appears currently paralyzed by the political polarization of these issues, we hope that our recent work of reaching consensus with a broad range of stakeholders provide a hopeful guide that solutions can be reached if all parties come to the table and focus their efforts on working together to reduce unnecessary injury, death and suffering.

A good starting point to implement a durable, nonpartisan and effective national strategy to reduce firearm related deaths and injuries would be to begin to implement the FAST Workgroup recommendations along with the recommendations supported by almost every single medical and public health organization in the United

States. Making firearm ownership as safe as possible while working to understand and address the underlying causes of violence in America is inclusive of both political parties' approaches to this problem. It really requires no significant compromise and is supported by a very large majority of Americans. The time is now to do this, and it can be done across philosophic and party lines. If we respect and listen to each other, we can find a clear path forward that will preserve and enhance freedom, while making our Country safer, stronger, healthier and more resilient.

ATTACHMENTS:

Recommendations from the American College of Surgeons Committee on Trauma's Firearm Strategy Team (FAST) Workgroup: Chicago Consensus I

Proceedings from the Medical Summit on Firearm Injury Prevention: A Public Health Approach to Reduce Death and Disability in the US

Ms. ESHOO. Thank you very much, Dr. Stewart.

I think each one of you gives us hope with your testimony.

I now have the privilege of recognizing Mr. Kerr, who is here today. We welcome you. He is the director of violence prevention for the city of Chicago.

You have 5 minutes for your testimony, sir, and welcome.

STATEMENT OF NORMAN LIVINGSTON KERR

Mr. KERR. Thank you.

Good morning, Chairwoman Eshoo and members of the committee. So great to see you, Illinois delegation here this morning, and to be at this great campus, Kennedy-King College.

I would like to thank the committee for holding this important hearing on community responses to gun violence. Let me start by introducing myself.

My name is Norman Kerr. I am the new director of violence prevention under Mayor Lightfoot's Office of Public Safety.

Since day one, Mayor Lightfoot has been clear that her highest priority and greatest responsibility as mayor is ensuring peace and safety in all of Chicago's neighborhoods.

And each and every day since May 20th, the mayor's Office of Public Safety has been building on our comprehensive reduction strategy with the goal of measurably reducing gun violence.

Chicago finds itself in a unique period. In 2016, the city suffered a dramatic increase in shootings and homicides more severe than that experienced by any of the other 5 largest American cities over the past 25 years.

The vast majority of these homicides were committed with illegal guns. Across Chicago, communities have been devastated by the hundreds of homicides and by the thousands of nonfatal shootings that occur each year.

In addition to long-lasting trauma, estimates of the direct and indirect economic costs run to billions of dollars per year.

Since 2016, the trends have improved. Shootings and homicides have seen double-digit year-over-year decreases 2 years in a row.

In fact, over this past summer, we saw an accelerated decrease in violent crimes with June, July, and August seeing the lowest number of shooting victims since 2014.

And, while many organizations are tackling gun violence independently of city leadership through various privately funded frameworks, the experience of peer cities shows that violence reduction efforts are far more successful through effective coordination of resources, policy, and management decisions across all stakeholders.

Mayor Lightfoot's commitment to promoting safe communities and reducing gun violence is evident in her appointment of Deputy Mayor for Public Safety Susan Lee, who leads the city's first-ever Office of Public Safety.

As the mayor's point person for all antiviolence efforts, the deputy mayor is responsible for public safety oversight and operations with activities grounded in three areas:

Leading a comprehensive violence reduction strategy by collaborating with street outreach and other community-based

antiviolence organizations while also ensuring coordination with city agencies and the police department;

Guiding public safety agency operations, including Chicago Police Department, Chicago Fire Department, Office of Emergency Management and Communications, Civilian Office of Police Accountability, and Police Board, managing consent decree reform priorities, leading gun policy strategy and liaising with State and county governments.

And finally, building on data and research critical to policy decisions, including regular analysis and review of violence trends as well as evaluation of violence reduction initiatives.

As core components of its initial efforts, the Mayor's office has convened biweekly regional coordination meetings on the West Side and South Side, facilitated broad yet targeted collaboration across city agencies through monthly public safety cabinet meetings, and launched a gun stat initiative, an unprecedented collaborative effort with the U.S. Department of Justice, the Cook County State's Attorney's Office, the Office of Cook County Sheriff, and other major partners that is designed to track gun offenders in order to identify trends and strengths and address any weaknesses within the criminal justice system.

We have embarked on a proactive strategy that looks at gun violence as a public health crisis, which is what it is. While we continue to seek consistent reductions of violence crime throughout the city, Mayor Lightfoot will be the first to say we have much more work to do.

Together, we have to restitch our broken safety net. We have to work on providing wraparound services and job training in the neighborhoods that have been under siege and economically distressed for decades.

We recognize the fact that this will not be solved overnight. By investing in neighborhoods and addressing the root causes of gun violence, we can continue to make meaningful gains in public safety and communities throughout the city.

We will continue working with Chicagoans from every neighborhood and background, from block clubs and faith groups to businesses and school communities who have joined us hand in hand in our multifaceted, comprehensive approach to reducing violence in our city.

Continued improvement for the people of Chicago will also take cooperation by all levels of government. I look forward to working with this committee to further policies and programs that create and maintain safe communities for our families to thrive.

Thank you, and I look forward to continued work.

[The prepared statement of Mr. Kerr follows:]

**Testimony of Norman Livingston Kerr
before the U.S. House of Representatives
Committee on the House Energy and Commerce
Subcommittee on Health**

October 3, 2019

I'd like to thank the Subcommittee for holding this important hearing on community responses to gun violence. Let me start by introducing myself – my name is Norman Kerr, and I'm the new Director of Violence Prevention under Mayor Lightfoot's Office of Public Safety.

Since day one, Mayor Lightfoot has been clear that her highest priority and greatest responsibility as Mayor is ensuring peace and safety in all of Chicago's neighborhoods. And each and every day since May 20th, the Mayor's Office of Public Safety has been building on our comprehensive violence reduction strategy with the goal of measurably reducing gun violence.

Chicago finds itself in a unique period.

In 2016, the City suffered a dramatic increase in shootings and homicides more severe than that experienced by any of the other five largest American cities over the past 25 years. The vast majority of these homicides were committed with illegal guns.

Across Chicago, communities have been devastated by the hundreds of homicides and by the thousands of non-fatal shootings that occur each year. In addition to long-lasting trauma, estimates of the direct and indirect economic costs run to billions of dollars per year.

Since 2016, the trends have improved. Shootings and homicides have seen double-digit year-over-year decreases two years in a row. In fact, over this past summer, we saw an accelerated decrease in violent crimes – with June, July and August seeing the lowest number of shooting victims since 2014.

And while many organizations are tackling gun violence independently of City leadership, through various privately funded frameworks, the experience of peer cities shows that violence reduction efforts are far more successful through effective coordination of resources, policy, and management decisions across all stakeholders.

Mayor Lightfoot's commitment to promoting safe communities and reducing gun violence is evident in her appointment of Deputy Mayor for Public Safety Susan Lee, who leads the City's first-ever Office of Public Safety. As the Mayor's point person for all anti-violence efforts, the Deputy Mayor is responsible for public safety oversight and operations, with activities grounded in three areas:

- Leading a comprehensive violence reduction strategy by collaborating with street outreach and other community-based anti-violence organizations while also ensuring coordination with city agencies and the Chicago Police Department.
- Guiding public safety agency operations, including Chicago Police Department, Chicago Fire Department, Office of Emergency Management and Communications, Civilian Office of Police

Accountability, and Police Board; managing consent decree reform priorities; leading gun policy strategy, and liaising with State and County governments.

Building on data and research critical to policy decisions, including regular analysis and review of violence trends as well as evaluation of violence reduction initiatives.

As core components of its initial efforts, the Mayor's Office has convened bi-weekly regional coordination meetings on the West Side and South Sides, facilitated broad yet targeted collaboration across City agencies through monthly Public Safety Cabinet meetings, and launched the GunStat Initiative, an unprecedented collaborative effort with the U.S. Department of Justice, the Cook County State's Attorney's Office, the Office of Cook County Sheriff and other major partners that is designed to track gun offenders in order to identify trends and strengths, and address any weaknesses within the criminal justice system.

We have embarked on a proactive strategy that looks at gun violence as a public health crisis, which is what it is. While we continue to see consistent reductions of violent crime throughout the City, Mayor Lightfoot will be the first one to say it: we have much more work to do.

Together, we have to re-stitch our broken social safety net.

We have to work on providing wraparound services and job training in the neighborhoods that have been under siege and economically distressed for decades.

We recognize the fact that this will not be solved overnight.

But by investing in neighborhoods and addressing the root causes of gun violence, we can continue to make meaningful gains in public safety in communities throughout the city.

We'll continue working with Chicagoans from every neighborhood and background — from block clubs and faith groups to businesses and school communities — who have joined us hand-in-hand in our multifaceted, comprehensive approach to reducing the violence in our city.

Continued improvement for the people of Chicago will also take cooperation by all levels of government. I look forward to working with this Committee to further policies and programs that create and maintain safe communities for our families to thrive.

Ms. ESHOO. Thank you, Mr. Kerr, and please give the best of all of the committee members to the mayor. Thank you for being here this morning.

The Chair now recognizes Mr. Leak for his 5 minutes of testimony. Thank you for being with us.

STATEMENT OF SPENCER LEAK, SR.

Mr. LEAK. Thank you, Madam Chairman. Would it be out of order if I give honor to God, my maker, my creator, this morning, as we approach these most important hearings where —

[Applause.]

Ms. ESHOO. Amen.

Mr. LEAK [continuing]. Our congressmen, who represent us well who are here today, Congressman García, Congresswoman Schakowsky, and Cook and Davis, and my brother, Congressman Bobby Rush, who gave us the invitation to come here.

I thank you for this privilege, and I want to say to you that I am the CEO of an 85-year-old funeral service organization that no week goes by, Members of Congress, that I don't service the families of at least two gun violence victims.

I have to service them and then try to counsel them and try to answer the question that is invariably asked by the mothers and fathers of the children that I service, and that question is one word: "Why, Mr. Leak? Why?"

Of all of the families that I have serviced, one comes to mind this morning. Let me share with you. It is on March 12th, 2013. The mother and father of 6-month-old Jonylah Watkins came to our funeral home seeking our service. The city of Chicago had to lay this precious child to rest, and her death touched my heart even though I am a professional funeral director.

When I think about her short lifespan, a verse of Scripture found in the Book of Revelations, the sixth chapter and the thirteenth verse, seems to define her in a profound manner: "And the stars of heaven fell onto the Earth even as a fig tree casts her untimely figs when she is shaken by a mighty wind."

Truly, this little baby girl was an untimely fig who was not allowed to reach her potential. Her life was cut off by the mighty winds of guns and drugs causing so much death and destruction to the hearts of the future of our children—death and destruction caused by Black-on-Black gun violence. So much evil is manifested in its wake.

The challenge to all of us who live in this city as well as this Nation is to engage those mighty winds of adversity. We must reverse the tide that has seen too many figs cast out, untimely figs here in Chicago and across our Nation.

Thirty years ago, Madam Chairman, I had the honor to be the director of the Cook County Department of Corrections. Inmates coming into the jail accused of homicides were predominantly black, their perpetrators were predominantly black as well as the victims. They were abusing alcohol and drugs during the commission of the crime.

And finally, the perpetrators and the victims were known to one another. There was a relationship, and because of that relationship

the police were able to arrest the perpetrator in the majority of the instances.

Today, Madam Chairman, those circumstances are reversed. In the majority of homicides, the perpetrator has no relationship to the victim. These homicides are mostly random violence and so often render the police and the courts a challenge in seeking an arrest.

The role, I believe, of Congress must be one that recognizes that, unless in an earlier period of the life of the would-be perpetrator, they must receive some type of special crime prevention.

It is not found as it could be in the home, in the church, but it is found, in my examination, in the schools. The perpetrator and the future victims were students at one time in the Chicago public schools.

If we can create an environment that in those particular schools that teaches morals, character, good citizenship during their formative years, we will be able to save hundreds, even thousands of lives.

My brothers and sisters, you, who are Congressmen, we are depending on you today to leave Chicago knowing that you are going to do something about what plagues us as a city.

God bless you.

[Applause.]

[The prepared statement of Mr. Leak follows:]

Leak and Sons Funeral Chapels



On March 12, 2013 the mother and father of six month old Jonylah Watkins as well as the whole city of Chicago laid to rest this precious baby girl. She at her young age was caught in the cross-fire of the violence that permeates our city. Her transition touched the hearts of an entire nation and sent our city to another funeral of another precious child, one who was only six months old.

When I think about her short life span a verse of scripture found in the book of Revelation, the sixth chapter and the thirteenth verse seems to define her in a profound manner.

And the stars of heaven fell unto the earth, even as a fig tree casteth her untimely figs when she is shaken of a mighty wind.

Truly she was a beautiful untimely fig who was not allowed to reach her potential. Her life was cut off by the mighty winds of guns and drugs causing so much death and destruction to the heart of our future. Death and destruction caused by Black on Black gun violence. So much evil is manifested in its wake.

The challenge to all of us who live in this City as well as this Nation is to engage those mighty winds of adversity. We must reverse the tide that has seen too many fig trees cast out untimely figs here in Chicago and across our Nation.

Since 2002, the city of Chicago has recorded over five thousand homicides. Of those five thousand homicides the victims were predominantly black. The perpetrators were predominantly black. The victims as well as the perpetrators are all products of the Chicago Board of Education. The perpetrators are functionally illiterate, unable to read or write at their grade level when they dropped out of the Chicago public schools.

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Recently Mayor Emanuel was asked by the media to respond to the violence that permeates our city. His response was given in one word, yet a most powerful word. That word was *values*. Could that word, values, be the answer to the mystery of why our city is so victimized by gun-violence?

Could the teaching of values in our public school system be the answer to our dilemma? Is there a book where the subject of values is addressed and presented in a most profound manner? Could that book be the missing element that if included in the curriculum of our school system, is the agent of change that would cause potential perpetrators to see clearly the direction of their lives and cause them to chart a different course? That this course might lead them in another way, a way out of the quagmire of guns and violence?

2,000 years ago Pontius Pilate asked Jesus Christ a most profound question during the course of our Saviors trial. The question was; "What is truth?" Jesus did not respond since He was the truth as well as the light. However, may I answer that question with a question? The question is; "Where is truth, where can truth be found?" I'll tell you. Truth can be found in one unique book.

It is also the book where eternal values are found. That book is the Bible. That book is the reason for this letter to you my dear friend in the ministry. Can a united clergy in this city come together for the purpose of requesting that the Bible be included in the curriculum of the Chicago Public Schools? Is the Bible the Book whose time has come to be taught in our schools? Can the Mayor of our City and the Superintendant of schools withstand the power of our quest to make the greatest Book in the world a Book that will be apart of their curriculum?

Can truth, values, history and philosophy which make the Bible a remarkable book, be taught in such a way that it will change the lives of our students and cause them to turn away from guns, violence and drugs?

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Recently Mayor Emanuel was asked by the media to respond to the violence that permeates our city. His response was given in one word, yet a most powerful word. That word was *values*. Could that word, values, be the answer to the mystery of why our city is so victimized by gun-violence?

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In closing I want to state that the inclusion of the Bible into the curriculum of the Chicago Public Schools will cause values and truth to spring forth, enveloping teacher and student alike and will transform the Chicago Public Schools into an oasis of truth and values.

I know that some may question the constitutionality of the inclusion of the Bible into a government controlled school system. Will it be a violation of the establishment clause of the U.S. Constitution? It is my opinion that is not. I have included with this letter a thesis as to my opinion, that there is no violation. After reading my thesis, please let me know if you would be willing to join me in my quest to make the Bible a staple in the classrooms of the Chicago Public Schools.

Ms. ESHOO. Thank you, Mr. Leak. You have summoned us to a higher place, for sure.

I now would like to recognize, last but not least, Dr. Niva Lubin-Johnson, the immediate past president of the National Medical Association, and welcome to you and thank you for being here.

You have 5 minutes for your testimony.

STATEMENT OF NIVA LUBIN-JOHNSON, M.D.

Dr. LUBIN-JOHNSON. Thank you, and thank you, Congressman Eshoo, for the invitation this morning, to all of the Health Subcommittee members for holding this hearing today here in my hometown of Chicago.

I would especially like to thank subcommittee member Congressman Bobby Rush, who is my Congressman, as well as Congresswoman Robin Kelly, who I have had the pleasure with—working with quite frequently on a myriad of health issues dating back to when she was a State representative, and the other Chicago Congressman here today, my colleague in healthcare, the Honorable Danny K. Davis, and to Jesús García and Jan Schakowsky, also fellow natives of Chicago.

I am here today to talk about policies and solutions to the public health threat posed by gun violence, not only as a physician who has practiced internal medicine for over 30 years here in Chicago but also as the immediate past president of the National Medical Association.

NMA is the largest and oldest national organization representing African-American professionals, doing so for over 50,000 African-American physicians and our patients in the United States and its Territories.

We are the collective voice of African-American physicians and the collective voice and the leading voice for parity and justice in medicine. Gun violence has been a key issue for NMA and continues to be on the forefront this year as it was throughout my presidency.

As you know, it is one of the leading causes of death in America, where more than 39,000 people die by guns every year and 85,000 more suffer nonfatal injuries.

It costs our economy \$229 billion annually, and the cost of firearm assault injury includes work loss, medical and mental healthcare, emergency transportation, police criminal justice activities, insurance claims processing, employer cost, and decreased quality of life.

We know the statistics about what has gone on here in Chicago. Fortunately, those numbers are decreasing. But also I want to make note that Chicago per capita is not the highest city of gun violence. I believe we rank about number 15 in the country, definitely not in the top 10.

So what do we do about it? One, as mentioned before, we have got to look at where the guns come from. Sixty percent come from outside of Chicago, and we have to deal with how they get into the city.

In November of last year, the National Rifle Association had the audacity to tweet “Someone should tell self-important anti-gun doc-

tors to stay in their lane” after the American College of Physicians released a report calling this a public health crisis.

Physicians, including NMA, countered, “This is our lane,” and, as you heard, more than 40 medical organizations, including NMA, joined forces as a coalition to raise money to confront this related death and injury epidemic as a public health initiative.

It hit close to home here in Chicago after the tragic shooting of award-winning NMA member Dr. Tamara O’Neal outside of Mercy Hospital.

I, too, am on staff at Mercy Hospital and have been so for over 30 years. I didn’t know Dr. O’Neal, but I wish I had.

As you know, she was a graduate of University of Illinois and worked at Mercy Hospital. Two physicians I know closely were involved that day.

One is a urologist who saved my husband’s life—he is a prostate cancer survivor—who actually was going across the hall when he heard the shots, and another who—I will tell a little bit of my age. I am over 50, yes, and I need a colonoscopy. The first man to do that was in a room getting ready to do a procedure on a patient, had to lock himself in the room when that perpetrator knocked on the door where he was.

NMA has long been an advocate of stemming gun violence in our communities and the country at large. We are in full agreement with the American College of Physicians that gun violence and violence prevention is a public health crisis, and we believe it demands a multifaceted approach because, as we all know, as the late Carl Bell said, this is a multifaceted problem. There are different types of violence.

In 2017, we published a position paper on gun violence. In 2018, we developed a fact sheet on gun violence and advocated for it while on our Capitol Hill day during March of this year.

In July, with 10 other African-American professional organizations, we crafted a letter to all of the presidential candidates outlining gun violence as one of our top issues of concern.

On August 4th of this year, myself along with Dr. Stewart and Dr. Roger Mitchell, who is the chair of our task force, appeared on “CBS Sunday Morning” on a story about gun violence and the public health coalition that has formed as a result of that NRA tweet.

We have endorsed the House-passed H.R. 8, and we have also advocated for other pieces of legislation that have been crafted by the House of Representatives.

We call on the Federal Government to immediately convene a bipartisan commission to evaluate steps to reduce and eventually eliminate gun violence utilizing a public health approach.

Especially I would like to include in this research the fact that NMA is now surveying our four historically black medical schools to see where they can come and help in this space, but also to study the effects of lead in terms of violence and aggressiveness, but also to continue the work of Dr. Carl Bell in terms of fetal alcohol syndrome. It is decrease of choline levels and that leading to increase of violence.

I want to thank you all for the opportunity to be here this morning on behalf of NMA and our president, Oliver Brooks, and I look forward to your questions.

Thank you.

[The prepared statement of Dr. Lubin-Johnson follows:]

**Testimony of Niva Lubin-Johnson, MD
Immediate Past President, National Medical Association
United States House of Representatives
Committee on Energy and Commerce- Health Subcommittee
Field Hearing- Chicago, IL
"A Public Health Crisis: The Gun Violence Epidemic in America"
October 3, 2019**

Good morning. I am Dr. Niva Lubin-Johnson and I would like to thank Energy and Commerce Chairman Frank Pallone, Jr., Health Subcommittee Chairwoman Anna G. Eshoo and **all** Health Subcommittee Members for holding this field hearing today, **in Chicago**. I would especially like to thank Subcommittee Member Congressman Bobby Rush who is my Congressman, as well as Congresswoman Robin Kelly, who I have had the pleasure of working with quite frequently, on a myriad of health issues confronting our community.

I am here today to discuss policies and solutions to the public health threat posed by gun violence, not only as a Physician who has practiced internal medicine for over 30 years here in Chicago, but also as the Immediate Past President of the National Medical Association (NMA). NMA is the largest and oldest national organization representing African American Professionals, doing so for the over 50,000 African American physicians, and our patients, in the United States and its territories. We are the collective voice of African American physicians and the "Collective voice for African American physicians and the leading force for parity and justice in medicine".

Gun Violence has been a key issue for NMA and continues to be on the forefront this year, as it was throughout my NMA presidency.

Gun violence is one of the leading causes of death in America, where more than 39,000 people die by guns every year and 85,000 more suffer non-fatal gun injuries.¹ Gun violence costs the American economy \$229 billion

¹ 1. CDC. WISQARSTM. Report run 24 February 2018. Atlanta, GA: CDC National Center for Injury Prevention and Control. Available at: http://webappa.cdc.gov/sasweb/ncipc/dataRestriction_inj.html.

annually.² The societal costs of firearm assault injury include work loss, medical/mental health care, emergency transportation, police/criminal justice activities, insurance claims processing, employer costs and decreased quality of life. In Chicago, according to *The Chicago Tribune*, while shootings and homicides have decreased in 2019, there have been at least 300 homicides this year and 1,600 people shot, as of August 6th. During the 1st weekend of July, alone, at least 52 people were wounded — 8 fatally.³ Fortunately, during September there has been a continued decrease and murders are down 10% for 2019. While there are many causation factors surrounding the depth of the gun violence in Chicago, according to U.S. News and World Report, about 60 percent of illegal firearms seized and recovered by Chicago police come from out of state. They're traced back to states with less restrictive firearms regulations, with Indiana, next door, at the top of the list.⁴

In November of last year, the National Rifle Association (NRA) had the audacity to tweet "Someone should tell self-important anti-gun doctors to stay in their lane", after the American College of Physicians released a report calling gun violence a public health crisis. Physicians, including NMA, countered, "This **IS** our Lane" and more than 40 medical organizations have since joined forces as a coalition to raise money to confront the firearm related death and injury epidemic, as a public health initiative.

Gun violence hit very close to home for our organization after the tragic Chicago shooting of award-winning NMA member, Dr. Tamara O'Neal outside of Mercy Hospital, later that same month of November. Dr. O'Neal was killed by her ex-fiancé, who proceeded to also kill a pharmacy resident, Dayna Less and Chicago police officer, Samuel Jimenez.

Dr. O'Neal was a graduate of the University of Illinois, College of Medicine in Chicago (2014), completed her emergency medicine residency in 2017

² Follman M, Lurie J, Lee J, West J. The true cost of gun violence in America. Mother Jones. Available at: <https://www.motherjones.com/politics/2015/04/true-cost-of-gun-violence-in-america/>. Accessed Feb 29 2016.

³ Chicago Sun Times- July 3, 2019

⁴ The Myths and Truths About Chicago's Guns and Murder Rate, *U.S. News and World Report*, December 10, 2018

and at the time of this unforeseen tragedy, was an ER attending at Chicago's Mercy Hospital and Medical Center.

In response to the tragic domestic violence shooting of Dr. O'Neal, The Emergency Medicine (EM) Section of the NMA has made Social Advocacy and Violence Prevention a standing theme on their annual program. They have dedicated a Tamara O'Neal Social Justice Memorial lecture named in her memory to continue this important advocacy work.

NMA has long been an advocate of stemming gun violence in our communities and the country at large. We are in full agreement with the American College of Physicians that gun violence and violence prevention is a public health crisis, which we believe demands a multifaceted approach:

- In 2017, we published an NMA position paper on gun violence in our journal, entitled "The Violence Epidemic in the African American Community".
- In 2018 we developed a fact sheet on gun violence and advocated for the issue on Capitol Hill at our Colloquium in March of this year.
- In July, on behalf of 10 African American professional organizations, NMA spearheaded a letter to the Democratic Presidential candidates outlining gun violence as one of the top issues of concern.
- The NMA has endorsed the House-passed HR 8, which expands background checks and we have also endorsed the fiscal 2020 Labor-HHS-Education spending bill, which would provide \$25 million each to the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health to "better understand and prevent injury and death as a result of firearm violence." We have publicly called on the United States Senate take immediate action to bring gun violence prevention bills to the floor for a vote and passage, as well as for President Donald Trump to sign these measures into law.
- The NMA also calls on the federal government to immediately convene a bipartisan commission to evaluate steps to reduce and eventually eliminate gun violence utilizing a public health approach.
- On August 4th of this year, a CBS Sunday Morning Cover Story on gun violence and the public health coalition that formed as a result of the NRA tweet was aired featuring 2 NMA members, myself,

taped while I was President and Dr. Roger Mitchell, Chair of the NMA Violence and Prevention Task Force and Washington, D.C. Medical Examiner.

Other Recommendations

Public Health

- Establish local **Violence Fatality Review Boards** and the development of local systems that interface with at risk youth who are the victims or perpetrators of violence.
- Establish the **National Violent Death Reporting System of the Centers for Disease Control and Prevention (CDC) (NVDS–CDC)** which will identify, qualify and quantify the problem.

Deterrence/Investigation

- Have Police Departments to **train officers** in, and promote, community policing.
- Develop **Uniform Standards** requiring police officers to receive implicit bias training, mental health assessment and de-escalation response training.
- Establish Officer **re-certification requirements**
- Create sites for **Safe Fugitive Surrender**.

Research Conducted with University Partnerships

- Conduct **National Gun Violence Research Studies** to be funded by the CDC.
- Establish **best practices** in violence prevention, which can be evaluated and reproduced, with testable methods and solutions to treat and prevent violence.

Programming

- Employ **Multidisciplinary Services/Access** utilizing Community Partnerships, Community Building Strategies (**Interrupter Model) and Community Stabilization Programs with an acute and sustained approach to Wrap Around Services.
- Promote **Equitable Access** to Economics, Education, Housing, Healthcare, Mental Health, Social Services & Criminal Justice
- Deploy an **Interrupter's Model** which integrates workers who are community based and trained to identify persons or situations that pose a risk for violence in the community and act to utilize systems in place to break the cycle of violence.
- Promote **'healthy community' initiatives**, i.e. community gardens, safe spaces to exercise, community education programs, safe affordable childcare and senior care options. Aggressive screening for lead toxicity with early intervention in high-risk communities.

Partnerships/Collaboration

- Establish an **extensive network** with coordination across disciplines, comprised of community-based organizations, faith-based organizations and public institutions such as law enforcement departments, public health departments, academic institutions, hospitals and public schools.
- prosecute, if indicated, all officer involved misconduct and fatal shootings.
- **Documentation:** Physicians to routinely screen patients for any history of interactions with police, the nature of these interactions and any physical or mental symptoms that are a result of these interactions. These histories and any physical exam findings to be documented in the patient's record.
- Establish a **Police Registry**, which lists law enforcement agents that are fired from any police department due to misconduct, insubordination, or knowingly falsifying an application to a police department and is designed to prevent disqualified officers from moving from one department to another.

Investment

- In addition to investment in the above listed recommendations, **grant and local/federal funds** will be needed for programming aimed at public education on the risk factors for violence and violence prevention strategies.

Accountability Standards

- **Transparency:** Endorse and support the use of both body cams and dashboard cams.
- **Oversight:** Police and citizen review boards to address police officer misconduct and complaints against officers. Establish a Police Registry, which lists law enforcement agents that are fired from any police department due to misconduct, insubordination or knowingly falsifying an application to a police department. This registry is designed to prevent unqualified officers from moving from one department to another.
- **Impartiality:** Support and advocate for local municipalities, state and federal mandates that require special prosecutors be assigned to review and prosecute, if indicated, all officer involved misconduct

Other recommendations include community trust and engagement, research and training, law enforcement officer support modalities, and reporting standards for deaths in custody.

On behalf of the National Medical Association and our President Oliver Brooks MD, I thank the members of Congress of the Energy and Commerce Committee, other members, and staff for having this hearing today and again to share the views of African American physicians in America and its territories and our patients.

About the National Medical Association

The National Medical Association (NMA) is the nation's oldest and largest organization representing the collective voice of more than 50,000 African American physicians and health professionals in the United States, and the patients they serve. Established in 1895, the NMA is the leading force for parity and justice in medicine and the elimination of disparities in health. NMA is committed to improving the quality of health among minorities and disadvantaged people through its membership, professional development, community health education, advocacy, research and partnerships with federal and private agencies. Throughout its history the National Medical Association has focused primarily on health issues related to African Americans and medically underserved populations; however, its principles, goals, initiatives and philosophy encompass all ethnic groups.

The Violence Epidemic in the African American Community: A Call by the National Medical Association for Comprehensive Reform

Eva Frazer, M.D., Roger A. Mitchell, Jr., M.D., LaQuandra S. Nesbitt, M.D., M.P.H., Mallory Williams, M.D., M.P.H., F.A.C.S., F.I.C.S., F.C.C.P., Edith P. Mitchell, M.D., F.A.C.P., F.C.C.P., Richard Allen Williams, M.D., F.A.C.C., Doris Browne, M.D., M.P.H.

Conflict of Interest: All Authors have no disclosures and there are no conflict of interests.

Abstract: While much progress has occurred since the civil rights act of 1964, minorities have continued to suffer disparate and discriminatory access to economic opportunities, education, housing, health care and criminal justice. The latest challenge faced by the physicians and public health providers who serve the African American community is the detrimental, and seemingly insurmountable, causes and effects of violence in impoverished communities of color. According to statistics from the Centers for Disease Control (CDC), the number one killer of black males ages 10–35 is homicide, indicating a higher rate of violence than any other group. Black females are four times more likely to be murdered by a boyfriend or girlfriend than their white counterparts, and although intimate partner violence has declined for both black and white females, black women are still disproportionately killed. In addition, anxiety and depression that can lead to suicide is on the rise among African American adolescents and adults. Through an examination of the role of racism in the perpetuation of the violent environment and an exploration of the effects of gang violence, intimate partner violence/child maltreatment and police use of excessive force, this work attempts to highlight the repercussions of violence in the African American community. The members of the National Medical Association have served the African American community since 1895 and have been advocates for the patients they serve for more than a century. This paper, while not intended to be a comprehensive literature review, has been written to reinforce the need to treat violence as a public health issue, to emphasize the effect of particular forms of violence in the African American community and to advocate for comprehensive policy reforms that can lead to the eradication of this epidemic. The community of African American physicians must play a vital role in the treatment and prevention of violence as well as advocating for our patients, family members and neighbors who suffer from the preventable effects of violence.

Keywords: Violence ■ Police use of force ■ Public health ■ Racism ■ Social determinants

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<http://dx.doi.org/10.1016/j.jnma.2017.08.009>

INTRODUCTION

Over the last 122 years, the NMA has advocated for health equity across all disciplines by promoting health policy positions on issues such as Women and Minorities in Clinical Trials, the Paris Climate Agreement and equity in the Affordable Health Care Act. Most recently, the NMA has taken a position against Police Use of Excessive and Unnecessary Force.¹ At the NMA 2015 Annual Convention & Scientific Assembly, in response to the killings of unarmed African American men, in particular, Eric Garner, Michael Brown and Freddie Gray, a resolution was passed by the House of Delegates regarding lethal and sub-lethal injury resulting from law enforcement altercations. This resolution called for law enforcement agents to end the police practice of subjecting unarmed suspects to physical force that includes a ‘chokehold’ or placing the knees or body weight on a person’s chest, neck or head, which can result in debilitating or deadly injury. In July 2016, the NMA Statement on Police Use of Force² was released in recognition of the continuing and growing number of killings of unarmed African Americans by police officers. The NMA further established the Working Group on Gun Violence and Police Use of Force, which was charged with advocating for a public health approach in addressing the broad topic of gun violence as well as confronting the ongoing problem of excessive and unnecessary use of force by police officers within communities of color. To facilitate these efforts, the NMA joined the Movement towards Violence as a Health Issue and endorses their recently released Framework for Action.³

Of equal importance is the continuing work to eradicate policies and social norms that create barriers for African Americans to achieve health equity in the United States. The paradigm, defined as the ‘Social Determinants of Health’, makes clear that understanding where one lives, works, plays and builds relationships will affect an

individual's ability to achieve healthy outcomes. This paradigm has enormous consequences for the health and well-being of our patients.

It is impossible for medical and public health communities to have a conversation about health equity without speaking about violence. Overall rates of homicide have decreased in the United States since 1999. Despite this decline, a significant increase in the homicide rate continues to be observed in the African American community and is a major concern for the NMA.⁴ The July 2016 U.S. Census data reports that white Americans are 61.3% of the population while African Americans represent 13.3% of the U.S. population.⁵ In 2016, 15,070 homicides were recorded in the United States of which 7881 were African American victims and 6576 were white victims.⁶ In many communities of color, homicidal violence is one of the leading manners of death. This type of violence has a 'ripple effect', adversely affecting a community's ability to gain equitable access to education, economics, housing and health care. Whether it takes the form of youth/gang, intimate partner/domestic, child abuse/maltreatment or police use of excessive force/legal intervention, violence can cause deadly and debilitating injuries for the individual as well as long lasting adverse effects on the community.

The purpose of this paper is to reinforce the need to treat violence as a public health issue, to highlight the effect of particular forms of violence in the African American Community and to advocate for comprehensive policy reforms that can lead to the eradication of this epidemic.

HISTORY OF THE NATIONAL MEDICAL ASSOCIATION

"The National Medical Association (NMA) is the nation's oldest and largest organization representing African American physicians and health professionals in the United States. Established in 1895, the NMA is the collective voice of more than 30,000 African American physicians and the patients they serve."

The NMA was founded in 1895, during an era in US history when the majority of African Americans were disenfranchised. The segregated policy of "separate but equal" dictated virtually every aspect of society. Racially exclusive "Jim Crow" laws dominated employment, housing, transportation, recreation, education, and medicine. Black Americans were subjected to all of the injustices inherent in a dual medical care system.

Under the backdrop of racial exclusivity, membership in America's professional organizations, including the American Medical Association (AMA), was restricted to whites only. The AMA determined medical policy for the country and played an influential role in broadening the expertise of physicians. When a group of black doctors sought membership into the AMA, they were repeatedly denied admission. Subsequently, the NMA was created for black doctors and health professionals who found it necessary to establish their own medical societies and hospitals.

"Conceived in no spirit of racial exclusiveness, fostering no ethnic antagonisms, but born out of the exigency of the American environment ..." the NMA extended equal rights and privileges to all physicians. Although the NMA has led the fight for better medical care and opportunities for all Americans, its primary focus targets health issues related to minority populations and the medically underserved. The NMA remains committed to improving the health status and outcomes of African Americans and the disadvantaged."⁵³

VIOLENCE AS A PUBLIC HEALTH ISSUE

The World Health Organization (WHO) defines violence as the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.⁷ In 1986, US Surgeon General C. Everett Koop presented findings from the *Workshop on Violence and Public Health* which highlighted the need for cooperative and collaborative efforts among health and health-related professions and institutions to address violence.⁸ This mandate was further developed by US Surgeon General David Satcher in the article, "Violence as a Public Health Issue" presented during the Annual Meeting of the Institute of Medicine in October 1994. Dr. Satcher, in his 1994 report, stated "we have identified violence as an important threat to the public's health and we have developed a program in violence prevention that applies a problem-solving approach to the issue."⁹

According to the Centers for Disease Control (CDC), homicide is the leading manner of death for African American males ages 10–35 and the second leading manner of death for Hispanic males of this same age group. A review of data from 2012 to 2014, regarding fatal gun deaths, reports that guns are the third leading cause of deaths for children under the age of 17.¹⁰ Nearly 80% of all

homicides are due to firearm related injury. There are approximately 30,000 hospitalizations for gunshot wounds (GSW) each year in the United States. Nearly 6000 African American men die due to gun violence each year.⁷ Men are nine times more likely to be hospitalized for GSW when compared to women; and African American men are twice as likely as whites to require life-saving measures. Moreover, African American men make up only six percent of the population but make up greater than 50% of firearm related deaths.¹¹ Cook et al. reviewed epidemiological data from the National Inpatient Sample (NIS) 2004–2013 and found that the majority of GSW hospitalizations resulted from assaults on young African American males and suicides among older white males. They also identified that these injuries were associated with elevating health care costs. It was determined that the costs of hospital treatment and admissions for GSW from 2006 to 2010 were approximately \$88.6 billion and that single year productivity losses due to GSW approaches \$35 billion dollars.¹² The annual cost of gun violence is projected to be \$229 billion dollars or \$700 per American citizen.

The costs of violence in our communities and its effect on our patients exceed what can be measured in dollars and cents. The epidemic of violence affects not only the individual victim of violence or perpetrator of violence but impacts the entire community. Psychological trauma from exposure to violence, defined as post-traumatic stress disorder (PTSD), increases a person's risk of adopting violent behavior. This informs our understanding of the disease quality of violence. Violent behavior has the ability to transmit, spread and cluster based on exposure — consistent with an epidemic disease.³ Thus, the presence of violence in a community increases not only the potential number of victims of violence but also increases the likely number of perpetrators of violence, fostering an ongoing cycle of violence in the communities afflicted by this public health disease.

The disease quality of violence is also exemplified by its ability to affect different systems. Researchers in the Jackson Heart Study measured the impact of neighborhood social conditions, including social cohesion and violence, documenting that poor neighborhood economic and social conditions may contribute to an increased risk of cardiovascular disease among African American women.¹³ More recently, The Washington Post reports that, “In four separate studies, researchers found that conditions that affect blacks disproportionately compared with other groups — such as poor living conditions and stressful events such as the loss of a sibling, the divorce of one's parents or chronic unemployment — have severe consequences for brain health.”¹⁴ These risk factors have been identified as being correlated with an increased risk for

Alzheimer's Disease among African Americans. Furthermore, violence has the potential to not only affect the health of women in a community but also their gestating offspring. In an article published this year in the American Journal of Obstetrics and Gynecology, researchers identified an association between a high rate of youth violence and preterm births.¹⁵ The mechanism through which community violence and other environmental factors influence prenatal health is not well understood but it is proposed that increased stress of the mother as well as logistical barriers to receiving prenatal care (i.e. transportation, employment, childcare for other children) may play a significant role in this finding. In addition to birth outcomes and an increased risk of cardiovascular disease and Alzheimer's disease, violence in a community has a deleterious effect on how individuals gain access to food; in turn, household food insecurity is linked to an increased risk for intimate partner violence and adverse childhood experiences.^{16,26}

Current research documents that violence not only erodes the health of community members but also the physical environment of a community. The place where a person lives, eats, sleeps and breathes, can foster and perpetuate individual violent behavior. A well-publicized example is the overwhelming evidence that documents the devastating impact of lead toxicity on individual behavior. Excessive lead exposure has been shown to limit an individual's learning potential and increases the risk for impulsive and aggressive behavior.^{17,18} Communities most impacted by lead exposure often have other confounding risk related variables such as poverty and public school systems where older buildings in disrepair increase the risk for exposure to lead paint and lead contaminated water sources.¹⁸ In contrast, community neighborhoods that promote health provide easy access to physical activity, healthy nutrition, education and jobs as well as ensuring environments free from exposure to toxins, such as lead. These healthy communities become resilient-to and protective-against violence.

The decrease or absolute removal of poverty, crime, environmental toxins and food deserts inoculates against the presence and persistence of violence in the community. When violence does occur, the implementation of a violence interruption protocol, to break the cycle of violence, is an important tool to ensure that the spread of violence in a community is controlled. All of these factors have the potential to eliminate the cycle of violence and subsequently improve the health outcomes of the individual patient and the entire community. The African American physician, representing minority communities that are disproportionately impacted by violence, must effectively articulate violence as a public health issue and

take a leadership role not only in the intervention, treatment and prevention of violence but also in advocating for a comprehensive public policy in addressing violence.

IMPACT OF VIOLENCE IN THE AFRICAN AMERICAN COMMUNITY

In order to appreciate the fundamental role and impact violence has on the African American community, it is imperative that we review in greater depth patterns of violence that cluster in communities of color. Gang Violence, Intimate Partner Violence (IPV) and Child Maltreatment as well as Police Use of Excessive Force are major subsets of violence that disparately and disproportionately affect communities of color. In the following sections, we will give a brief overview to highlight how these forms of violence adversely affect our communities.

Gang violence

Violence in the African American community is often associated with youth or gang violence. This limited context identifies the perpetrator and the victims of violence as “thugs, predators or monsters” - individuals engaged in immoral behavior that will inevitably lead to the death, injury, or imprisonment of all involved.¹⁹ Newspaper headlines in urban centers like Chicago, Detroit, Newark and Washington, D.C. often highlight the scourge of gun violence and its destructive role within these communities. However, to understand violence in America’s cities one must be cognizant of the influence of structural racism and racial discrimination on the health outcomes of an entire people. In the review paper entitled, “Racial Discrimination: A Continuum of Violence Exposure for Children of Color”, K. Sanders-Phillips defines the major theoretical models that establish racism as a risk factor toward violent behavior. Sanders-Phillips asserts that racial discrimination (1) causes trauma by creating isolation, alienation, marginalization, psychological harm and perceived danger; (2) limits the ability of the community and parents to protect children and promote resiliency; and (3) creates a level of psychological distress affecting a child’s ability to cope with external stress.²⁰ The impact of racism on access to education, economics, housing and healthcare is complex and multifaceted. Racism is baked into the foundation of the American experience and therefore requires a separate analysis to comprehend its complete influence on violence in the African American community. Nonetheless, the effects of structural racism are integral to the causative risk factors that lead to individual, family and societal violence. Therefore, the physician who advocates against violence in the African American community must also take into

account the effects of institutional/structural racism, its significance in communities of color and its effect on health equity.²¹

One can argue that the social environment that leads to a lack of equity in America also lends itself to a propensity for young people to seek gang membership. The National Gang Center has defined a gang as a “group {that} has three or more members generally 12–24. Members share an identity typically linked to a name, and often other symbols. Members view themselves as a gang and are often involved in an elevated level of criminal activity”.²² According to the National Crime Prevention Council, young people join gangs for a myriad of reasons. Risk factors for gang involvement include but are not limited to poverty, a perceived need for protection, truancy, peer pressure and poor community conditions. Compared to similar at-risk youth, gang members are twenty times more likely to commit a drive-by shooting, ten times more likely to commit homicide and four times more likely to commit assault.²² Because gang membership tends to occur during adolescence, members are exposed to violence during a critical period of psychological and biological maturation. Gang members are reported to have higher levels of anxiety and psychosis and are more likely to attempt suicide.²² These facts reinforce the postulate that exposure to violence is profoundly detrimental to normal development and mental health. Research performed by Wood and Dennard found that gang affiliated prisoners had a greater exposure to violence, increased levels of anxiety, PTSD and paranoia when compared to the non-gang affiliated prisoners.²²

It is of critical importance that effort be directed towards diversion of young people away from gang affiliation and membership. In the recent report by the National Institute of Justice (NIJ) *Changing Course: Preventing Youth from Joining Gangs*, experts call for a comprehensive integrated public health and public safety approach. Strong and resilient family and community structures were identified as protective against gang membership and its violent outcomes. Gang membership and its associated violence is preventable and requires the unique tools of the public health sector with its ability to leverage multiple agency partners, community organizations and faith-based community resources. The public health approach is inherently capable of developing the definitions, data elements and data systems required to elucidate the enormity of gangs and gang-related violence in communities of color.²³

In addition, the public health model is structured to help communities develop, fund, implement and evaluate a comprehensive strategy. The physician practitioner can play an integral role in facilitating these efforts and

representing the interests of patients who may be gang members and/or the victims of gang violence. Physicians must be willing to ask their youth and young adult patients about their involvement in crew, gang, or violent behavior and their sense of safety at home and school. The health-care provider must be willing and able to connect their patients to the resources needed to make responsible life choices. Physicians dedicated to serving at risk youth must maximize opportunities to be mentors in their communities and neighborhood schools and to advocate for investments in out-of-school time, community-based workforce development programs that target 12–24 year olds. Physicians will also need to advocate for restorative justice practices which divert youth, who are low level offenders, from the criminal justice system and instead utilize community service activities to promote career based opportunities.

Intimate partner violence & childhood maltreatment

The gang culture is also associated with high-risk sexual activity and a culture that reinforces the stereotypes of black boys as “sexually insatiable” and black girls as “objects of sexual availability”. It is important to note that African American woman, regardless of gang affiliation, bear a disproportionately high burden of violence including intimate partner violence (IPV).²⁴ The CDC’s 2010 National Intimate Partner and Sexual Violence Survey reported that more than one in three women have been the victims of IPV.²⁵ It is estimated that IPV costs exceed \$5.8 billion each year and child maltreatment ultimately costs the nation \$134.6 billion annually in medical and other costs.^{25,26} Exposure to violence also results in psychological sequelae which can include chronic stress, depression and symptoms consistent with PTSD, affecting children and adults. For children, violence can induce high levels of stress “which manifests itself in children’s compromised cognitive functioning, as well as in their academic performance, emotional responses and social interactions.”²⁷ Exposure to violence during childhood is also associated with a higher risk of deliberate self-harm in adolescence and later suicide attempts. More importantly, intervention into the cycle of childhood maltreatment may decrease the potential negative impact on the subsequent well-being of victims of abuse and reduce the potential mental health outcomes of such maltreatment.²⁸

Research into the physical and psychological effects of IPV and child maltreatment documents a variety of short and long-term ramifications.^{29,30} A study of children living in a high crime neighborhood conducted by Theall et al. found that neighborhood level violence resulted in biological changes and changes at the cellular level, which

included shortening of telomere length and blunted recovery of cortisol levels with steeper diurnal rhythms. These findings suggest that violence may be a significant factor in changes associated with the physiological and cellular markers of stress in children and may have implications for long-term health outcomes.³⁰ Recent studies have suggested that IPV exposed African American women are more likely to engage in deliberate self-harm (DSH) in an effort to escape or avoid symptoms of PTSD.²⁴ In addition, food insecurity has been shown to particularly increase the risk for IPV, child abuse and neglect.^{16,26} In a study of predominately African American women, researchers found that women who are victims of IPV and suffer PTSD were nearly 15 times more likely to have daily co-occurrence of drug and alcohol use when compared with the control group.³¹ These, along with other examples, reinforce the complex co-morbidities that are integral to understanding violence in the African American community and the risks associated with adverse childhood experiences.

Individual physicians serving at risk communities must ask patients questions regarding safety in the home and make referrals to appropriate service providers, advocates and/or legal authorities; refer patients to early childhood development and parenting skills programs that are designed to reduce the risk of child maltreatment; and counsel teens, adolescents and young adults regarding healthy relationships. Physicians may also establish his/her practice as a “Safe Haven” for victims of IPV.

Police use of excessive force

Compounding the presence of violence within communities of color is the fear of the potential for unjustified use of force by police officers. The use of excessive and unnecessary force by law enforcement is both disproportionately and disparately directed towards the African American community. According to the Bureau of Justice Statistics (BJS), African Americans are more likely to have face-to-face contact with law enforcement and are 2.5 times more likely to experience threat or use of non-fatal force by police.³² The BJS reports that African Americans are also more likely to experience excessive force.^{32,33} A Harvard study examining patterns of law enforcement injuries in America demonstrated that police-related firearm injuries requiring hospitalization were more likely to be suffered by Black and Hispanic males between the ages of 18 and 39 years old.³³ Police officers, who are tasked with protecting and serving the community, frequently engage in intrusive policing practices in high crime neighborhoods, where the subjects of their policing are young men who are often experiencing barriers to equity. Researchers have shown that young men who

experience these intrusive police practices display higher levels of stress, anxiety and trauma associated with these police interactions.^{34,35} The reality is that the fear and anxiety that accompanies law enforcement interactions is justified. This fear is justified by the documented practice of racially biased use of unnecessary, excessive and, on occasion, fatal force by police.^{36,51}

Law enforcement's use of excessive and/or unnecessary force adds to the disenfranchisement and oppression felt by many living in communities of color. There must be an end to unwarranted violence by the police against the communities they are duty bound to protect and serve. We reject the notion that communities of color must be policed in a way that results in the increased injury, death and unjustified incarceration of any of our patients. A survey conducted by DeVolder et al. to determine the prevalence and magnitude of police victimization within an affected community found that up to 6.1% of civilian participants in public-police interactions experienced physical violence; an additional 2.8% reported sexual violence and 3.3% physical violence with a weapon. Of equal significance, 18.6% reported psychological violence.³⁴ A history of negative interactions with police was also associated with psychological distress and depression. More importantly, DeVolder et al. found disparity in the treatment of particular cultural groups reporting, "Police victimization was more frequently reported by racial/ethnic minorities, males, transgender respondents and younger adults."³⁴ In a subsequent study, DeVolder et al. reported an increased incidence of suicidal attempts by the victims of police violence.³⁵ The psychological harm resulting from adverse police interactions is as important as the physical injury.

While psychological injuries may be more difficult to ascertain, the physical injuries that result from excessive police use of force are apparent and extensively documented. Physical injuries that occur due to excessive police use of force may include, but are not limited to, gunshot wounds, blunt force injuries that can result in multiple bone fractures as well as closed head injury. Many of these injuries can cause permanent disability and even death.^{36,37} When an arrest is indicated, it is imperative that police officers have been properly trained in techniques designed to safely restrain individuals with the goal of safe transport of the individual to the police station or area hospital. Life threatening techniques, such as the 'choke hold' and the practice of one or more officers placing their body weight on top of the restrained person must be banned. These techniques were the direct cause of fatality in the widely publicized deaths of both Eric Garner and John Hernandez. Furthermore, de-escalation techniques, which are similar to those employed in hostage negotiation, should be utilized whenever safely possible and uniformly used on all suspects

regardless of race, mental health status, ethnicity or gender. The Salt Lake City Police Department, which embraced de-escalation tactics following a series of questionable officer involved fatal shootings, has had no fatal shootings in over 20 months as a result of de-escalation training.^{38,39} Appropriate and safe restraint techniques should be the standard and in the event a person in custody is injured, the individual must receive prompt and appropriate medical attention.

One of the most daunting limitations in understanding police use of excessive force is the paucity of data. The reporting that occurs from each of the 18,000 jurisdictions is completely voluntary. The legislation that provides federal funding for agencies to warehouse and analyze this data must be renewed by Congress. The Death in Custody Reporting Program (DICRP) of the Bureau of Justice Statistics which reports on all deaths that occur in local jails or state prisons, was authorized in 2000 but expired in 2006. Although the BJS continued the program it was not reauthorized by legislation until 2013. The Arrest Related Deaths Report which is a part of the DICRP, reports on deaths that occur during an arrest. The legislation guidelines, which authorized the program, excluded death reports from categories such as: (1) Deaths of bystanders, hostages, or law enforcement personnel (2) Deaths perpetuated by Federal Law Enforcement Agents (3) Deaths of wanted criminal suspects before police contact and (4) Deaths of vehicular pursuits without any direct police action.

As a result, legislatively mandated reporting of arrest-related deaths still does not accurately reveal the complete toll that police use of excessive force has on our communities. The NMA can be an advocate for legislation that accurately measures the impact of police use of excessive force, particularly in communities of color. Appropriate parameters should include a medical examiner system dedicated to the proper investigation, examination, certification and reporting of arrest related deaths in custody to ensure an objective and accurate assessment of these fatalities.

The public health community can no longer be silent regarding the impact of police violence on the mental and physical health of our patients. As described by Cooper and Fullilove, there must be a coordinated multifaceted approach that develops viable solutions in the "life-cycle" that leads to excessive police use of force. This approach will require prevention and intervention strategies that focus on poverty, crime, policies of mass incarceration, police review and oversight, police culture and unions, as well as implicit bias to name a few.^{40,51} The public health practitioner must advocate for community policing. A community policing policy that requires officers walk or

ride in the neighborhoods they patrol and includes culturally competent training will afford officers an opportunity to develop the relationships necessary to reduce crime and have a positive impact on the communities they serve.

GUN RELATED RESEARCH IN THE UNITED STATES

Reports confirm that there are nearly 33,000 firearm related deaths in the United States annually.⁵⁴ Whether fatalities are due to homicides or suicides, the weapon of choice is the gun. Research performed by Kalesan and Galea found that gun safe counties in the United States were primarily white, less poor, with higher household income, lower unemployment and more likely to be urban. The counties more likely to be violent due to firearms had higher rates of minority population, greater poverty, higher unemployment and were mostly rural. The study reported a direct relationship with gun ownership and homicide rates.⁴¹ During the March 2016 Health Policy Colloquium convened by the NMA, *Violence and Its Impact on Health* panelist Dr. Steven Weinberger gave an overview of the ongoing effort to reduce gun violence in the United States. The USA is the global leader in firearm related deaths by almost three times the next highest country which is Finland.⁴² Dr. Weinberger noted that there are approximately 90 firearm fatalities per day, the majority of which are suicides.⁴³

Research into gun related injury and death has a sordid history. In order to understand the current state of gun related injury research it is important to be aware of this narrative. A CDC funded research study by Kellerman et al. published in the *New England Journal of Medicine* in 1993, reported that keeping a gun in the home increased the risk for homicide, most often suicide, independent of any other factor.⁴⁴ In retaliation, the National Rifle Association (NRA) successfully lobbied Congress to ban research into the association of firearms with fatal and non-fatal violence. This effort by the NRA resulted in the Dickey Amendment to the Consolidated Appropriations Act of 1997. The Dickey Amendment is a provision first inserted as a rider into the 1996 federal government omnibus spending bill which mandated that “none of the funds made available for injury prevention and control at the Centers for Disease Control and Prevention may be used to advocate or promote gun control.”⁴⁵

Following the 2012 Newton, CT School shooting, President Obama ordered the CDC to resume research into gun violence. Despite this mandate, Congress provided zero funding to the CDC for gun violence research. The medical community has subsequently united, demanding

an end to this restriction on the legitimate effort to understand and reduce gun violence in America. In 2014, the American College of Physicians (ACP) presented position papers on gun violence. Subsequently, in 2015, the ACP proceeded with a “Call to Action” that combined the collaborative efforts of seven medical professional associations in conjunction with the American Public Health Association and the American Bar Association.⁵² This “Call to Action” was endorsed by 52 organizations, including the National Medical Association (NMA).

Clear recommendations to reduce gun violence are outlined as follows:

- Universal background checks of gun purchasers
- Elimination of physician ‘gag laws’, which prevent physicians from asking about or documenting a patient’s possession of firearms in the home
- Restricting the manufacture and sale of military-style assault weapons and large capacity magazines for civilian use
- Research to support strategies for reducing firearm-related injuries and deaths
- Improved access to mental health services
- Waiting periods to reduce impulsive suicides
- Guns should be subject to consumer product regulations regarding access, safety and design
- Guns should be subject to law enforcement measures to aid in the identification of weapons used in crimes⁴⁵

* It should be noted that none of these recommendations violates the 2nd amendment or prior Supreme Court Decisions.

RECOMMENDATIONS FOR VIOLENCE PREVENTION

The effort to treat and prevent violence in our communities is both difficult and complex. Historically, physicians have never been discouraged by challenge and are now called upon to treat violence as a public health epidemic and apply the same tenacity that has been necessary in the fight against AIDS, tuberculosis, cancer and other diseases. If meaningful and sustainable change is to occur in ameliorating violence, it will require a systemic, well-coordinated public health approach on both the local and national level that should include:

PUBLIC HEALTH SURVEILLANCE

- Establish local *Violence Fatality Review Boards* and the development of local systems that interface with

at risk youth who are the victims or perpetrators of violence.

- Establish the *National Violent Death Reporting System* of the CDC (NVDS— CDC) which will identify, qualify and quantify the problem.

RESEARCH CONDUCTED WITH UNIVERSITY PARTNERSHIPS

- National Gun Violence Research Studies to be funded by the Centers For Disease Control.
- Establish best practices in violence prevention, that can be evaluated and reproduced, with testable methods and solutions to treat and prevent violence.

PROGRAMMING

- Multidisciplinary Services/Access utilizing Community Partnerships, Community Building Strategies (**Interrupter Model) and Community Stabilization Programs with an acute and sustained approach to Wrap Around Services
- Promote Equitable Access to Economics, Education, Housing, Healthcare, Mental Health, Social Services & Criminal Justice
- **Interrupter's Model which integrates workers who are community based and trained to identify persons or situations that pose a risk for violence in the community and act to utilize systems in place to break the cycle of violence.
- Promotion of 'healthy community' initiatives, i.e. community gardens, safe spaces to exercise, community education programs, safe affordable childcare and senior care options. Aggressive screening for lead toxicity with early intervention in high-risk communities.

PARTNERSHIPS/COLLABORATION

- Establish an extensive network with coordination across disciplines, comprised of community based organizations, faith-based organizations and public institutions such as law enforcement departments, public health departments, academic institutions, hospitals and public schools.

DETERRENCE/INVESTIGATION

- Police Departments to train officers in, and promote, community policing.
- Uniform Standards requiring police officers to receive implicit bias training, mental health assessment and deescalation response training.
- Officer re-certification requirements
- Establish sites for Safe Fugitive Surrender.

COMMUNICATION

- Technical and Strategic Communication Assistance for Community based initiatives

INVESTMENT

- In addition to investment in the above listed recommendations, grant and local/federal funds will be needed for programming aimed at public education on the risk factors for violence and violence prevention strategies.

SUSTAINABILITY

- Review of Efficacy & Data Outcomes that will drive legislation including Health Care cost savings derived from decreased ER/Trauma visits
- Reduced societal costs that result from reductions in lost human potential and crime rates.

ADVOCACY

- "Public Health Approach Towards Violence Prevention" - development of a policy statement with quarterly reviews of ongoing practice guidelines and actionable recommendations

In addition to the above criteria, Excessive Police Use of Force will require the following at the federal, state and local levels:

ACCOUNTABILITY

- Transparency: Endorse and support the use of both body cams and dashboard cams.
- Oversight: Police and citizen review boards to address police officer misconduct and complaints

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against officers. Establish a Police Registry, which lists law enforcement agents that are fired from any police department due to misconduct, insubordination or knowingly falsifying an application to a police department. This registry is designed to prevent unqualified officers from moving from one department to another.

- **Impartiality:** Support and advocate for local municipalities, state and federal mandates that require special prosecutors be assigned to review and prosecute, if indicated, all officer involved misconduct and fatal shootings.
- **Documentation:** Physicians to routinely screen patients for any history of interactions with police, the nature of these interactions and any physical or mental symptoms that are a result of these interactions. These histories and any physical exam findings to be documented in the patient's record.
- **Establish a Police Registry,** which lists law enforcement agents that are fired from any police department due to misconduct, insubordination or knowingly falsifying an application to a police department and is designed to prevent disqualified officers from moving from one department to another.

REBUILD COMMUNITY TRUST AND ENGAGEMENT

- **Community Initiatives:** Training in community policing with 'top down' leadership. Listening sessions for open and civil dialogue lead by community leaders. Involvement of police officers in local community activities. Encourage officers to live in communities they police. Work with and organize neighborhood watch groups. Maintain anonymous tip lines.
- **Youth Initiatives:** Create mentoring programs designed to expose youth to police officers as positive role models and inform youth on opportunities in police and community work. Work with local community leaders to engage youth in strategies to prevent gang membership.

RESEARCH AND TRAINING

- Review and assess current state, local and federal law enforcement hiring practices, criteria for selection and required training protocols.

- The immediate and universal ban on police use of dangerous takedown techniques such as, but not limited to, the 'chokehold' or the placing of knees or body weight on a person's chest, neck or head which has the potential for severe consequences.
- Recommend research into appropriate techniques for restraining suspects that will not carry a high potential risk for permanent or life threatening injury to an individual in circumstances of no immediate danger.
- The immediate implementation of De-Escalation Training for all officers
- Training in bias mitigation modalities such as computer simulation training designed to reduce racial bias in shooting unarmed suspects.⁴⁶

LAW ENFORCEMENT OFFICER SUPPORT MODALITIES

- Review and assess current state, local and federal law enforcement training criteria, continuing education requirements and mental health risk assessment.
- Further development of psychological support services, bias mitigation, de-escalation techniques, conflict resolution protocols and ongoing training in community policing.

REPORTING STANDARDS FOR DEATHS IN CUSTODY

- Establish a uniform practice to capture all relevant details regarding cause and manner of deaths in custody to include the *pre-custody period* (interval during commission of a crime, during a fight, chase and apprehension, during a siege or hostage situation or during restraint or submission); *in custody period* (interval soon after being admitted to jail, during interrogation, during incarceration or legal execution); and *post custody period* (interval after re-entry into the community when at risk for revenge by rival criminals or by police).
- Require mandatory state, local and federal adherence to H.R. 1447- Death in Custody Reporting Act of 2013 amended to require the inclusion of Independent Medical Examiner reports and the US Standard Death Certificate.

CONCLUSION

The case for Violence as a Public Health Issue has been studied and clearly documented by healthcare leaders for more than two decades. Workshops like the 2013 Contagion of Violence, organized by the Institute of Medicine, National Research Council and the Movement towards Violence as a Public Health Issue Framework for Action have outlined treatment programs and strategies that successfully interrupt patterns of community violence.^{3,47,48,50} The comprehensive Framework for Action gives a detailed breakdown of the role that systems, institutions and physician leaders will have to play in the effort to reduce violence in our communities and in the lives of our patients. Any violence intervention strategy must take into account the complex multifactorial aspects of violence, incorporating racism and issues related to police use of excessive and unnecessary force, in order to achieve a successful outcome. There is evidence that formal police-public health partnerships can play a key role in reducing violence in impacted communities. These partnerships can augment the effort to reduce violence and garner greater community support. Examples of such partnerships were reviewed by Shepherd and Sumner in a March 2017 editorial published in JAMA.⁴⁹ By recognizing violence as a public health disorder and implementing key intervention and prevention strategies we can and will reduce the ramifications of this devastating disease in our communities. Communities of color and other marginalized communities are disproportionately impacted by violence and thus it is imperative that the NMA, currently representing over 50,000 predominately African American physicians nationally, take a leadership role and partner with other physician organizations in the effort to eliminate violence in our communities.

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Ms. ESHOO. Thank you very much, Dr. Lubin-Johnson, and thank you for the support that you just expressed for H.R. 8, the comprehensive background check legislation that is now at the doorstep of the United States Senate, and we pray that that will be taken up because we know the good that can come from that.

Now, all of our witnesses have testified. I am going to call on Congresswoman Robin Kelly. I won't start with the questioning.

I want to make sure that both Congresswoman Kelly and Congressman Kinzinger get to ask their questions. They both have time limitations today.

So I will set my questions aside for now. Recognize the gentlewoman for her 5 minutes of questioning.

Ms. KELLY. Thank you, Chairwoman Eshoo, and thank all of you for your testimony. It is very much appreciated and we are listening, believe me.

I am not—you know, I am not going to call you Pastor Mitchell. I am going to call you Brenda, because you call me Robin.

[Laughter.]

Ms. KELLY. Thank you so much for testifying today and, as you have heard me say before, thank you for being so selfless, because you could go in your home and close your door and not be bothered. But as you chose to be an advocate, you chose to turn your pain into passion. So thank you so much.

I am just going to cut right to the chase. What do you want Congress to do? What do you feel like we can do to be helpful, to help families and communities?

Ms. MITCHELL. I think that what we need to do is to, number one, pass H.R. 8, which I did—I am speaking for the Senate to take seriously what is happening in our communities and the blood that is left on the ground in our communities, to understand that that becomes holy ground for us.

It is sacred. And even with the lack of resources around trauma-informed care, it took me to almost have to lose my life three times to realize what I was going through.

And in addition to that, to be vulnerable enough to remove the stigma of accepting therapy and counseling to move through all the emotions that I was experiencing that were attacking my internal organs and to be able to understand what it is to try to come back to yourself, because that is life changing.

I became somebody that even I didn't recognize or know anymore, and I had to find my way back to myself. And so I ask Congress to put forth more research into trauma, and when we talk about trauma to move it from being a mental health issue, because I don't identify with mental health, but I do identify with being traumatized and having my heart ripped out of my chest and a sore that I know would never be healed.

Ms. KELLY. Thank you. And also, I don't know if anyone in the audience was there, but I just want to publicly thank all the people that got on the bus to come to Washington, DC. I think that was so very important.

And I don't know if everyone knows, but after the rally was over we took families from Kentucky into Senator McConnell's office to talk to them about please passing both bills that we sent over in February.

Dr. Stewart, I wanted to ask you—you stated in your testimony that there is a workgroup to address the social determinants of health and its impact on violence in vulnerable communities.

Can you explain the intersectionality of structural violence and social determinants of health, especially as it relates to gun violence in underserved communities?

Dr. STEWART. Yes, ma'am. The——

[Disturbance in hearing room.]

Ms. KELLY. We talked—we talked about that.

Ms. ESHOO. If the Chair can just——

Ms. KELLY. I talked about that in my statement.

Ms. ESHOO. If the Chair can just intervene here. We have——

[Disturbance in hearing room.]

Ms. ESHOO. Well, we need to go on. We need to go on with our hearing. Congresswoman Kelly, you have the floor and keep your—please, sir, we are trying to have a hearing here. All right.

[Disturbance in hearing room.]

Dr. STEWART. Yes, ma'am. You want me to just answer? So, if you look at our—if you look at the strategy—if you look at the strategy for the American College of Surgeons, I was clear with respect to that. Make firearm ownership as safe as reasonably——

[Disturbance in hearing room.]

Ms. ESHOO. Why don't we—why don't we just pause for a few moments?

[Disturbance in hearing room.]

Ms. ESHOO. I think if we can ask—I think if we can ask the gentleman to move with the others out of the room so that we can continue with the hearing, please.

I think that it is very important to understand that this is not a town hall meeting. This is a congressional committee having an official congressional hearing to listen to witnesses that will instruct us in order to address the epidemic of gun violence.

Each one of us does town hall meetings in our congressional districts. We are thoroughly accustomed to people shouting out at us and being unrestrained and hearing from them.

But that is not what today is. Today is the hearing with the witnesses, professionals all, being instructive to the Congress on how we can shape tangible legislation that is going to have an effect on addressing this epidemic in our country.

So I think it is important to delineate the difference between the town hall meeting and a congressional hearing.

So now I would ask my colleague, Congresswoman Kelly, to resume her questioning. And I thank you, everyone, for your patience.

Ms. KELLY. I just wanted to add to that. We did have Members of Congress come to Illinois, and we did meet with a group of—of course, we can't meet with everybody, but we specifically met with young folks under 25. Most of them were under 20. So we have done things like that also.

But, Dr. Stewart, do you remember the question?

Dr. STEWART. I do.

Ms. KELLY. OK.

Dr. STEWART. And so working to understand and address the root cause of violence is one of our two-prong strategies, and that

means we have to get to what many people have testified and what many of you commented on: addressing social determinants of health and structural violence.

What do we mean—what does Dr. Rogers mean by structural violence? It is the ways we put individuals in our communities in harm's way, and there are things it is not easy to see.

As a fish—we have a colleague, Wayne Meredith, who would say a fish can't see water. And so it may not be obvious to us, but there are structural issues that lead to increased violence and increased rates of death.

And so we have put together a workgroup, which is a national workgroup of experts, in addressing social determinants of health and structural violence.

We call that the I Save workgroup. We view that as complementary to our Firearm Strategy Team workgroup—making firearm ownership as safe as reasonably possible while trying to work to understand and address the root causes of violence.

And violence, too, I will just say—feel free to interrupt me—but I would say that it is a bigger problem than what we realize, because it is true that there is a hundred to 109, a hundred to 110 people who die every day from firearm violence.

There is actually 182 who die every day from intentional violence from all mechanisms. So working to understand and address the root causes of violence is critical, and that is just the death.

That is just the deaths. It does not take into account the magnitude of the health burden, which is tremendous, and an investment by Congress in this, I believe, is critically needed, and I think it will return benefits far beyond that investment.

Ms. KELLY. Thank you, Dr. Stewart.

And finally, I would like to submit for the record my Kelly Report on Gun Violence in America, which includes commonsense policy recommendations to reduce the gun violence epidemic.

Ms. ESHOO. So ordered.¹

Ms. KELLY. I yield back.

Ms. ESHOO. The gentlewoman yields back.

And now I would like to call on Congressman Adam Kinzinger for his 5 minutes of questioning and thank him again for being here and making our hearing, very importantly, a bipartisan one.

Mr. KINZINGER. Well, thank you, Madam Chair. And again, thank you for yielding the time. I appreciate it, and to all my colleagues and Robin, thank you for your good questions, too.

But especially to the witnesses. Thank you for being here. Your stories were both emotional and also informing. So thank you for that.

Pastor Mitchell, I don't know what to say except my deepest condolences, and I appreciate you sharing your story because I think it is important for all of us to see how it affects family, how family can do their best to overcome, and it brings a human element that sometimes when we talk about statistics, which, you know, we have to talk about statistics, but sometimes that gets missing, and

¹The report has been retained in committee files and also is available at <https://docs.house.gov/meetings/IF/IF14/20191003/110968/HHRG-116-IF14-20191003-SD008.pdf>.

I appreciate you doing the very difficult thing, but bringing a human face to that.

And so my deepest condolences and to you.

Mr. Leak, I just want to say to you—I don't have any questions, but I wanted to make a point, which is thank you for your testimony as well.

You know, evil is a very real thing, and we don't talk a lot about it.

But for whatever reason, there is a generation of young people, and I think it transcends race and it transcends income and boundary lines, that are listening to the whispers in their ear and doing really terrible things at very young ages.

And I attribute that partially to evil, mental health, and I appreciate you bringing that up.

But to the questions, Dr. Rogers, you mentioned in your testimony that the University of Chicago has developed a program that employs people with similar life experiences who help connect trauma patients and families to wraparound services, which include vocational training, mental health counseling, and other social services.

Can you elaborate further on how this kind of hospital-based intervention and outreach to high-risk individuals presents a unique teachable moment, basically improves outcomes and prevents future violent injuries?

Dr. ROGERS. There is a network of hospital-based policy and prevention programs across the country. Approximately 30 hospitals have invested in these programs, and they basically take people who have been injured by violent injuries, be it gun violence, stabbings, or assault, and use that moment to intervene in their lives.

Basically, think of violence as a chronic disease instead of an acute event. And in the context of that, people often come in with preexisting social issues that they need, educational disparities, economic opportunities they have not taken advantage of, and being able to invest in people through these hospital-based intervention programs has found significant effects in decreasing recidivism rates of recurrent injury or retaliatory violence.

The other aspect is preventing people from injuring someone else. There is a common saying that hurt people hurt people, and when you think about the opportunity that hospitals, health systems, may have to intervene in people's lives who have been hurt to prevent retaliatory violence, it is a very important possible intervention.

Mr. KINZINGER. And I want to add to that. So a lot of people don't know this about me, but my father was a director of an organization that helped the homeless, and one of the things that they really took as a way to do that is to understand that homelessness was not just the fact that you don't have a shelter over your head at night.

There was a lot of other things that lead to that, and how do you wrap that around.

And I think the same thing comes—when it comes to violence. Somebody comes into a hospital with a gunshot wound, obviously,

your priority is to heal that person and ensure they continue to live.

But if they are just pushed out the door or they are not given any other opportunity, you will likely see that person back in the same position. So it is how do we interdict that, and I appreciate you bringing that up.

Dr. Stewart, you were the lead author of a study published which you discussed that identifies some common ground solutions to reduce violent harm.

Number five in the consensus statement raises the importance of engaging both firearm owners and populations at risk. Can you elaborate further on the need to engage the community of firearm owners and why, as part of that solution?

Dr. STEWART. I can, and I do think it is a critical piece of the public health approach, which is to engage people who are at risk and a part of a knowledgeable stakeholder group.

I will just give an example. If we were going to do a bicycle safety initiative in a neighborhood, we would come with data. We would come with expertise. We would have all that.

But one of the things that we would do right away is we would engage with the bicycle riders. We would engage with them for their expertise, for their knowledge, and for their buy-in, and we have done that in the past, and we know that we learn from bicycle safety initiatives.

We learn that bicycle helmets were not cool. They are not thermally cool and they weren't culturally cool, and so we made bicycle helmets thermally cooler and culturally cooler, and you see people wearing bicycle helmets.

Mr. KINZINGER. Yes, that has always been a surprise to me. I was raised in the generation where you never wore bicycle helmets.

But I will tell you, we have got a lot of questions. Thank you all for being here.

My time is up and, Madam Chair, I yield back.

Ms. ESHOO. The gentleman yields back, and I know both of the Members that just questioned have other commitments and need to leave the committee, the witnesses, and everyone that is here today. Thanks, both of you, both for your leadership and your ongoing work and your attendance today.

And you may have noticed that we were leaning over and kind of whispering to each other. It is part of our team building because you are giving us ideas. So travel safely. Make your meetings, and thank you for being here today.

I want—let us applaud them. Let us applaud them.

[Applause.]

Ms. ESHOO. All right. The Chair now recognizes herself for 5 minutes to ask questions. Is there anyone on the panel that does not agree that this—that gun violence is an epidemic and that we work through the public health lens to address it? Is there agreement across the panel on that?

I think I heard all of you. Yes, I see everyone nodding. Because that is what this hearing is addressing itself to.

In the work of the Congress, if you were to advise us on shaping legislation, what would the top three or top five initiatives be that you would recommend to us?

I think at the top of the list is that we need to, first, secure the kind of data that can be shared when there is an epidemic.

Certainly, the CDC and the NIH develop the information, so we can work off of facts. It is very important, especially in the scientific community, that we have facts. And we have already—as I said in my opening statement, Congress has appropriated \$50 million.

If you divide that by 50 States, it is not a lot of money. But it is a start, and we have to start somewhere, and we can build on that.

But aside from that, what would you recommend to us that we take back to DC with us and build into legislation to address this epidemic in the public health lane?

Whoever would like to go first. Mr. Kerr?

Mr. KERR. Sure, I will go first.

So with an epidemic you have to go to the population that is most infected, and in this case you have to go to the population that is violent, and there is no way around it. You have to develop that relationship with them and change their trajectory.

So if you are going to vaccinate them, if you will, and provide opportunities and guidance and support so that vaccination will take and they will be on different trajectory.

Now, I am not opposed to prevention programs. I think it all has to be in concert. It is not a competition between intervention and prevention. But we have to look at where the data says.

OK, this is the group that is most violent, and if we don't develop a relationship with them, that change is going to be minimal.

So this is something that we have to invest in. Just even this thought is that this population is not a throwaway population, that they can change, and we have seen this.

We have worked with individuals who have been on a certain path, and the intervention is with them and then they change what they are doing.

Now they are actually working for the program and helping others to make that change as well. But it has to be something that is really thought out, and also we have to look at their ecosystems.

So it is not just working with that individual. What does their home life look like? What does the people who are in their network—social networks, family networks—look like? What are they going through, because they impact that individual.

Ms. ESHOO. Thank you. The doctors, I think, want to lean in on this.

Dr. ROGERS. I will lean in and add what Mr. Kerr said. There has to be a lot of investment to reverse the chronic disinvestment in communities, especially communities of color that have been disproportionately affected by violence.

Way too often, violence can be intergenerational. I meet with families every day who say that not just their cousin, not just their father, not just their brother has been impacted by gun violence, but multiple people in their families over generations have been impacted.

And without really thinking about what the psychological, emotional toll that that takes upon families and how that leads to sec-

ondary trauma in people, we will not be able to make a lasting impact.

And in many ways, because this is so longstanding we are going to have to make a very deep, concentrated effort to make an impact, and I think, if I could make any recommendation to Congress, it is not going to be a simple Band-Aid solution.

Ms. ESHOO. No, we know that.

Dr. ROGERS. This is going to take years of commitment over time to reverse what has been present for decades.

Ms. ESHOO. Well, in listening to Pastor Mitchell talk about all that she went through physically and the depression that surrounded her and deepened her grief even more that we do a lot through the Department of Defense relative—and the Veterans Administration relative to PTSD.

It seems to me that you are a witness and someone that has experienced that, and I think this—it needs to be a part of what we do.

Did you want to add to that?

Ms. MITCHELL. Yes. I think—I was on a town hall with Senator Chris Murphy and Congresswoman Lucy McBath and the question was asked, What was the one thing that we are not speaking about or addressing in terms of the gun violence initiatives? And the laws—we know how important that is and, though they have not made it to the Senate floor for reality to be our experience, we realized that there is devastation in our communities, and those things have not been addressed.

And as Dr. Rogers has stated, it is not anything that has happened overnight. But I believe that, with the research that has to happen in our community, there also has to be dollars that deal with the socioeconomic issues in the communities as well as the devastation and to have more resources out there.

I had the luxury of having insurance. I had the luxury of being able to talk through my issues. Everybody doesn't have that luxury, and unfortunately it is not even available in most cases because we are not even creating the narrative around trauma and trauma-informed care until most recently.

But there still needs to be more work and support driven in those avenues.

Ms. ESHOO. Thank you very much.

My time has expired. I now would like to recognize the gentleman, and a gentleman he is, Mr. Butterfield from North Carolina.

Mr. BUTTERFIELD. North Carolina. Thank you so much, Madam Chair.

Let me just begin by reiterating what Chairwoman Eshoo said a few minutes ago. This is not a town hall meeting. All of us have our own individual town hall meetings from time to time.

This is a congressional hearing. Why do I make this point? I make the point to say that this is not a political exercise that we are conducting today. This is serious business.

The Congress of the United States spends billions of dollars every year in nondefense discretionary spending, and if we are to invest in this issue and invest in methods of gun prevention and the other issues that we care about, including education, we have

got to build a congressional record, and that is what this is all about today.

We are building a congressional record. We will take this information, and a verbatim copy of what is being said here today is being placed in a congressional record.

We will take this information back to our committee. Our committee will then have further hearings. We will mark up legislation, and at some point it will be presented to the entire House of Representatives for a vote.

And so I just wanted to go on record making that known, for those who may not fully understand the scope of what we are doing today.

The statistics show, Madam Chair, that 39,000 firearm-related fatalities occurred in 2017—39,000. Eighty-three children injured or killed by guns each day. Inaction is not an option.

Even more disturbing is the way in which we fail to treat this as a public health issue. We have not invested Federal dollars in public health research to better understand how to prevent firearm-related injuries and death.

We have invested in criminal justice initiatives, but we have not invested significantly in public health research.

We were able, a few weeks ago, to approve appropriations in legislation in the House to provide \$50 million to support this research, and that is just the beginning.

So let me ask our witnesses—and thank you to all six of the witnesses—but let me ask our medical experts, if I can.

Can you share how you think this investment could help us better understand and address this crisis and the impacts it has on your patients and your friends?

Let us start with Dr. Rogers.

Dr. ROGERS. Every day I am struck by the fact that gun violence has devastating effects not just on those who are killed but those who are left behind, and I think those people who are left behind we often don't provide much in the way of any services.

And echoing your comments, Mr. Butterfield, we have to invest in research to better understand what works and what doesn't work. Even for our returning veterans, post-traumatic stress disorders are a very difficult problem to fix.

And, as Ms. Mitchell noted—Pastor Mitchell noted—it has long-ranging effects for decades after the traumatic event, and we have to find ways and approaches to address this in a more lasting way.

Only through research can we do that. We have found incredible ways of addressing the AIDS epidemic, for example. So AIDS is now a chronic illness—that people can live for decades with HIV.

We have to find ways of intervening in people's lives to prevent violence and find solutions to problems that in the greater society are often ignored.

And I think if that focus can happen through this congressional hearing, that may be an important start.

Mr. BUTTERFIELD. Thank you.

In the last minute that I have remaining, Dr. Stewart and then Dr. Lubin-Johnson, please.

Dr. STEWART. I would say the impact on our patients would be that they would be—if we invest in these things we have talked

about, they would be healthier. They would be more resilient. They would be stronger and they would be more free.

And it is critical that we make this investment, and we do it across the entire spectrum of violence.

Mr. BUTTERFIELD. Thank you.

Dr. Lubin-Johnson?

Dr. LUBIN-JOHNSON. Yes. Yes, and thank you for that question, Congressman Butterfield.

I believe, you know, the investment is important for our patients, our communities, especially their families who are remaining, whether they have been—their loved ones have been injured or killed.

I took care of two patients that come to note. One, her daughter was killed going to the grocery store and left a 5-year-old son behind, who she cared for during the week, and the father—they had a great relationship. He took care of the child during the weekends.

She ended up obtaining care through her job through employee assistance programs, but I think other programs need to be available to those who are left behind after these tragedies.

But also we need programs to help those who remain in the families, because we know part of structural violence is also there are some elements of structural racism and we have to do something and level the playing field in terms of the economics, the education, and the healthcare that these victims and their families have to receive and go through also.

Thank you.

Mr. BUTTERFIELD. Thank you. My time has expired. Thank you for your response.

I yield back.

Ms. ESHOO. The gentleman yields back.

It is a pleasure to recognize Mr. Rush, whose district we are in today, for his 5 minutes of testimony—I mean, of questioning.

Mr. RUSH. Thank you, Madam Chair.

Madam Chair, I certainly want to associate my remarks with my friend, Mr. Butterfield.

I want to just reiterate the fact that this is not a town hall hearing where we are going to have a lot of rah-rah and a lot of—the applause meter is going to go up. It wasn't intended for that purpose.

This is a sober and somber gathering of witnesses and Members of Congress so that we can do the work that we were elected to do, and that is to try to provide Federal resources to solve the problems that we are discussing today, and that is the epidemic of gun violence, and eliminate or ameliorate the tragedies and suffering and the pain of families and communities and nations that are affected by this senseless and ceaseless epidemic of gun violence.

And with that, I want to ask my friend, Mr. Leak, who I have known for many years and he has funeralized so many families, including my family.

Mr. Leak, has there been a significant and striking demographic change that you recognize among funeralizing families during this particular era of epidemic gun violence? Do you see a significant change in the demographics of your—of gun violence victims that you have to funeralize twice a week?

Mr. LEAK. What I have seen, Congressman Rush, is that the perpetrator and the victim, as I have said, were African American, and what I have seen is that there is not today the relationship between perpetrator and victim that resulted in a successful arrest and adjudication of the particular perpetrator.

And the reason that we are not seeing that as we did 30, 40 years ago, the fact that there is no relationship between the perpetrator and the victim.

Random violence is what we are seeing now, violence as we talked about—this 6-month-old baby. That baby was not targeted. It was just random violence that plagues us. And I would say there is only one solution to that, and I—

Mr. RUSH. Mr. Leak, let me just get to the heart of this. You know, I remember in Chicago locally in the late '70s there was a young man on the near North Side by the name of Dantrell Davis, and he was shot down on the grounds in Cabrini-Green.

I think he might have been on his way to school that morning, and he was shot down. And since that time, there have been more and more younger people who are killed, and when Dantrell Davis was killed there was a general alarm because he was a young man, 9 years old, who was murdered.

But now the incidences of young people being killed has increased, and I am saying do you agree that unlike our—when we were becoming adults, most funerals were for older family members who had died mostly of natural causes. But today, is it the same today or is it—has there been a subtle and significant switch that most funerals now are not folks who die of natural causes, but young people who die of gun violence or some other type of violent behavior?

Do you see that?

Mr. LEAK. Yes, I do see that.

Congressman, I should not have to be servicing a family of a 6-month-old girl. I should be servicing families where the deceased person is my age. I should not be servicing families who have lost their loved ones through homicide, suicide, drug overdoses.

I am seeing more of that now than I had in the past, and I just say to you I must reiterate and I ask that the Congress—you have an effect upon the schools of our city.

Federal dollars come from Washington to our city, and all due respect to my friend who represents the mayor, I am saying to you that take back to Washington this story.

Two young kids were acting up. They were sent to the principal's office. The principal asked them to come in one by one. The first one came in. The principal asked him, he says, "Johnny, where is God in your life? And go ask Jimmy to come in here."

Johnny went out to Jimmy and he said, "Jimmy, we are in big trouble. God is missing, and the principal thinks we have something to do with it."

God is missing from our schools, and we have a lot to do with it, and I am asking you, when you go back to Washington, DC, send some money here and most of all put God back into our schools.

Mr. RUSH. Thank you.

Dr. Rogers, I want to ask you, you made a statement in your—you made a declaration in your statement. I want to quote you: “This violence is a public health issue as a disease, and it means it can be treated and it can be cured.”

Can you expound upon treatment and the cure for it? What can we do as Members of Congress to provide Federal resources, more dollars, to cure this epidemic?

Dr. ROGERS. I will start by saying there is so much about gun violence that we don’t understand. We have made tremendous progress on the ability to do surgical procedures and medical interventions to fix physical parts of human beings—broken bones, or put back together damaged organs.

But we haven’t really done much to figure out how to help people’s souls and minds, and investing more in the mental health impact of violence both on people who have been directly impacted by violence physically but also those who are in close contact, because there is secondary trauma to everyone who is in close contact with that individual who has been shot and/or killed.

And to think about ways that we can actually create greater mental health support for individuals who have been victimized by violence, but also their close contacts.

Mr. RUSH. I want to ask, Madam Chair, if I could, Dr. Stewart—Dr. Stewart, are you saying that—

Oh. I yield back the balance of my time that has already run out.

[Laughter.]

Ms. ESHOO. I thank the gentleman.

And I understand you are being driven to ask more questions because you care so much about this issue. But now I would like to start recognizing our colleagues that are here as guests of the committee today, all Members of Congress, all from the great State of Illinois.

And I want to recognize first my friend and colleague, Congresswoman Jan Schakowsky. She has—for many years she has served on our Health Subcommittee. In this Congress she is chairing another one.

But she turns up religiously to our subcommittee hearings and has to wait for everyone else to ask their questions, and then it is her turn, and it is the same today.

But she is here. She cares enormously, and it is a pleasure to recognize her and welcome her once again to the committee and its work.

Ms. SCHAKOWSKY. Thank you. I want to thank you, Chairman Eshoo. It is really a privilege to be able to waive onto the Health Subcommittee, and so I don’t mind waiving. I thank you for the opportunity.

I want to ask a question of everyone here today. How many of you have lost a loved one due to gun violence that are here in this room? Raise your hand so I can see that.

So it has affected a good chunk of this room for the panel to know—on the panel and people behind you and including—we have talked about Bobby Rush, but also I was at the funeral for Danny Davis’s grandson.

So two issues I want to talk to. I want to talk more about the issue of trauma-informed care, which you raised, Pastor Mitchell,

but also the intersection with race, which is really in many ways, I think, an elephant in this room and on this issue.

We know that black children and teens are 14 times more likely than white children and teens to die because of gun violence, and that black men make up 52 percent of all gun homicide victims.

So when you were talking about how it is people around those that have been killed, I think we are talking about whole communities—whole communities—where black children in particular, but children of color—let me put it that way, black and brown children—are traumatized just from the time they are aware in this world of the dangers of their communities.

So racial disparities—we know, for example, that women of color in Illinois are six times more likely to die related to childbirth than white women.

So these disparities in healthcare are a real challenge. So I wanted to ask Dr. Lubin-Johnson, Dr. Rogers, anyone who really wants to answer this, to share what has been successful in dealing with trauma-informed and culturally competent care as we look at solutions to these problems.

Did you want to start, Doctor, on the end?

Dr. LUBIN-JOHNSON. Thank you for the question, Congressman Schakowsky, and I am not a trauma surgeon, so I will leave that to Dr. Rogers.

But in terms of the culturally informed competent care, I think we really need to start with what I alluded to before, which is the structural racism in our country, in our—that is affecting our communities, the healthcare that is received where those residents live, the education they receive, the housing that they live in, and understand and recognize that there is a disparity there that leads further due to the socioeconomic differences between our communities and others, that really serves as a nadir, let us say, for violence to occur.

And so, you know, I have become someone who is a proponent of implicit bias training as to start with in terms of helping to eliminate some of the bias and discrimination in our country.

And so what is implicit bias? It is bias that we are not conscious of but gets exhibited in various ways. And we are discovering, as you mentioned, with the issue with maternal mortality in African Americans, that this plays a basis in it.

I mean, if Serena Williams can't get the healthcare she needs, you know, post partum, who can? And because of that, we have developed now—most States have a maternal mortality review board.

And maybe we need a violence fatality review board in our municipalities that take a look at the systems that interface with at-risk youth and who are victims of the perpetrators of violence and that will work.

There are programs that do work—

Ms. SCHAKOWSKY. I am going to cut—sorry.

Dr. LUBIN-JOHNSON. Mm-hmm. No problem.

Ms. SCHAKOWSKY. I do want to ask anyone. Dr. Rogers?

Dr. ROGERS. Addressing the point about trauma-informed care, basically involves meeting people where they are, not where you want them to be.

Oftentimes, when we face people who have been the victims of violence, we don't think about the lived experiences that those people have had and how that impacts how they relate to the trauma that they are experiencing.

Oftentimes, the trauma is not just an event that happened today but something that happened a week ago, a year ago, a decade ago, a generation ago.

And we often do not find ways to incorporate that into care that will provide for that individual patient.

Ms. SCHAKOWSKY. Let me—I am sorry, let me just let Pastor Mitchell finish.

Ms. MITCHELL. I think the other thing, when you talk about the trauma-informed care, is to really identify that there is a need for that in our communities, because in the communities of color we don't identify with mental health or trauma care. There is always the stigma of being treated or seeking counseling and therapy.

As a pastor, it is very difficult to say because in the congregation we believe that, if God and I can't fix it, then it is not meant to be done.

But to actually, as I stated before, to allow yourself to be vulnerable enough to understand that God has said in that day knowledge would increase and to be able to accept the knowledge that is before us and to move ourselves toward wholeness.

Ms. SCHAKOWSKY. I just want to say one more sentence. While I agree with all of you that it is going to take time, I also want to—the T-shirts are Moms Demand Action, and I think whether it is going to take long or short, what people want to see now is steps—concrete steps—that represent action that is going to address this problem of gun violence in our communities.

Thank you. I yield back.

Ms. ESHOO. The gentlewoman yields back.

And now I would like to recognize the gentlewoman from New York, Congresswoman Yvette Clarke, and thank you for traveling from New York to be with us here today.

You have 3 minutes for—5 minutes for your questioning.

Ms. CLARKE. Very well. Thank you so much, Madam Chairwoman.

Let me thank you for doing this field hearing. Let me thank my colleagues of the Illinois delegation for welcoming an East Coast sister from Brooklyn for this hearing.

And let me thank our expert witnesses who have come to testify before us today.

Dr. Rogers, in the colloquialism of a New Yorker, it is a lot of levels to this thing, and I think that is one of the things that you have mentioned in and repeatedly through your testimony here today.

Reverend Brenda Mitchell, I want you to know that we are on the same wavelength. I am going to give you three names: James E. Davis, Gabrielle Giffords, Steven Scalise.

Each of these are colleagues of mine. One is in the past tense. His name is James E. Davis. He was a colleague who was gunned down before me in the New York City Council.

I walk with that trauma every day. Every single day. And as you spoke of your experience, my experience is sitting here bubbling up.

There is a lot of walking wounded, and there are many levels to this. It is proximity to what happened, relation to the individuals involved, community, and we have not really wrapped our arms around the extent to which Americans are being subjected to the pain of violence in our communities, in our Nation overall.

Because for many it may not even be someone who is immediate in their families. It may be a colleague. I have had two colleagues now in Congress gunned down. Thank God they were able to survive.

But it is—and we still haven't acted. One Republican, one Democrat. All of us walking around knowing that our colleagues were gunned down before us.

So my question is, and I am going to open this to the panel, a comprehensive approach from a health and well-being standpoint, how does gun access and availability through trafficking create a dynamic for those who are looking to commit violence?

And then what are the socioeconomic indicators that we need to look at in terms of education and the opportunity gaps that help to fortify us against future actions?

So it is a multipronged approach, but I would like to just sort of get your take on it because I think that we are only scratching the surface of the many levels that we have to address through legislation and through behavior modification.

Ms. MITCHELL. I am going to yield to the experts in just a second. But I think that I am also on the school board in my community, and so I get to see the disparity in terms of the education system and what children are presenting themselves with when coming into the classroom.

I also get to see the socioeconomic and the institutional racism that kind of denies access to individuals.

And so, unless we take care of all of the different layers—because it is not a one size fits all. There is trauma. There is gun violence. There is a lack of action from the Senate to move on things like the firearms and the red flag laws.

And so all of those things, while they are not being taken care of, is still our reality, and until, as Dr. Rogers said, we deal with the different levels of gun violence and the byproducts of gun violence, then we are doing a disservice to the public.

Ms. CLARKE. We only got a couple minutes. Does anyone else want to address that issue?

Dr. LUBIN-JOHNSON. So I would like to add something to that issue in terms of the intersectionality of what occurs with victims of, you know, violence and the socioeconomic status.

One thing is, you know, we talk about adverse childhood experiences, and this is one of those, but also others are, you know, housing and access to food, et cetera.

All these things are interrelated. I mean, we know that even those stressful childhood experiences of violence can carry over into adulthood with increased rates of heart disease, diabetes, high blood pressure, et cetera, and I think we have to develop programs that take all of that into account.

Even, you know, the increased stress level of a mother could lead to increased preterm births, you know, as—you know, as she is pregnant.

And so I think we really have to look at how all these things, you know, in terms of efforts, childhood experiences, social determinants of health, how they all play a part in any program that is crafted to help —

Ms. CLARKE. Dr. Rogers, I did invoke your name. I did want to get your response very quickly.

Dr. ROGERS. Thank you. I do think, as you said, Ms. Clarke, it is multilevel, and I think it is not going to be any one simple solution to this problem.

But we have to be willing to tackle it on multi levels. I think—I was going to make the comment earlier that race matters. I think if gun violence—intentional gun violence—was disproportionately affecting only white people, there would be a different impetus for making some impact.

But, similarly, if you look at the issue across the United States, we don't talk about the impact of suicide—gun suicide—upon people's lives, the silent burden that families bear, and we need to be more open about the impact that that has throughout the country.

Ms. CLARKE. The red flag law.

Madam Chair, I yield back. Thank you.

Ms. ESHOO. The gentlewoman yields back. It is now an honor to recognize our colleague, Congressman Danny Davis. I said earlier "the voice of God," and the sorrow of the tragedy of losing a family member, that burden is being carried by the Congressman and his family when they buried their grandson.

So this is—it is very important to us that he is here with us today and that he will work to be part of the solution, learning from the witnesses. You have your 5 minutes to question, my friend.

Mr. DAVIS. Thank you very much, Chairman Eshoo, and I really want to thank you for bringing this hearing to Chicago. As far away as New York might be, California is even much further.

And I want to thank Congressman Rush for requesting and the entire committee for acceding to that request.

I am so pleased that so many members of the Committee on Energy and Commerce are here participating. We often have these kind of discussions throughout the country.

But oftentimes, we don't have as many individuals who come from their districts to participate because there are things going on where they are.

And so, Madam Chairman, this is an absolute great day for us. I want to thank all of the expert witnesses who have come, and as I have listened I thought of the fact that less than 2 months ago, 2 young individuals were tried, convicted, and sentenced to prison for the murder of my grandson, 15 years old.

Their families are traumatized as much as our family, and my son was amazed when, at one of the eulogies, I said, you know, "I am hurting for the families of the individuals who shot Javon."

And he asked me—he says, "Daddy, did you mean what you said?" I said, "Yes, I really did, because just as there are going to be empty spaces at our Thanksgiving dinner table, there are going to be empty spaces at their Thanksgiving dinner table." And he said, "Well, the only thing I can say is, I think you are a better man than I am."

But that is one of the reasons that I am so pleased to have introduced with Senator Durbin a trauma-informed care bill that, hopefully, will move us in the direction of providing greater access to individuals who have experienced traumatic events.

As we have heard, all of us, one way or the other, either collectively or individually, are having these experiences. And so yes, we need resources.

But when I think of public health, my mother taught us that prevention was worth much more than cure. She would say an ounce of prevention is worth more than a pound of cure. And so we know that there are things that we need to do in order to reduce the presence of guns.

For example, I am big on mental health, trying to recognize its impact. But, you know, if a person is feeling a certain kind of anxiety and all they have got is a toothpick, they cannot kill 10 or 12 people in 30 seconds or less.

So we must find a way to reduce the presence of guns in our society. We must find a way.

[Applause.]

Mr. DAVIS. We must find a way to eliminate access to these automatic and semi-automatic weapons that shouldn't be in the hands of anyone except military and perhaps in some instances law enforcement.

[Applause.]

Mr. DAVIS. We know what to do, but we must have the will to do it. Had there not been a gun present in the little conversation that my grandson and his friends were having, he would be alive today and they would not be traumatized and facing prison. And so recognizing what to do and then doing it.

My question is and my comment: Gun violence is a crisis, but so is poverty a health crisis. So is economic oppression. I understand the young man over here who is talking about jobs, and he has come to believe that of all the issues—because when we talk about the stats and the group that has the most homicides, half of those individuals are out of work, don't have a job, don't go to school, are not engaged in any kind of training program. So this also contributes to their utilization of other forces to do what they do.

So, Spencer, my question—Mr. Leak—and I have attended many of those services that you provided, and we see each other pretty much on a regular basis, almost every weekend there is one.

How do we comprehensively face the issue that we have and try and make sure that we can seriously reduce gun violence and provide the help that individuals need to have once they have experienced it?

Mr. LEAK. Well, thank you, Congressman Davis. Let me say that I have found that, if we can change the mindset of the individuals, that we—these groups that we are talking about.

When I was director of the jail, I was telling Dr. Lubin that 50 percent of the inmate population were there because of mental health issues, and what can the jail do about mental health other than to contain?

But I submit that we have not brought into play the correctional systems—Federal and State and county—of our nation.

When I was the director of the jail, I did not, Congressman Davis, think that my job was to contain inmates or to confine them.

My job was to correct them, and what I tried to do in that jail is to correct the individuals who come to us. They have no else—they are confined, and therefore they are individuals that we may change their life set.

So that is one area there. But I cannot—I cannot reiterate to you and all of the Congressmen here that when I sit down with those mothers, Congressman, of those children killed in violence, I can't come up with anything comprehensive. I can't be really profound. I can only put my hand around that mother and say to her, "Let us have prayer."

And the only thing that will get us through this crisis in gun violence and violence in general is we must—there must be a faith-based solution. And I know that there are those who say it is unconstitutional.

We should not—we should separate church and State. But I say to you, we have got to change the mindset, and the only one who can change the mindset is the one who changes not.

Mr. DAVIS. Thank you again, Chairman Eshoo. I really do, from a personal vantage point, thank you, Congressman Rush, and the entire subcommittee for bringing this tremendous hearing to Chicago.

And I yield back.

Ms. ESHOO. The gentleman yields back.

And you should know that we all hold you in the center of our hearts, and we think you are very, very special.

I would just like to say to Mr. Leak that, when you see a picture of the floor of the House of Representatives and the Speaker's chair, what is engraved over it are the following words: "In God We Trust."

I now would like to recognize, last but not least, certainly, our colleague, Chuy García, from the Chicago area, and thank you for joining us today and for your patience.

You now have 5 minutes to question.

Mr. GARCÍA. Thank you, Madam Chair, and to all the members of the committee and, of course, all the panelists. As all of you are keenly aware, gun violence is ravaging our communities.

It is sad to think how normalized gun violence has become in our city and across the country, and it is time for the Government to quit cowering to the NRA and to do something about it.

[Applause.]

Mr. GARCÍA. I am sick of seeing headlines of shooting after shooting occurring all over our country.

This week marked a 2-year anniversary since my wife was coming home from going to visit a friend and parking her car in the garage and heard four gunshots.

She ran to the front of the house to check to see what had happened. A 26-year-old was shot while standing over his bike. She called me to hurry home because this had happened. This is just one more testimonial to others that Members have shared, that none of us are immune to gun violence in our country today.

Mass shootings have captured the national attention but are, in fact, a small share of gun violence in our country, and Chicago is

no stranger to the gun violence. It is constantly demonized by the President. It is a popular talking point for those who claim that gun control doesn't work.

But there is a big difference between the factors that create the conditions for shootings and our city and mass shootings other places. Our Black and Latino communities have been harmed for generations by disinvestment, racism, poverty, and gang violence.

I want to ask Dr. Rogers, why is it important that research properly identifies the root causes of gun violence and distinguishes mass shootings from the types of gun violence we witness in Chicago?

Dr. ROGERS. Thank you, Congressman García.

As noted, mass shootings represent less than 1 percent of total shootings in the United States but disproportionately gets all of the media attention when, in fact, daily people die from gun violence and suicides by guns without getting the same attention.

It is only through dedicated research will we understand exactly what works, be it safer guns, be it hand-imprinted ways of protecting who actually fires a handgun, for example, or actually thinking more holistically what are the primary and secondary prevention efforts that we can do to prevent people from being injured by firearms in the United States.

Mr. GARCÍA. And very briefly, how do we get stakeholders, including the media and law enforcement, to properly and responsibly report and highlight these differences?

Dr. ROGERS. I think one of the things that is happening today, the ability to try to listen in a way that actually respects people's different viewpoints. I think that is a important starting point for dialogue.

Mr. GARCÍA. Very well.

So recently our country witnessed the deadliest racially motivated attack targeting Latinos in modern American history, in El Paso. But this is not an isolated incident.

In fact, nationally, from 2016 to 2017, there was a 24 percent increase in hate crimes against Latinos, fueled by white supremacy and hateful rhetoric coming from the White House.

I visited El Paso in the wake of the shooting, and as our community mourned we also understood that the President is not contributing to preventing these incidents. He is contributing to encouraging this type of violence.

I want to ask Dr. Kerr as my final question—Mr. Kerr—what types of resources and community engagement will the city and the relatively new administration commit to providing communities most afflicted by gun violence in Chicago?

And I ask that understanding that this is a national panel, but we are also looking at what cities are doing to—in response to the gun epidemic.

Mr. KERR. Sure. So, as I mentioned earlier, Mayor Lightfoot's investment in violence—this is something I know is a big issue for her, and we are poised to work with other organizations and entities because this is an all-hands-on-deck approach that is needed to address this issue.

So we are doing inventory of our programming to making sure that we have ample prevention programs but also thinking in a

comprehensive way. We need prevention and we need intervention, and we need that comprehensive approach to also go along partners.

So who needs to be at the table? So, of course, city, county, State, Federal, but also including our local partners in the process.

So we have been able to have different town hall meetings over the last few months to engage organizations, to engage residents to be on board to give their input, to contribute to the strategy, because we know it is important to have them available on the ground.

Mr. GARCÍA. Thank you, Madam Chair. I think my time has run out.

Ms. ESHOO. The gentleman yields back.

I think that this now concludes the time of questioning on the part of Members. On behalf of every member of the subcommittee, we want to thank each one of you, the witnesses.

Chicago is known as the Windy City. But I think here today you have really put some wind at our back to address this issue that we are grappling with that has caused so much grief not only here in this community but in communities across our country, the damage to people's lives, the loss of life, but what we can do about this relative to public health and the epidemic that it really represents.

So each one of us are extraordinarily grateful to you. What you have given to us will be the—is foundational for us to build legislation on, and I believe that we have a lot to work with because you have given us examples of what is happening at the medical center here, what is happening at the medical center in Texas. That can be highly instructive to us, that we have wraparound services.

Pastor Mitchell, for what you referenced and other witnesses, this is a rich record that you have provided for us. We are very grateful to you for it.

I want to remind Members that, pursuant to committee rules, each Member has 10 business days to submit additional questions to the witnesses.

We hope that you will respond in a timely manner, because that part of the record is very important to us, as well, that all of it be captured, and I trust that you will do that.

I now would like to ask unanimous consent to enter into the record the letter of support from the Association of American Medical Colleges. We thank the association for that and, hearing no objection, so ordered.

[The information appears at the conclusion of the hearing.]

Ms. ESHOO. Isn't that nice that I can say that? Hearing no—just like that, it is like my little magic wand.

And, again, to everyone that is here in the audience, there are advocates here that give so much of their time to push and to push, to push and to push.

Your time is not wasted. You are really—you have formed a national corps of patriots to address gun violence in our country, and we are so deeply grateful to you.

To those who have suffered the losses in your family, I said in the beginning that your grief more than fuels the effort that we are taking on. We carry you with us, and we want you to know that.

To all the press that is here—I also want to salute and thank the committee staff. It is not an easy thing to do, to take a committee on the road and to get everything set up.

So they not only worked in Washington, DC, but they came here before the Members arrived to get everything organized, and I think that we can show our appreciation by applauding and thanking them.

Thank you.

[Applause.]

Ms. ESHOO. Thank you to everyone. And with that, at this time the subcommittee —

Mr. RUSH. Madam Chair? Madam Chair?

Ms. ESHOO. Yes, Mr. Rush?

Mr. RUSH. I also want to acknowledge the work of my own district staff who worked hand in hand with the committee staff to make sure that this was set up.

Ms. ESHOO. Well, of course, and I know how closely they worked with the committee staff. Thank you.

[Applause.]

Ms. ESHOO. With that, the subcommittee is now adjourned.

[Whereupon, at 11:58 a.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Megan L. Ranney MD MPH FACEP
Chief Research Officer, AFFIRM Research
Associate Professor of Emergency Medicine, Alpert Medical School, Brown University

WRITTEN TESTIMONY:

I am an emergency physician, a violence prevention leader, and the Chief Research Officer of AFFIRM Research, the country's only non-profit dedicated to solving gun violence through the public health approach. I have hundreds of stories about the very human toll of firearm injury. Last February, I collected those stories in a tweet thread.¹ Last November, I was a leader of the twitter response to #ThisIsOurLane.² I could fill my written testimony with the very real and very personal effects of a bullet on a life. I do this work, because of these stories.

But stories are only the beginning. The numbers matter, too. And the facts are, that in 2017, 39,773 people died and 133,895 were injured by guns across the United States.³ Firearm injury is the second leading cause of death for U.S. youth. In contradiction to popular press coverage, very few firearm deaths, nationwide, are due to mass shootings. The vast majority (60%, or 23,854) of U.S. firearm deaths are suicides, 38% (15,095) are homicides, less than 5% are unintentional ("accidental") shootings, and less than 1% are public mass shootings.³ The majority of non-fatal firearm injuries, in comparison, are assaults (108,207) or "accidental"/undetermined intent (20,488).³ Gun deaths are equally common in rural and urban America, as measured by rates, although the cause of firearm death and specific firearm death rates vary by state and community.

The costs of the epidemic of firearm injury are staggering. Each year, firearm injuries cost ~\$734 million in acute medical costs alone; the government is responsible for

¹ Lockwood B. The ER Doctor Gathering Physicians' Up-Close Experiences With Gun Violence. The Trace. 2018.

² Ranney ML, Betz ME, Dark C. #ThisIsOurLane — Firearm Safety as Health Care's Highway. New England Journal of Medicine. 2018;380(5):405-407.

³ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). 2017.

almost half of these costs.⁴ However, as noted by the authors, these cost estimates are low: *“These costs do not include the costs of readmissions, rehabilitation, long-term care, or disability. They also exclude the costs of those who were treated and released or died before admission. Finally, these health care costs do not include the broader social cost of firearm injuries such as quality-adjusted life-years or health-related productivity loss, which provide a broader but more abstract estimation.”*

Many of the long-term effects of firearm injury are difficult to quantify. Each shooting has a ripple effect of long-term effects on survivors and their communities. Studies also suggest a “contagion” effect to firearm injury, in which those connected to victims or perpetrators of firearm injury are likely to be affected by firearm injury themselves.^{5,6,7} A first episode of firearm injury too often leads to future violence, injury, and death. Youth exposed to shootings have higher rates of anxiety, depression, substance use, and future firearm injury, compared to those not exposed to shootings.⁸ And studies suggest that as many as 30% of people exposed to a mass shooting develop post-traumatic stress.

Gun death rates have increased 14.8% in the last 5 years.³ Suicide rates among youth and adults have increased 33% in the last 20 years.⁹ The downstream, reactive approach is not working.

What **could** work? The public health approach.

The public health approach focuses not on treatment, but rather on stopping disease and injury before it happens. This approach has been successfully applied to myriad health issues ranging from car crashes (resulting in ~70% decrease in death rates since

⁴ Spitzer SA, Staudenmayer KL, Tennakoon L, David A, Spain DA, Weiser TG. Costs and Financial Burden of Initial Hospitalizations for Firearm Injuries in the United States, 2006–2014. *American Journal of Public Health*. 2017;107(5):770-774.

⁵ Green B, Horel T, Papachristos AV. Modeling Contagion Through Social Networks to Explain and Predict Gunshot Violence in Chicago, 2006 to 2014. *JAMA Intern Med*. 2017;177(3):326–333. doi:10.1001/jamainternmed.2016.8245

⁶ Towers S, Gomez-Lievano A, Khan M, Mubayi A, Castillo-Chavez C (2015) Contagion in Mass Killings and School Shootings. *PLoS ONE* 10(7): e0117259. <https://doi.org/10.1371/journal.pone.0117259>

⁷ Gladwell M. *Thresholds of Violence*. The New Yorker. 2015

⁸ Hurt H, Malmud E, Brodsky NL, Giannetta J. Exposure to Violence: Psychological and Academic Correlates in Child Witnesses. *Arch Pediatr Adolesc Med*. 2001;155(12):1351–1356. doi:10.1001/archpedi.155.12.1351

⁹ Hedegaard H, Curtin SC, Warner M. Suicide Rates in the United States Continue to Increase. *NCHS Data Brief*. 2018(309)

1970, despite more cars on the road and more miles traveled)¹⁰ to HIV (resulting in an 90% decrease in death rates since 1995, without banning sex).¹¹ Unfortunately, the public health approach has not been systematically applied to firearm injury.

Since 1996, exactly \$0 have been appropriated to the Centers for Disease Control and Prevention to study the prevention of firearm injury and death. Overall federal funding for firearm injury prevention is less than 2% of what other diseases with similar mortality rates have received.¹² Despite the fact that firearm injury is the 2nd leading cause of death for American youth (age 1-18), funding amount, number of grants, dollars per death, and publications for firearm injury prevention research pales in comparison to that of other common childhood diseases and injuries.¹³ The funding is grossly inadequate relative to the burden of this problem.

Not surprisingly, as a result of this lack of funding, the science of firearm injury prevention has stagnated. According to a recent systematic review,¹⁴ in the last 20 years only 72 peer-reviewed publications have addressed clinically relevant firearm injury prevention; of these articles, only 12 assessed patient-level interventions and only 6 were randomized controlled trials.¹⁴ As of 2016, only 42 researchers were working on firearm injury prevention.¹⁵

Without coordinated funding and dissemination, we are unlikely, as a nation, to effectively decrease firearm injury rates.

Many people ask “What would you do with research funding?” A popular misconception exists that firearm injury prevention research is, inherently, the same thing as gun control. Indeed, this misconception lies at the heart of the Dickey Amendment, which led directly to the de-funding of the CDC’s work. However, even Jay Dickey came to understand that firearm injury prevention research is not the same as gun control: before his death, he wrote to Congress to say *“Research could have been continued on*

¹⁰ Fairfield H. Driving Safety, in Fits and Starts. New York Times. 2012.

¹¹ Mortality Slide Series. Center for Disease Control and Prevention. National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.

¹² Stark DE, Shah NH. Funding and Publication of Research on Gun Violence and Other Leading Causes of Death. JAMA. 2017;317(1):84–85. doi:10.1001/jama.2016.16215

¹³ Carter, Ranney, & Cunningham; Health Affairs, in press Oct 2019

¹⁴ Paul J. D. Roszko, Jonathan Ameli, Patrick M. Carter, Rebecca M. Cunningham, Megan L. Ranney, Clinician Attitudes, Screening Practices, and Interventions to Reduce Firearm-Related Injury, Epidemiologic Reviews, Volume 38, Issue 1, 1 January 2016, Pages 87–110

¹⁵ Alcorn T. Trends in Research Publications About Gun Violence in the United States, 1960 to 2014. JAMA Intern Med. 2017;177(1):124–126. doi:10.1001/jamainternmed.2016.7076

gun violence without infringing on the rights of gun owners, in the same fashion that the highway industry continued its research without eliminating the automobile."

Extensive firearm injury research agendas already exist. These include the Institute of Medicine (now National Academy of Medicine's) Research Agenda;¹⁶ the American College of Emergency Physicians' Research Agenda;¹⁷ the National Academy of Medicine's Proceedings on Health Systems Interventions to Reduce Risk of Firearm Injury and Death;¹⁸ the American College of Surgeons' Agenda on a Public Health Approach;¹⁹ and the Firearm Safety Among Children and Teens Research Agenda.²⁰

Unfortunately, the little progress that has been made on these agendas is piece-meal and not disseminable. Private funders are beginning to step up to the problem. This private funding is critically important. But to solve a public health epidemic, we also need federal funding. Without adequate federal funding, we simply will not be able to scale up the amazing efforts that are going on, piecemeal, across the country. We will continue to create solutions that are driven by emotion, rather than fact. We will continue to see our country waste money, increase anxiety, and increase deaths.

In close: We are the United States of America. We do not accept failure. We do not say that problems are too hard. We have used science to put men on the moon, to solve cancer, and to eliminate polio. We can do the same for gun violence. It just takes conviction, and a unified commitment to a public health approach.

Although I cannot be present with you today, I am honored to provide this written testimony in support of a strong, sustained federal commitment to a public health approach to firearm injury prevention. As a healthcare provider, my patients and my community deserve no less.

¹⁶ National Research Council. Priorities for research to reduce the threat of firearm-related violence. National Academies Press; 2013.

¹⁷ Ranney ML, Fletcher J, Alter H, et al. A Consensus-Driven Agenda for Emergency Medicine Firearm Injury Prevention Research. *Ann Emerg Med*. 2017;69(2):227-240.

¹⁸ National Academies of Sciences, Engineering, and Medicine. 2019. Health systems interventions to prevent firearm injuries and death: Proceedings of a workshop. Washington, DC: The National Academies Press. doi:10.17226/25354

¹⁹ Bulger EM, Kuhls DA, Campbell BT, et al. Proceedings from the Medical Summit on Firearm Injury Prevention: A Public Health Approach to Reduce Death and Disability in the US. *Journal of the American College of Surgeons*

²⁰ Cunningham RM, Carter PM, Ranney ML, et al. Prevention of Firearm Injuries Among Children and Adolescents: Consensus-Driven Research Agenda from the Firearm Safety Among Children and Teens (FACTS) Consortium. *JAMA Pediatr*. Published online June 10, 2019;173(8):780–789. doi: 10.1001/jamapediatrics.2019.1494



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David J. Skorton, MD
President and Chief Executive Officer

October 1, 2019

The Honorable Anna Eshoo
Chair
Committee on Energy & Commerce
Subcommittee on Health
U.S. House of Representatives
Washington, DC 20515

The Honorable Michael Burgess, M.D.
Ranking Member
Committee on Energy & Commerce
Subcommittee on Health
U.S. House of Representatives
Washington, DC 20515

Dear Chairwoman Eshoo and Dr. Burgess:

On behalf of the Association of American Medical Colleges (AAMC), I write to thank the Subcommittee for convening the Oct. 3 field hearing, "A Public Health Crisis: The Gun Violence Epidemic in America." The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 154 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems; and more than 80 academic societies.

As I wrote in [USA Today](#) last month, with an average of 100 deaths by firearms each day in the U.S. as a result of suicide, interpersonal violence, unintentional injuries, and mass shootings, we must pursue comprehensive strategies to prevent these avoidable tragedies in our communities nationwide. Like any public health crisis, a meaningful response will require engagement from multiple sectors, including the health care community and policymakers.

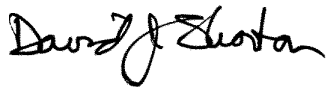
As I suspect you will hear from at least two of the witnesses at the hearing, physicians and health professionals at academic medical centers and other Level I trauma centers are on the front lines of treating both the physical and the emotional traumas that result from gun violence. They also can play a role in preventing injury and death through violence prevention programs, screenings, and lethal means counseling.

But we cannot expect our health care providers to solve this problem on their own – we must equip them and their communities with the tools they need to reduce these preventable deaths. Lawmakers can play an important role by advancing public policy solutions that help promote gun safety. For example, dedicated funding for firearm morbidity and mortality research by the Centers for Disease Control and Prevention, funding hospital-based violence prevention programs, implementing background checks, and promoting meaningful extreme risk protection orders that prevent at-risk individuals from harming themselves or others, are important steps that Congress can take to enhance everyone's safety and help health professionals better serve their communities. To that end, over the last two weeks, nearly 5,000 medical students, residents,

faculty, researchers, and others in the academic medicine community have signed a petition urging lawmakers to treat gun violence like the public health crisis that it is.

I firmly believe we can and must implement, with urgency, solutions to help advance safety while respecting the rights of responsible firearm owners. Thank you for your attention to this important issue.

Sincerely,

A handwritten signature in black ink, reading "David J. Skorton". The signature is fluid and cursive, with the first name "David" and last name "Skorton" clearly legible.

David J. Skorton, MD
President and CEO