Podcast Transcript

Firearm Injury and Gun Violence: Healthcare's Role

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Content warnings: Mentions of death, domestic violence, shooting, suicide

Guest

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  - Trauma Medical Director, Department of Surgery, Hackensack University Medical Center
  - Fellow, American College of Surgeons
  - Association of Women Surgeons, council member
  - Eastern Association for the Surgery of Trauma, committee member
- Advocate
  - American Association for the Surgery of Trauma, Injury Prevention Committee Vice Chair
  - American Foundation for Firearm Injury Reduction in Medicine (AFFIRM), advisory board member
  - Experienced member of many injury prevention/violence intervention committees/groups
- Educator, Researcher
  - Experienced professor
  - Experienced surveillance director and intervention program leader

Host

Jannah Amiel, MS, BSN, RN

- Jannah Amiel is a visionary nurse leader with extensive clinical experience in high-acuity hospital settings. In addition, she has education expertise in pre- and post-licensure nursing education and leading organizational teams in building and developing products and talent. She is the founder and nurse educator of an online bootcamp-style course experience that prepares pre-licensure nursing graduates to pass the NCLEX-RN and enter the workforce. She is currently Head of Learning, Healthcare, with Colibri Group.

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Transcript

Episode 1 – Firearm Injury and Firearm Violence: What's Happening and How Do We Talk About It?

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JANNAH AMIEL, HOST: Hello. And, thank you for joining us for another podcast episode. I'm Jannah Amiel. I'm the Head of Learning here at Colibri Healthcare. And joining me, a very special guest, Dr. Stephanie Bonne. And Dr. Stephanie Bonne, you are the chief, chief trauma surgeon, right?, at Hackensack. Is that correct?

DR. STEPHANIE BONNE, GUEST: Yes. Yes, that's correct.

AMIEL: Yes! Okay. But I have a whole list of other things that you do as well. You are a member of the American Association for the Surgery of Trauma. You lead a leadership position there. Is that right? … on the Injury Prevention Committee?

BONNE: Yep … mm hmm.

AMIEL: … advisory board member of AFFIRM. We'll talk a little bit about what AFFIRM is, but that's the American Foundation for Firearm Injury Reduction in Medicine.

BONNE: Mm hmm.

AMIEL: And a council member of the Association of Women Surgeons and member of the Eastern Association for the Surgery of Trauma. So basically, you don't do very much … is what all of this is. (Laughter)

BONNE: Yeah, it's pretty busy.

AMIEL: You have a lot going on. Tell us a little bit about these. Yeah. Talk to us about this. I would love to hear a little bit more about yourself here. … and your involvement in trauma, in AFFIRM, on these committees, and really how it's going to lead to our conversation here about firearm violence.

BONNE: Yeah. So I am, you know, a trauma surgeon by training. So, I work in a trauma center where I see patients who are injured by all different types of ways, you know, whether it's falls or car crashes or firearm injury or anything else. I'm also an ICU doctor, so I take care of patients in the surgical ICU, and I have a leadership role in my trauma center, where I'm also leading the entire group of trauma surgeons and all of our physician extenders and various colleagues in nursing and quality to manage the level one trauma center in Hackensack. Um, the part of it from the other organizations is really something that I do in addition to my clinical job.

So, I'm very interested in the physicians' associations and, and the professional groups that are moving our field along. So, doing good science to help us treat patients better, helping us to better understand some of the public health issues around trauma, um and helping to address some of these public health problems like gun violence or like motor vehicle injury and falls and all of these other types of injuries that we see.

So, my role in all of these organizations has been to lead various committees and other groups and organizations that are working on some of these issues. So, I am part of the American Association for the Surgery of Trauma. I'm the vice chair of their Injury Prevention Committee. So that's a group of injury prevention professionals and physicians across the board who are interested in providing information about injury prevention, providing guidelines to physicians about how to screen for various types of risk factors for injury, and who work together to provide materials to our colleagues.

So, like presentations or guidelines that help other surgeons understand these problems better and work on them in their practices. So that's all part of what I do with all of the organizational work. And most of that is very similar in many of the other organizations. Um, I was involved in AFFIRM for a while, and they have sort of blown up and expanded into this very large organization that's involved with the Aspen Institute.

But a few years ago, even just before COVID, a bunch of the surgeons and professionals from all different areas of medicine came together in Chicago and had a really big meeting to say, like, "Hey, what, what are we doing as physicians?" And, and "What can we be doing better?" And AFFIRM was really at the, the very beginning of this movement of physicians that are very interested in addressing the problem of gun violence in our country.

AMIEL: Yeah, that's, that's really fascinating. And one of the things that's top of mind, and I, I'm going to bet that you get this question in a lot of different ways. How does a physician get involved in firearm violence? Right? And even in a way that you spoke about it as a public health issue as it is. Right?

We think about like community and public outside of this hospital type of healthcare setting that, you know, all the healthcare professionals live in that box, but don't maybe touch what's really happening in the real world, if you will. So, I'm curious, how did you get involved in this particular space?

BONNE: So, I think many physicians have similar stories. My story, my personal story is that, you know, I was interested in trauma and injury and critical care and went to medical school and did a surgery residency and wasn't sure I was going to be a trauma surgeon. But I had seen a lot of that and was very interested in it, and even as a resident, when I was in training, I had, you know, sometimes to go and speak with families and tell them that their child or their loved one had died. And I remember thinking that this is so preventable, these problems that, you know, oftentimes, particularly with firearm violence, but also with other types of injuries, you … it's always such a shock, because typically that person was well and going about having a normal day and something terrible happened to them.

And, now they're dead. And it's very unexpected. And it was hard to tell families that. But I remember the first time after I became a parent that I had to go tell another parent that their child was dead. And it had a profound effect on me. And I was like, I just can't continue to stand by and do this without addressing it.

And we have a voice in this problem, because we see it. It comes to us, it comes into our house, into our hospital, and comes to our door. And, we can't just ignore that we're seeing all of these injuries and say that there's nothing that can be done about it. There are things that can be done. And so, I learned a lot about, about the different approaches to this problem.

And there are different approaches. There are approaches that are very much based in policy, and there are other approaches that are very much based in violence prevention globally. You know, there's ... gun violence isn't the only kind of violence that we see. And then there are all of these other approaches that involve public health, safety, making gun ownership as safe as possible in our society.

So that's what I became sort of interested in learning about. And there's been a big groundswell of physicians who are having these discussions in our various organizations, because I think in some sense it's just exasperation, like we're just exhausted from seeing this very preventable problem over and over again.

AMIEL: Yeah, that's a really good point. So, speaking of the problem, right, because we bring up the problem, that's a good segway into what exactly is the problem. Right? So, we're talking about firearm violence in this way, but I'm curious what the prevalence is .... Like what do the stats say, what's the data say? And, I'm going to kind of segway into timely things, right?, in that, in the same vein. But I'm curious like when we talk about this, what is really the reality of firearm violence in the United States?

BONNE: Sure. So, there's some pretty basic statistics. And I'll, I'll actually also give some comparison statistics. So ...

AMIEL: Okay, great!

BONNE: ... there's about 40,000 people that die by firearm every year in the United States. And to, for comparison, it's just about the same number who die in motor vehicle collisions. Um, the, and actually we surpassed that. That, that line crossed a couple of years ago. And so now there's actually probably a few hundred to maybe a few thousand more people that die by firearm every year than die in motor vehicle collisions, because motor vehicle collisions continues to go down as we develop safer roadways and safer cars.

AMIEL: Interesting.

BONNE: Um, the, um, other thing that happened that's really demoralizing to my profession in the past year is that **firearm injury is now the number one cause of death of children in the United States**. So, it used to be just injury in general like lots of kids have, you know, car crashes, they fall, they um, you know, have other issues and, you know, die from these really tragic circumstances.

But now firearm injury has surpassed as the number one cause of death over all other types of injury, **which means that is the single biggest risk to our children's lives.**

And so that's another statistic that's pretty sobering. But I think where I sort of became interested on the research side in this problem is that we actually don't have any idea really how many people in the United States every year are shot and survive. So, it's very easy to count the deaths, because we have death records and vital statistics. But there's no really good public health system that is completely accurate in figuring out how many pecople are shot and survive. And, there's a lot of reasons for that. People go to various types of hospitals. Not all hospitals report into the same data systems. People may not go to the hospital at all. Some people die before they get to the hospital.

So, they're in the vital statistics systems, but they're not in the hospital records. Other people die in the hospital. So, there's overlap between those records and vital statistics, and many of those of us who work in public health and who have access to hospital data have been trying to figure out that number and have really been trying to understand better how many people are shot and survive every year.

And also what is the makeup of those people? Are ... you know, what are their demographics? Is this men? Is it women? Is it children? Is it, um ... what, you know, is the racial makeup? The geographic makeup? Is it more common in places that have different types of firearm laws, and what does that mean for us, you know, moving forward? And how does that inform us as a society about how we prevent this problem?

And so that has been a big focus of my research. ... has been really on the epidemiology of this problem, because we don't understand it as well as we need to in order to make meaningful prevention strategies.

AMIEL: Yeah. And it seems like, you know, when I think about firearm violence, and we should touch on this point too as well. Right? We're kind of being purposeful in the way that we're saying this in firearm violence. And I've seen different terminology, too, that kind of floats around. And, we hear all sorts of things in the media, in the paper, and it's gun violence, it's gun control, or firearm this or assault this or this and that.

But I'm curious, even one piece is the language like landing on what the language is that we're talking about. Because to your point, we have a lot of data on deaths, but not a lot of data on just injuries, you know, alone. I'm wondering just kind of two-part, how we got to this new bit of language where that, that stemmed from. And the other thing I want to talk about is how that demographic is changing. You touched a little bit about children. We talk about that. But really, it's, it's changing the setting right? Now we're seeing it too in the hospitals. We just had a Dallas incident that happened in clinics. Right? We continue to see it in schools in this way.

But let's start with the first piece. The language around talking about firearm violence versus gun control. What's, what's that about? What's, in your opinion, why, why is it important that we use really pointed language and be really, really clear about what it is that we're saying?

BONNE: Yeah. So, I prefer the term firearm injury. Guns to me sounds a little more ... I think there's a connotation to it that's just a little bit different. And some people really want to use that connotation to get their point across. I think the terminology that we've settled on in sort of academic, you know, like we're looking at this problem from a, trying to look at it from a very objective lens. I think that that has landed us on firearm injury and firearm injury prevention. I mean ...

AMIEL: Right.

BONNE: ... that's really what we're trying to do. I think, you know, when we bring violence into it, there's also a connotation of a person perpetrating an act of violence onto another person.

AMIEL: Right.

BONNE: That is not to say that, you know, suicide or other things are not, are not violent acts. They are. But I think that there's when we talk about violence, you know, our minds tend to go toward this sort of like urban, you know, scene.

AMIEL: Yeah.

BONNE: And that's really not accurate. You know, much of the firearm violence in the United States is happening in the suburbs, and it's happening in rural areas. And then when we use the term violence, it also discounts unintentional injury or, you know, accidents.

I don't like the term accident, because it implies that something's nonpreventable, and I think all of these problems are preventable. So, I prefer unintentional injury.

AMIEL: Yeah.

BONNE: ...and that, you know, is also a huge problem. And that's a lot of what's happening to our children is, you know, finding firearms around the home and, you know, that the accidental or unintentional discharge of a firearm either upon themselves or upon another child or another adult, and that's a big problem, too.

So, I think firearm injury really encompasses everything. I really hate the term gun control. I don't think any of this is about trying to control people's weapons. We have a constitutional right to carry a firearm in this country. I think that it's really about changing the narrative to bring that right and marry it with responsibility and say that, you know, this is a right that comes with a responsibility.

And, what we need to do is use these public health principles, this multidisciplinary science of public health, to make that firearm ownership as safe as possible. And that does mean things like safe storage of firearms and, you know, being mindful about child access prevention. You know, children should not have access to weapons, being mindful about people who are maybe unstable or older folks who develop dementia, and making sure that those folks don't have access to weapons, because these are some of the bigger problems that we're seeing in our society.

AMIEL: Yeah, that's a really good point, too. So now the demographics right now, if, I feel like if we were to ask just random people, you know, where do you feel like firearm violence is the most prevalent? We would get all sorts of different answers, like maybe in this group, maybe in this city, maybe in this area. But right now, like, what are the primary or the largest risk? Maybe risk is not even the word, because everyone's at risk. Right? But really the largest population that's affected by firearm violence today and are we taking into account the different settings that we're seeing that happen?

BONNE: Yeah.

AMIEL: So, who, who's most affected right now?

BONNE: So, when I think about who's most affected by firearm violence, I put this into four buckets.

AMIEL: Okay.

BONNE: The first is children, which we've already talked about. The second is women.

AMIEL: Interesting.

BONNE: And women often come into contact with a firearm injury or firearm violence in the setting of a, a intimate partner violence situation. So, you know, one sort of shocking statistic is that if you take two homes in the United States where there's some sort of domestic violence that's regularly happening, and you put a gun in one of those homes, the woman is 500% more likely to die, five times more likely to die than in a home without a firearm.

So, women are definitely at higher risk. The intimate partner murder rate in the United States is much higher than anywhere else in the developed world. And much of that has to do with just the lethality of means and the ease of access of firearms. So that's the second sort of at risk group.

The third at risk group is the young African American, primarily male population, that's urban. This is urban violence that's happening in our cities, is largely related to social determinants of health. Like, like access to safe housing, access to food, access to education, opportunity, jobs. This is really very much a social problem that manifests as firearm violence but really has its roots in the way that we're supporting and investing in our communities, particularly communities that have been traditionally marginalized like communities of color.

And then the last bucket, I think of is, is those with mental and psychiatric illness. So, that comes in two forms. One is that, you know, is the obvious one, which is suicide. People who have psychiatric problems tend to die by suicide more. And then again, that lethality of means and having the firearm available. And that actually is quite the opposite of the, the young black male problem! It's really a old Caucasian male problem. So, this is, primarily affects rural and suburban older white men. They're the primary demographic for suicide by firearm. But then I also want to just say that there's also this trope that those who have psychiatric problems or mental illness are likely to become the perpetrators of gun violence. And so, we need to invest in our mental health system. We do need to invest in our mental health system for a lot of reasons!

AMIEL: For sure!

BONNE: But it's not because those with psychiatric illness are going to like go into the schools and, and you know, whatever. That does happen. But, on a population level, those who have mental illness are far more likely to become the victims of gun violence than they are to ever become a perpetrator.

And then there is this very small percentage that gets, you know, highly sensationalized of schools and public places and grocery stores and now hospitals where those problems manifest themselves. But it is important to note that, that sort of mass shooting that gets put onto the news is actually a very small percentage like single digit percentages of the total gun violence that's experienced in the United States every year.

AMIEL: Yeah, and I think that's a really important point, because we, we see it all the time. And, and I want to be sensitive to the fact that, like, yes, this is true, and it's happening. And unfortunately, we, we know it's happening, and we're seeing it happen in these different public places like schools and like churches and, you know, and like hospitals.

And one of the things that I think about, one, as a, as a nurse myself, but two, just as a person, just a human being human with other humans, is that when we, we kind of create this, this alarm, if you will, right? ... for the things that we see with the mass shootings that happen in public places like schools, churches, hospitals in that way.

And it oftentimes feels like a lot of like the resources, a lot of the light is shined in that way and saying we need to look at this and fix this and solution for this. But on the other end, you know, I think about the firearm violence that happens every single minute, every single day, and a whole lot of communities, communities that I'm from that don't seem to quite get all of that light that shined, you know, in that way.

And this is an ongoing problem forever and ever that does play a role into, you know, kind of where we see it float to the top in the news. And I'm curious about that, because it shifts demographics for sure, right? Because we're talking about one very specific setting. We're talking about schools, we're talking about hospitals versus in the community, and I'm curious how physicians, how pharmacists, how any, you know, these different allied fields, how nurses can also help to advocate and push the conversations about research and about funding and about, you know, the ways that we can support outside of our own fields and just want to kind of get your opinion on that. You know, from your perspective, how do you think that we can help really in the public space outside of, you know, what we know is just major demographics that are being affected in our own profession.

BONNE: So, I think that there is a lot that we can do to, number one, just tell the stories of the people. You know, this becomes a faceless problem, because it becomes numbers, it becomes 40,000. Then, you know, and, you know, 10,000 of this and 20,000 of that. And it really depersonalizes the problem. And I think that we need to tell the stories of the people that we are seeing in our professional lives that are being affected by this.

And that is valuable and important, and our lived experience as healthcare professionals is incredibly valuable to this conversation, not only in the sort of, you know, very sensationalized way of like, “Oh, my gosh, I just got blood all up and down me, and it's all over my shoes.” “And I gave somebody 50 units of blood, and then I had to go tell their family that they died.” “And Mom was screaming.” And, you know, those are really common narratives. We do that almost every day in our line of work.

But there's also, you know, the person who had, you know, a firearm injury where they got shot across some fat, you know, and really came to the hospital, didn't have any injuries. It went across their arm or across their leg. And, they essentially didn't need any intervention from the hospital. Sometimes we just put band aids on these wounds and send people back out of the hospital. But now that person doesn't feel safe in their community. They don't feel safe in their home. They're waking up at night with PTSD. And in medicine, we're seeing these patients too, the patients that just can't seem to find a space where they feel safe and healthy again.

And number one, providing the types of resources and support through things like trauma survivorship clinics, mental health support and trauma recovery programs, and also violence intervention programs where we partner with community groups to prevent violence in the communities, both in the hospital and through community organizations using this public health approach. ... engaging our communities in the conversation! So, the conversation is going to look very different in a, in a, if you're a nurse or a healthcare professional working in a maybe a smaller rural hospital than it is if you're working in, you know, a big or a small urban center. Maybe in that smaller hospital, it's about talking to those sort of people who utilize the emergency room

frequently about you know, “Hey, do you have a firearm in your home?” “How do you store it?” “Is it locked up?” “How, you know, do you feel safe there?” Or, you know, the children that are now thinking about what they're going to do with mom as she gets advanced dementia and saying, “Okay, just, you know, just so you know, like if you have a gun in the house and mom's going to be staying alone, you might want to think about getting that out of there.”

That's the kind of conversations you can have in those places. And then, you know, in urban places, it might look differently. It might look more like violence prevention. It might look more like getting the faith leaders in the community and the leaders of community organizations and various community initiatives together into a forum to talk about this problem and talk about what they're doing in their neighborhoods and with their, with their neighbors and with their churches and with their schools to address the problem of, you know, safety in those neighborhoods.

And so that may look like something very different in those kinds of places. But I think we as healthcare providers, because we care for everybody, really have a unique opportunity to highlight this problem and say, “Hey, look at what's happening here.” And, “Here's how we can help be part of the solution.” “Let's get this together.” “Let's use the hospital conference room for a community meeting.”

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Let's, you know, do these kinds of things. So, I think that you don't have to be a doctor to do that. You can do that, you know, in any of the health professions. So, these are some of the ideas and some of the ways that, that I've seen colleagues and, and others throughout the healthcare profession work on this problem.

And also, this is a lot of what the professional organizations are trying to do to support people who want to build these types of relationships and programs in their own communities and their own hospitals and their own medical centers.

AMIEL: Yeah, and I love that like, we're all getting involved in this way, all of us, you know, in healthcare, whatever discipline that we are, really getting involved in this way and supporting what we know is happening and trying to change that narrative and really provide some solutions, or at least push for solutions. And one of the things, you touched on it earlier, too, you know, you're doing a great job and healthcare providers are doing a great job really trying to uplift this issue.

We’re gonna to take a break and conclude episode one. We talked about a lot today from what firearm injury looks like, gaps in research, and who may be at higher risk for injury related to firearms. Please join us again for episode 2 where we’re gonna discuss funding for research and multidisciplinary and interprofessional approaches for addressing the significant and serious issue of firearm injury in the United States.

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Episode 2 – Research, Funding, and the Influence of an Interprofessional Healthcare Team

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AMIEL: Welcome back to episode 2 of our podcast, Firearm Injury and Gun Violence: Healthcare's Role. Let's jump right back into the conversation and dive into the interesting backdrop of how funding, the CDC, and legislation influences the research for firearm-related studies.

What happened to funding, right? Like this was a, in my brain, this was a public health thing that was researched, and it was funded at some point. And, really we did a good job about that, I thought, in the same

way that we fund lots of different research for diseases or looking for, you know, different curative options, but it doesn't not feel like firearm violence and the research behind it.

And, even ... I don't know what happened to the funding behind it? And, I'm curious, one, what happened, if anything at all? And, if we're not really researching it at the level that we could be and that maybe we were at some point, how does that play into the problem?

BONNE: Sure! So, there's a little bit of history here. So ...

AMIEL: Okay.

BONNE: ... the Centers for Disease Control like way back in the day, back in like the 1980s, 1990s funded this problem, and they funded research. And then in the nineties, there was an amendment passed. It was part of the, the federal government funding bill that goes through every year called the Dickey Amendment.

And it said that none of the funds made use for, that the Centers for Disease Control gets, can be used to promote or advocate for gun control. And so that was sort of interpreted to mean that if a research project or a program that was being offered by the CDC would somehow come to the conclusion that gun control or firearms or some sort of legislative solution to firearms would be beneficial, then they weren't allowed to do that research. They weren't allowed to fund it.

So, this really created a almost total freeze on gun violence funding across most of the federal agencies for many years and had a really chilling effect on gun violence research. So, from many years, researchers didn't enter this field. You know, if you're a researcher, you have a position in an academic institution, your whole sort of life depends on, you know, getting tenure, which requires funding.

So, you're gonna study something that you can get funded to do. And so, you know, many researchers went into other things that are funded much, at much higher rates, like cancer and, you know, HIV and heart disease, rightfully so. But they had this chilling effect on gun violence research. So now, that has really sort of fallen by the wayside over the last couple of years.

And so, the government is now funding gun violence research. And so, the CDC has about 25 million. The NIH has about 25 million. And then the National Institute of Justice has also been funding research through sort of criminal justice agencies and criminal justice schools for a number of years. So, the problem, though, is that, first of all, $25 million dollars is like a drop in the bucket, I mean, compared to that amount of funding that ... get ... cancer research and heart disease research ...

AMIEL: Truly, truly.

BONNE: ... I mean, it's like an incredibly tiny amount of money and such that the CDC is funding somewhere along the lines of maybe 6 to 10 projects a year around the country, which is really just not very much. And also, the ... for years, you know, decades now, there's been so little investment that they don't really ... there's no real um like groundswell of sort of mentors and experts in this field.

So, you know, cancer research, for example, is really cutting edge and at the forefront. We're learning so much everyday about how to treat cancer, but all of that is being built on the backs of people who've been doing cancer research for decades, like, you know, we know more in 2020, because we knew a lot in 2015, because we were learning from what they found out in 2010.

But there's basically been almost a 25- or 30-year gap in gun violence research. So, both in data collection, we don't really have a lot of data from the last 20 years to be able to look back and say, here was the effect of this on this problem or the effect of that on this problem. And there's just not a huge number of people who are doing this work, even today, relative to some of these other major problems.

AMIEL: Wow. So do you in your opinion, this is a loaded question.

BONNE: Okay. (Laughter)

AMIEL: Do you, (laughter) do you think that when we aren't, you know, providing funds, and we really aren't doing the research, we really aren't putting, you know, all of our eggs that we could in that basket to make sure that we're addressing something, that it exacerbates an issue?

BONNE: I do. I mean, I think that, you know, for I mean, I think what you're asking is, does not researching gun violence mean that there is more of it? It ...

AMIEL: Yeah.

BONNE: Can we draw a direct line between the research funding and, and I think, you know, this is sort of hard to conceptualize sometimes, because, you know, how does what's happening in a cancer lab with a bunch of cells growing on a plate lead to better cancer treatments? Well, it does. You know, you develop drugs, you learn more about how the body reacts to those drugs. You do all of those things. And then we get new treatments. But also you learn about prevention. So, we learn about how to prevent cancer. Things like when is the right time to do a colonoscopy? Well, it used to be 50. Now we think maybe it's 45.

And all of this comes together for all of these problems from this public health approach, which is a multidisciplinary and interprofessional approach to a problem. So, there's not one solution to firearm injury in the United States. It's going to take multiple facets. And understanding the best way to go about this problem is going to require research.

And the research is intended to inform policymakers, right? So the ... whether that comes, those policymakers are people that we elected into government or those policymakers are people who are creating hospital policies or city policies or policies that govern, you know, law enforcement agencies and other types of, of community organizations or agencies. So, without data, anytime somebody forms a policy, it's kind of just like an assumption or a shot in the dark.

But with data and research, we can really understand what actually does make a difference, what does work. And then we know that that's where we need to make our investment either in changing policy or we need to invest in programming that works. So, you know, the colon cancer example is, you know, after a lot of research, we learned that colonoscopies are a great preventative care for colon cancer and that then changed the policies in healthcare organizations and insurance companies and what they're willing to pay for.

And in some cases, it changed policies on the state and federal levels, saying to insurance companies, you're actually required to pay for this, because we know that it's so beneficial. So, that's where I think, you know, better understanding the problem and better understanding the potential solutions and testing the solutions in small areas .... Does a certain type of violence intervention program work in one community versus another community?

And where does a certain type of access prevention for children work better than another type of access prevention for children? Those are the things that we're researching. We look at the data to better understand, and then that informs the policies that either come out of our communities, come into our lawmakers or come into our healthcare organizations.

AMIEL: Yeah, that makes a ton of sense, and that's a really good comparison, really good way to frame that up. So, let's talk a little bit about how this really plays out in real life. In real life, we're talking about our real life as healthcare professionals in this way, this multidisciplinary, interprofessional approach. So, you know, I'm curious, what does that look like and how are, you know, our team members coming together?

Is it a matter of an event happens in the hospital, and we're just all trained to react or, you know, how are nurses (myself), physicians like yourself, pharmacists getting together in this way to address this issue? I'm curious what that looks like and how do we do that more?

BONNE: Yeah, I think that some of the data and the research that's coming out has given us tools to better understand what, what we can, what interventions we can do that are both preventative and also supportive, when, after an incident of firearm violence. So I think, you know, some of the things that we've learned are that organizations that are trauma-informed, we're learning all of this about trauma-informed care now, and that the effects of adverse childhood experiences, of community disenfranchisement, and of the effects of generational trauma on entire populations of, of people has created situations where we really need to be trauma-informed in our approach and need to be sensitive to that. And so that's something that I'm really interested in developing, is how do we use trauma-informed care and a trauma-informed approach? And so, I would suggest that everybody goes to the SAMHSA website. It's I think SAMHSA.gov, and you can read all about trauma-informed care if you don't know anything about it. It's, it's really the best practice in the way that we interact with our patients.

So that's something that I've seen healthcare organizations come together across disciplines to say we as an organization want to be trauma-informed, and here's how we're going to bring together doctors, nurses, pharmacists across the entire allied health professions and create a trauma-informed organization, because that's a best practice in treating our patients. The other things that I've seen people do sort of in real time is, developing various types of prevention campaigns or using the ... the anchor institution of the hospital to ... as a vehicle to get prevention information out to people.

So, what does that look like on a day-to-day basis? Well, for your, you know, you may have a family practice physician who has a group of nurses and, and some other people from across the hospital who are interested in this. And, they work on providing brochures to patients in the clinic about safe storage. Maybe they get a small grant, it doesn't take a lot of money, hundreds of dollars even, to purchase gun locks that they distribute in their clinic so that people, if they want a gun lock, they can have a free one. Maybe it looks a, another group of multidisciplinary and interprofessional healthcare professionals teaching their colleagues about how to have a conversation about gun safety with the patient, with their patients. So, patients we know, because we've researched this, are much more likely to practice safe storage practices if it's discussed with them by their healthcare practitioner than by anyone else.

So maybe. But most doctors are really uncomfortable with that conversation. They don't know how to have that conversation with their patients. So, maybe we provide some training in our, in our hospital or in our organization about how to do that. So those are some of the kinds of ideas that we have or some of the things that I've been seeing as we've been working on this.

And then I think we can't really undervalue the value of community investment. And really, you know, for many years hospitals have been these sort of walled off places that stand in the middle of, of rich and vibrant communities with people who are really invested in their space, in their neighborhoods. And, the hospital sort of stands in the middle and people just come in and out of the door.

And I think what we really need to do is break down that wall and really recognize that hospitals are community partners. They're not just a tower in the middle of the neighborhood that we need to partner with .... Our community is ... we need to think about how we're investing in the communities that we're working in. And that can be anything from developing a big program where you're bringing together community leaders and having community advisory boards, or it can be something as simple as asking the cafeteria manager, are we sourcing our food from local vendors or are we using big companies? Because maybe one way we can invest in our community is to, you know, have a farmer's market, or maybe we can do some of our purchasing from these local places and support our, our community partners and our businesses. So that, I think, can't really be underestimated, that we need to be breaking down these barriers between the healthcare world and the spaces that they're existing in.

AMIEL: Yeah, I totally agree. And I'm so happy that you said that, because it feels like that. And then even as a healthcare worker within those walls, you feel disconnected from the community that you may very well live in. You know that you're there all the time. So, I really, I'm glad that you said that. And I'm curious, you know, at your place of employment where you're working, do you have these committees formed, these multi-

disciplinary interprofessional committees? And, you know, what's that look like? What are the, the different perspectives, you know, that come to the table?

BONNE: So yeah, I think that community advisory boards are incredibly important. I think that … and that we have to be very intentional about who we're asking, because sometimes advisory boards or boards of organizations tend to just sort of give honorific, you know, nods to the right people, you know, it becomes this sort of geopolitical thing. But having true community members that are involved and then when we're hiring for programs like community outreach workers or community health worker programs, really making sure that these are folks that know and understand the community that they're working in.

So, there's a lot of these sort of CHW type, these community health worker type positions now where the healthcare industry is recognizing the value of the lived experience of people from the community and reaching out and providing healthcare. And what that can look like, you know, in the case of firearms, is it can look like violence prevention, but it can also look like community health workers helping people understand their diabetes medications and their healthcare follow up.

And these are really navigators of the healthcare system, but they're culturally relevant to the communities that they live in. So, this isn't, you know, somebody who drives in from 30 miles away every day and then tells you when your next set of appointments is and then drives back out again. It's, you know, somebody who says, “Hey, I see that you need a walker.” Like, you know, that place up on the corner that, you know, Mike's pharmacy up there on the corner is the place that will have it for you. And here's your voucher. “How are you going to get over there?” “Did you know that the number two bus goes there?” So, you know, it's really much more community relevant. And I think that recognizing the value of those individuals and bringing that in is, is really, really important. And so that's, you know, some of, I think many of this is just in its infancy right now. But that's a lot of what I've seen that this sort of ends up looking like when we talk about community investment.

AMIEL: Yeah, absolutely. And you know, there's a parallel here that I'm seeing, like the community, the actual community, the people that are living there and, you know, breathing there and eating there and their whole life happens in the community. But then I think about the inside the hospital, right? The multidisciplinary community, like we are the community in there as well.

And it's, it's kind of both in this way, and it's, it’s, it’s fantastic that we have representation from all of these different fields. And I'm curious, you know, from your perspective, what do you think the benefits are in having this type of shared committee? You know, “we're all in it” approach versus let's say, just the nurses are working on the firearm violence committee or just the doctors are doing this or we got one pharmacist on, you know, what's the benefit of all of us getting together and having these conversations and trying to solution?

BONNE: So, I think that what we know, I mean, this has been proven in business, right?, over and over again, is that diversity matters. And, diversity brings all kinds of perspectives to the table. And that is so valuable. And, you know, business and industry and, you know, the, the Googles and Amazons of the world have been recognizing this, you know, for a while and recognizing diversity as an important pillar of building their businesses. It's just good, it's just good business practice. And so that is exactly the same in the hospital. Right? So, and it may be diversity in terms of diversity of individuals by, you know, gender and ethnicity and background. But it's also diversity of thought from the different disciplines. I didn't go to nursing school. There's a lot that is taught in nursing school, and there's a lot that nurses experience that I just don't understand, because I don't have that lived experience.

And so that lived experience is incredibly valuable to the conversation and so is the lived experience of all of the different people in the system. So, diversity doesn't always look like, you know, what we typically think of as diversity, but it's also diversity of thought. And, you know, we've learned so much even just in the group of physicians nationally who are working on the gun violence issue is bringing in the perspective, for example, of physicians who own guns versus physicians who don't. And physicians who work in rural settings versus those who work in urban settings.

And so, we're all seeing different things, and we all have different stories that all matter, and we're all bringing that perspective. So, even that within the hospital, multidisciplinary is always going to bring that diversity of thought that's necessary to really take it to the next level when it comes to solutions.

AMIEL: Yeah. And that thought in those perspectives, you know, one of the things that I remember learning in nursing school, what feels like a bajillion years ago, is you always have to check yourself at the door. Right? There was this kind of ... the, the old adage, like, you check yourself at the door before you walk in there and start handling patients and caring for patients and families.

Whatever's going on, know yourself, right?, first. And this is obviously one of these, these topics, these events, these themes. It's a, it's a big deal. And it elicits a lot of emotions and a lot of feelings. And depending on just your own perspective, how you feel about firearms, how you feel about, you know, the gun violence that we hear about, could certainly make a difference in your ability to participate in a committee or to, you know, help to solution in that way.

And I wonder how that shows up, you know, in real life. And is that a conversation that we're happening, or that we're having rather, in hospitals, you know, around, hey, like before you joined this committee, before we, we come in here, should we do a gut check on our own selves and think about how do I feel about firearms in general, how am I affected by firearms, what's my own experience, and can I contribute, do you think that that's something that, one, is happening and that we should include in the conversation?

Sometimes it feels like we all want to help, and that's fantastic. We all want to help and jump in. But this feels like one of those, those moments in nursing school that I feel like my professor would have said, “Check yourself at the door before you walk in there.”

BONNE: Yeah, well, I think that checking your emotions at the door is important when you want to look at data and be objective. So as a researcher, you know, I am passionate about this problem, because of what I see. But I also know that I can't let it guide me to a conclusion that doesn't exist, simply because that's what I want the data to show me.

You have to let the data show you what it's going to show you. So, in that sense, there is a check at the door. I do think that, you know, when you're working in a multidisciplinary setting or a committee or you're trying to bounce ideas about what you want to do, I think that you can bring your lived experience to that table.

You just have to do so in a way that's thoughtful and respectful of other people's lived experience as well. And I think, you know, like a lot of ... I've heard a lot of people say over the years, you know, non-gun owners don't have a voice in this, like what do they have to say about the problem? Or, you know, gun owners shouldn't have a say in this problem.

And I think actually both perspectives are really valuable and understanding that we can come together over being anti-bullet hole so we don't have to be ... it's not about the gun or the, the anti-this or anti-that. But, I think we can all agree that we should have a world where children don't have bullet holes in them. And so let's, let's start with that and then take it from there.

AMIEL: Absolutely.

BONNE: And I think in that way, the multidisciplinary sort of authentic self-conversations then become really valuable, because if you exclude gun owners from that conversation, they're ... you're not going to come up with a valuable solution. And if you exclude non-gun owners from the conversation, you're also not going to have a valuable solution. So, it really is about coming together and, and deciding that we want to be safe, that we want our children to be safe, and that we as a society should not accept this unacceptable level of injury and death in our society, when we know that it just doesn't have to be this way.

AMIEL: Absolutely. And you know, something that you mentioned earlier, I just want to piggyback on, because you've given a ton of great information around even like what we can be doing on our feet, in our settings

where we're at our place of employment, you know, and within our disciplines and within our multidisciplines to really address this issue and get smart about this. Dr. Bonnie, can you give us a little bit more granular details on what these community-based interventions might look like for firearm violence?

BONNE: Sure. So, one of the big things that hospitals have been working on over the last several decades actually, is this idea of hospital-based violence intervention. And so, this doesn't necessarily mean gun violence. It can mean any kind of interpersonal violence. But the idea is that when people are in the hospital and are a victim of violence, there's many reasons why this may have happened to them, and many of them are related to the social determinants of health.

And so, if we can help our patients mitigate those social determinants of health, then maybe we can prevent them from becoming revictimized or being a victim of violence a second time. So, believe it or not, many of the patients that we've seen in our emergency rooms have ... some of them have been shot before and are coming in shot again.

And some have been the victims of other types of interpersonal harm and are coming in either shot or stabbed or assaulted and being revictimized over and over again. And so, what we've done is we've helped our, our community organizations bring individuals into the hospital, or we hire people into the hospital who then help those patients understand and mitigate those social determinants of health.

Um, and we use that moment in the hospital to really create sort of like a fork in the road moment for our patients. So where this comes from is kind of some of the cardiac literature. For example, if I have maybe an uncle who is, um you know, overweight and smokes and has high blood pressure, I can say to him, like, you need to take your blood pressure medications and lose some weight and try to quit smoking. Um but when he's in the hospital having a heart attack, that's the moment that everybody's ready to eat better, and stop smoking, and start taking their blood pressure medications. And so the same sort of applies for violence, as we can say, like, look, if you are not in a safe living situation, if you haven't finished school, if you're not um with stable employment, if you don't have an identification, if you have certain tattoos that maybe you've gotten in the past, that makes you at a higher risk of becoming a victim of violence.

But we can help mitigate some of that. We can help you find safe housing. We can connect you with job employment agencies or with um, with educational resources. We can do tattoo removal. We can do all of those things to make sure that you don't ... we don't see you back here in this emergency room, in this place again. And we do all of that with the assistance of community health workers and community-informed and trauma-informed individuals.

So, people who really can deliver that message um in a way that provides that patient with a mentoring relationship, with the additional support that they need, with help navigating all of these community resources. Um it can be very, very difficult to navigate all of the resources that are available to people and then try to do it on top of recovering from an injury. And it's almost impossible. So, by giving people that extra help through these community health workers, through these navigators, we can help mitigate these social determinants to help improve and reduce um the chances that somebody is going to end up in these hospitals again.

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And this is actually a data-driven approach. So, people have been researching these programs for the better part of two decades now.

There's some really good organizations that have been doing this a really long time and have proven that it works over time by tracking the patients and tracking their hospital data. And there's even a national network of organizations that are doing this work. It's called The HAVI the Health Alliance for Violence Intervention. They have a website. You can check it out. And this is a national organization of hospital-based violence intervention programs that are working with community-based violence intervention programs to build these models that make sense to help people after they've been violently injured.

AMIEL: That's really fascinating! And it is small but powerful little changes that make such a big difference to, to really equip people with. That's fascinating. Thank you for sharing that.

Wow, we can clearly see how interprofessional violence intervention programs and partnering with the community can really make a difference to help prevent or address firearm injury and violence. We don't have to wait for a terrible incident to happen before we can make a difference. Prevention and partnering with the community is a great way to decrease injury and encourage better outcomes. Thanks for joining us for episode two! We wrap up our conversation about firearm injury with a short episode three where we discuss supporting healthcare workers and more about intervening at the community level.

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Episode 3 – Supporting Healthcare Workers and Intervening in Communities

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AMIEL: Welcome back for our last episode, episode three. Let's continue the conversation by talking about providing support to healthcare workers.

I hear a lot of what we can do for our communities and what we can do for our patients. Right? … and just the broader world. But I'm wondering then, so I sit here and I'm wondering, "What are we doing about our own selves?" And I'm thinking about what you mentioned earlier in our conversation about how your experience changed after becoming a mother.

You know, and I think about that, you know, there is a very real impact on all of our healthcare workers who have patients, are taking care of patients, or witnessing this type of violence. And what does that then mean for us? Who's taking care of us? Where's the committee for us after all of this, after this terrible week you've had, this terrible month, this terrible year of all of this. What about us?

BONNE: Yeah, I think that this is such an interesting issue and is actually something that really goes unaddressed. I think that we've seen more um, you know, healthcare burnout, healthcare worker burnout in the last few years. And particularly with the COVID pandemic, this became the forefront of everything. Um, and this is something that we're, we're not there yet. And we are still seeing a tremendous amount of healthcare worker burnout.

And some of that is, I think, you know, what is burnout? We work very hard. That's long hours. It's physically demanding. We are, you know, it's emotionally draining to be available to, to patients and their families all the time in the way that we need to be. Um, and we've recognized that by giving people tools for things like mindfulness and, um, and support systems through the hospital and, you know, de-stigmatizing mental health and saying, "You know, it's okay to talk to somebody if you need to." These are all things that have been positive changes.

But my feeling is that we're still not there yet, that we still need to be better about supporting one another and supporting our colleagues within the healthcare system. And I think we also need to really have a conversation about the difference between burnout and moral injury, which is, you know, burnout has to do with stress and work and all of those kinds of things.

But moral injury is really you know, I think what comes when you're seeing a problem over and over and over again, and you know that there are answers to it, and you just, you can't stop it. And that is where people really, really struggle with "I'm seeing children." "I'm seeing people in my emergency room every day who are shot." It's just pain after pain after pain. And I know that there are solutions to this, but we just can't seem to implement them, or people don't care enough to implement them. And that's where I think healthcare workers really need to look out for one another is when it becomes less about like, "Hey, I just need some time off. I need to collect

myself, I need to um be more mindful and, you know, use these tools that I have to prevent burnout" versus the conversation that is very different when it starts to feel hopeless. Um and those are the colleagues that we really need to be looking out for right now, because those are the ones who are either going to leave the profession, which is incredible losses, or those who are at risk of, you know, hurting themselves.

And so, I think that that's something we really, really need to focus on. And we're not doing the job that we need to do um for that right now. We can all do it in our own spaces. You know, check in, check in with the people that you work with.

AMIEL: Yeah, I think that that's ... I'm really glad that you brought up the two things: burnout and moral injury. Really, you know what that feels like. And that's just very different things. And you're totally right. And I think, um, you know, I bring this up, because with the pandemic that's happened, we are, we kind of heard all these key terms and these big like words, like "Be resilient" and, and, you know, "Push forward" and "Self-care" and all of these things. And I have to tell you, honestly, as an RN, I was wildly annoyed with it, wildly annoyed, because I don't need you to tell me to be resilient. My resiliency isn't the issue. The pizza party doesn't make me feel better at the end of this, you know, this shift.

BONNE: Yeah. There's no amount of yoga that's going to make me feel better about an ICU full of COVID patients.

AMIEL: Absolutely not! I don't care how much massaging that you're giving my shoulders, I don't feel better. Right? There's a bigger issue happening. So, I'm really glad that you, you brought those two things, you know, out. And so that's an, that's an important piece, because we are witnessing a lot of violence, and we are just witnessing a lot of, you know, working conditions that don't feel good and can really, really have profound effects on our own, you know, our own psyche in that way. Now, I'm just curious if you could speak a little bit. You gave us a lot of information, really good information. I'm curious if you could speak a little bit about maybe giving us a scenario, giving our listeners, our nurses, our pharms, our physicians, anyone who's listening in, just giving them a scenario of where a team like this, you know, where a multidisciplinary approach like this working towards firearm violence has really been a success or has started to be a success and played out and maybe give us some ideas and how we can carry that same thing back to where we are.

BONNE: I think that there are um several good examples around the country where we've had really good multidisciplinary programming. I think that. So, there's several ... So if we take urban violence, for example, and, and look at the, the urban violence issues that contribute to gun violence, then we might be thinking about things like cure violence programs, hospital-based intervention programs, community-based programs, and enforcement-based programs.

And I think there's a lot of places where one of those programs exists, but it's really having all of them, having all of them working together and then bathing all of that in the sort of bath of economic investment um and community that that has really become successful. I think we've seen a little bit of that maybe in, maybe in Oakland a little has, has had a pretty good success. Um and some of the other, there's some other cities that have seemed to really figure this out, but they're, it's really hard, I think, on a more micro level, looking at um like hospitals, for example, that have invested in community health workers, have invested in violence intervention programs, have invested in primary care and mental health, um and have really invested in the success of their community partnerships.

So, the one that really comes to mind is um there's been a lot of investment in Boston around housing and community investment from the medical centers, where the medical centers themselves are, you know, partners in um in housing, equitable housing projects, in not projects but um how like buildings and apartments really close to the medical center that help the patients and help the community, but also like uh investing in local businesses to do the work of building these, um this housing and how, how much housing is, is integrated into this.

And so that's like another really good example. And then, you know, just in individual groups and individual practices, you have groups of people who are like-minded, who have interests, who put on community

programming. You know, there's a getting out into the community, doing safe storage demonstrations, talking to families, going out to the schools. You know, a doctor and a nurse in a school is a tremendously powerful tool um to talk to. … you know, teachers and principals about being safe. And so that's, I think, what some of these multidisciplinary and interprofessional partnerships can look like from, you know, from the scale of an entire city down to the scale of an individual practice.

AMIEL: Yeah, that's excellent. That's excellent. Dr. Bonne, you have given us a ton of great information, and it really has been really great talking to you about this. And, you know, honestly, I hope that people are really feeling … maybe empowered, is the word to say, "You know what, we got to do something." Right? We got to do something about this and that we all have the individual power where we are, whether you are a physician, a nurse, a pharmacist, a medical assistant, unit secretary, it doesn't matter, to really stand up and say, like, this is a problem and you're right, we need to tell the whole story. And more importantly, we're a part of this, we're a part of this, and we can be a part of the solution for that. So, I appreciate you really, really, you know, uplifting that. And is there anything that we haven't covered that you'd like to leave our audience with?

BONNE: No, I just, I don't want anyone to feel um overwhelmed and/or like this is not something that we can address. I think that sometimes, you know, I look at those numbers that we talked about, the 40,000, and think, "How are we ever going to move the needle on this?" But if everybody comes together, if everybody takes their one piece of it, then there really are very viable solutions, and we can make this happen.

But it really, it's about compromise. It's about working together, it's about listening, and it's about really thinking about what the root causes of these problems are in a very real way instead of being reactionary when something happens … and not letting up. You know, we tend to have a whole bunch of stuff that comes up every once in a while when there's a big event that draws a lot of attention. But we really need to recognize that this is a problem that affects people every single day. And so, we need to be working on it every single day.

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AMIEL: Yes. Thank you so much, Dr. Bonne. Appreciate you taking the time, and I appreciate the work …

BONNE: Aww!

AMIEL: … that you're doing quite honestly. You're doing really big, important work, and I appreciate that. So, thank you for your time, and thank you for this knowledge. And I hope everybody enjoyed listening to this conversation today.

BONNE: Yep, thanks for having me.

AMIEL: Thank you all for joining this podcast. We can really make a difference by supporting our fellow healthcare workers and colleagues and by getting involved in our communities. One step at a time, one intervention at a time, one even small little thing at a time can make a difference in the prevention of firearm injury and for decreasing violence within our neighborhoods, our communities, our hospitals, …just generally where we live. Let's support those doing this work and see how we can get involved in helping make a positive difference!

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