COMMONWEALTH OF PENNSYLVANIA

HOUSE OF REPRESENTATIVES

JUDICIARY COMMITTEE

LEGISLATIVE SEMINAR

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In re: Defining the Public Health Problem of Violence

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Stenographic report of hearing in Fourth and Market Streets, DER Building, Auditorium, Harrisburg, Pennsylvania

Monday,
January 10, 1994
1:40 p.m.

GUEST SPEAKERS:

DR. ALLAN S. NOONAN, SECRETARY OF HEALTH
JAMES HOLLIMAN, M.D.
RICHARD MCDOWELL, M.D.
J. STANLEY SMITH, M.D.
KYM SALNESS, M.D.

MEMBERS PRESENT:

THOMAS CALTAGIRONE	HAROLD JAMES
RALPH KAISER	ROBERT FLICK
FRANK LAGROTTA	STANLEY JAROLIN
ALBERT MASLAND	DONALD SNYDER
DENISE LEH	
DICK HESS	
GREG FAJT	
JERE STRITTMATTER	

REPORTED BY: JANET E. SMITH

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MS. MILOHOV: I'd like to welcome the presenters to our first legislative seminars on roots of crime. Today, we should have excellent information for all those here regarding the issue of violence brought on by the use of guns and trauma.

And I would like to introduce the secretary of health Allan Noonan as our beginning speaker. Thank you.

DR. NOONAN: Good afternoon. I'm happy to be here to spread the word. And I'm going to talk for a few minutes and then open it up for questions if that's okay.

I've been in the public health for a quarter of a century. And now, as secretary of the fifth largest state, it becomes more and more apparent to me that each day the violence is much more than a matter of police and law enforcement, the courts and the judicial system, discipline and punishment.

Violence is a matter of public health. And even more important than that, violence is preventable. Violence takes a horrible toll in our society, has a devastating impact on all segments of life nationally and Pennsylvania alike.

Violence can be expressed in a variety of actions. But today, I'd like to focus on five specific areas: homicide, suicide, child abuse, elder abuse and

domestic violence.

I have a series of overheads to try lay out the picture for you. And Number 1, we see the homicide rates for males from age 1 to 24 in the United States compared to other western countries.

And you see that a male in the United States has a three times greater chance of dying of homicide than a male in Canada or in more than that, any other rest of the countries. We are dramatically more homicidal than other western countries.

The next slide shows that the overall homicide rate is much higher than the other nations and it holds for Pennsylvania. Pennsylvania's homicide rate is near that of the nation.

What stands out is the rate of homicide among black males. The increase in homicide deaths since 1985 is due, in large part, to the increase in deaths among black males.

This is a very interesting chart. One that I have been talking about for many years now. But it shows the history of homicide in this country.

And during 1991, '92, how high the rate of homicide was, and it was alarmingly high and never been higher. But we could see that there have been previous peaks, peaked in 1975. And then there's a long cycle.

This only goes back to 1930, this graph.

But there is information that indicates that in 1907, we may have had a rate of homicide as high as the rate in 1992. That data was not as good. So it's not as specific. So I can't be absolutely sure that that's the case.

But the point is that homicide is a sick problem and has been one in this country for many years. The rate for black males has risen since 1985.

It's part of that cycle that I just showed you. And if you look at the rest of the population, this is black males, if you look at the rest of the population, white male, female and black female, the rates are significantly lower. And that cycle isn't there.

So in 1985, we began again to see the cycle of increase in homicide and began to see it in black males. In the next slide, black males have a higher rate of homicide across all ages.

This is especially true for young men 15 to 24 and 25 to 34. A rate of 123 per hundred thousand and 25 to 34 age group; and 121 in the 15 to 25 range group.

For white males, these rates are 6.1 and 7.1. Homicide is the leading cause of death for black males from age 15 to 44.

As you can see from this next graph, a large

percentage of homicide deaths are from firearms and explosives, two-thirds of them.

Cutting and stabbing are now only 15 percent. If you looked at the figures in 1950, 1951, cutting and stabbing were more frequently the source of method used in homicide than explosives and firearms. So we're seeing that change. And then you see the strangulation and other forms are small part of the problem.

But not only do black males have a higher rate of homicide. They also have a higher rate of death due to firearms and explosives as compared to the overall population in slide 7.

Okay. So these numbers are bleak. It's true that homicide is going up. It's true that it's going up in black men, particularly in young black men.

And the devastation in the population is overwhelming, and the devastation station in the black population is more than overwhelming.

I'd like to turn now to another violent cause of death, and that is suicide. Pennsylvania, by and large, mirrors the national picture for suicide also.

And you can see, again, that males have a higher rate of suicide than females in almost every age group. The black lines are Pennsylvania. The gray bars are -- the black are Pennsylvania and the gray bars are the

United States.

And here we have white male versus black male. And you can see that suicide rates are absolutely higher among white male than black. And females are in a different category when it comes to committing suicide.

Let me mention that suicide, like homicide, is not a problem just of the cities, not a problem just of the ghettos. It's an urban and a rural problem.

In fact, in 1990, the suicide rate per 100,000 was 11.8 for urban people and 13.5 for rural people here in Pennsylvania.

In slide 9, you can see that suicide spans all age groups, white males 65 and over having the highest rate.

If you look at this, the 15 to 24 and 25 to 34, we have this is the black male bar. In most states, white males are always at the top of the frequency of suicide.

In this state, the 25 to 34, black males commit suicide more frequently than black males. That's a little bit of a difference between the national picture. But, except for that difference, this is pretty much the same as what we seen all over the country.

Now, how do people commit suicide? By guns

and explosives. No longer surprising to us. More than half suicides committed in Pennsylvania are committed with guns and explosives.

Hanging and suffocation comes in second and then the other more, what I think of as exotic ways of committing suicide.

Pennsylvania is has the second highest rate of people over 65 than of all states in this country. So he have a very elderly population.

Yet, elder abuse has not received the attention that homicide does. But it's a serious condition that exists in our communities and with which we must come to grip.

In fiscal year 1992, the Department of Aging reported that there were 8,000 reported cases of elderly abuse. 31 percent of these were substantiated as you can see in this slide.

In the next slide, of the substantiated cases in 1991/92 and '92/93, the largest percent of cases took place in the victim's own home.

You can see that more than three-quarters of the cases of elder abuse took place in the home of the victim.

And the top bar is for victims of elder abuse who live alone. That's what the A stands for. And the

second is for victims of elder abuse who live with others. That's what the O stands for. Whether they're alone or with family, elder abuse takes place primarily in the home of the victim.

And just for comparison, this is caretaker home. Nursing homes, you hear a lot about nursing homes. But look at the difference.

Personal care home. We have problems in all of these facilities. But here again, you have to teach people how to behave themselves in their own situation just as much or more so in regulating facilities that we have direct control over.

The next slide, we have a breakdown of elder abuse by type. What do we mean by elder abuse? And this is the percent. And we see we're not talking about physical abuse. We're talking about emotional abuse, self-neglect, a major part of the elder abuse as is caretaker neglect and financial problems which lead to abuse.

So elder abuse is a very complex problem. It's a problem that we need to address looking at nursing homes and looking at the facilities we have.

But we need to address much more aggressively looking at people who are out in the community, trying to help them take care of themselves and keep from abusing

themselves or abusing people they're taking care of.

Then the other end of the spectrum takes us to child abuse, back to pediatrics and paternal and child health.

And the Department of Welfare reported over 25,000 cases of child abuse in 1992. Of those 25,000, 8,000 were substantiated. Over the last 10 years, the number of substantiated cases have risen from over 5,000 to a little almost 8,500.

So child abuse is becoming reported probably more efficiently. But we also think that the rates of child abuse are increasing.

Almost two-thirds of all substantiated child abuse cases are committed by the parent of the child. One-quarter of these cases are committed by another relative.

So we can see that 88 percent of child abuse cases are perpetrated on the children by members of the family. We get back again to the behavior of people in their own setting, not in settings where we have direct control.

Another important and shocking part of the child abuse is the number of repeated cases of child abuse. You can see the unsubstantiated gray bar, the black bar is substantiated. Look how 5 to 9 year olds, 10 to 14 year

olds have been abused before, have documented abuse before and see them again in seeking medical care for child abuse at that age.

So we have a major job to do in teaching people who have already identified themselves as abusers how to deal with the stress that makes them resort to child abuse.

Domestic violence causes more injuries to women which require medical treatment than any other. Nationwide, there are over 2.1 million women battered each year.

In Pennsylvania, in the 1990/91 fiscal year, in Pennsylvania Coalition Against Domestic Violence received 78,000 reports of domestic violence.

Again, this is a problem that exists in all pockets of the Commonwealth; urban, rural, rich, poor or black/white.

The problem that we have to see as part of the violence picture, a problem that we have to see as preventable as we get public health more and more involved in the violence picture.

The last slide shows domestic violence child abuse, elder abuse, street violence and the cost. In looking at the agenda of this retreat, I see that a lot of the people have talked about cost. And I hope these

figures coincide with the figures you already seen.

But what you can see is that violence, if you look at the dollars, costs a tremendous amount here in Pennsylvania.

And, in fact, one of the things I didn't mention when I talked about homicide was that we look at homicide as a measure of violence.

For every case of every one case of homicide, it's estimated that 100 people seek care in an emergency room for an attempted homicide.

So the homicide figures are just the tip of the iceberg. So, we can see that violence is an intolerable situation and one that is preventable.

Injury and death caused by intended acts of violence in Pennsylvania are robbing our people of their life, their health and their security.

But the people we know that are frustrated by unemployment, poverty, inter-personal strive, marital difficulties, racism and other problems living in the society. The problem is further compounded by drugs, the fact the first place where we put our action was in parallel with drug and alcohol programs.

And another part of violence in this country is what I will label here the American macho lifestyle. It's not acceptable for men to negotiate, for men to feel

hurt. It's only acceptable for men to lash out and fight back in many societies here in this country.

As I've pointed out racial and minorities, in particular, are at the highest risk of death of injuries and violence.

That's what we see in many other health problems. We must accept that violence is a learned behavior. And that to reduce it, we must change broadly the behavior within the society.

Human behavior will have a permanent place in the future of public health. We can change public health and human behavior. We've already demonstrated that.

If you look at some of the successes that we can brag about, we changed the behavior that led to smoking. We changed behavior in many cases that led to drug abuse, and we hope to change that behavior more and more as we integrate drug abuse and drug abuse prevention into public health in preventing AIDS.

And that's a behavior change. That's the way we prevent AIDS. So behavior changes, getting the population to change behavior is going to replace the focus on infectious disease in public health.

Public health started out in controlling infectious disease. I am convinced that during the next half century public health will focus on this. But there

are many parts of the public health where this has not been recognized.

We would not have experts in behavior in health departments in public health agencies. And there are still people in public health who are insulted when they call them social workers, etc.

But that kind of ability, that kind of skill is so key if we're going to work with communities and work with families in helping them to develop strategies, develop behaviors which will reduce violence.

As you've heard time and again, programs for children are of paramount importance here in Pennsylvania. If the children of today are taught to solve their problems without violence, then the children of tomorrow will develop in an environment that discourages violence and encourages creativity, thought and knowledge.

When I first came to Pennsylvania, I was upset, as I am with many health departments, to find there was no anti-violence strategy within the health department.

But one of the first things we did in the health department was to undertake a strategic planning effort where the leaders of the department were asked to spend time sitting down talking with one another and also with some national public health experts and asking, What is our mission and priorities?

And violence was among the top six priorities identified by the health department during that exercise. So based on that exercise and based on the need that we've seen here today, we took our first step last year in allocating $400,000.00 of the preventive health block grant to award many grants to communities to help them develop violence prevention programs especially for children.

I am pleased that the first round of awards of totalling 112,000 was made to 13 community-based organizations around the state.

The grants ranging in varying amounts from 4,000 to $10,000.00 will be used to assist groups with violence prevention in communities such as Harrisburg, Wilkes-Barre, Philly, Pittsburgh and several other parts of the state.

Grants have been made to agencies in urban and rural communities alike. And acknowledging that no city or town or neighborhood is immune to the ravages of violence. Programs which have been selected are community-based and custom-tailored to respond to the community's specific needs and issues.

They encourage the investment of individuals within the community to work on the problem and reflect collaborative efforts of the church, law enforcement, schools, businesses and health.

Violence prevention programs are designed to meet the needs of different communities around the state. And I'd like to give you a couple of examples which are very exciting to me.

Right here in Harrisburg, the design academy church received over $8,000.00 for a program that targets African-American youths for conflict resolution and mentoring.

While in Philadelphia, the Big Sisters Organization received $10,000.00 to conduct outreach crisis intervention programs for Hispanic girls who are at risk for substance abuse, teen-age pregnancy and domestic violence.

In Cumberland County, the Carlisle YWCA received close to $5,000.00 to provide 13 hours of training and mediation to 4th and 5th grade students, elementary schools, who will then go out and work as mediators of conflict among their peers.

I had the joy of running into one of the students at a local conference. And it was a young man. He was probably in the 6th grade who had on this glowing yellow hat, and I couldn't read what it said on his hat.

And I went up and said what is the hat all about. On the hat, it said, Fuss busters. What's that? He said, Well, when it comes time for recess at our school,

we go out and have our hats on. And if anybody is getting into an argument or a fight, our job is to go over and mediate the dispute and keep it from coming to conflict.

I could see then that the ideas are out there. The strategies are working. And in Allegheny County, the Wilkinsburg School District received $10,000.00 to increase the self-esteem of 150 6th graders by having them participate in alternatives to street gangs by performing random acts of kindness gangs.

The names of the gangs is Random Acts of Kindness gangs. These gangs include all aspect of the gang membership which are attractive to young people, the rituals, the signs. But the member's duties or responsibility as a member of the gang is to carry out a anonymous acts of kindness in their own neighborhood.

So these are some of the things that we've done. We have worked closely with the State Police, with corrections, with welfare, with education, in trying to develop a collaborative strategy to prevent violence. Our focus is on young people.

We realize that that is just the beginning. We have major issues to deal with around the area of collection of data.

If you look at violence data, police data is different from corrections data is different from health

data. And nobody knows what the reality is.

So we have that part of the problem to address. This is a start in addressing the health promotion part of the problem, and we will also have some quality assurance problems once we get into the business of preventing violence so that we can know who is being effective and who is not. And thereby, place priorities on the most effective strategies within the population.

So that's just a brief overview of where the health department has started to go in this arena. Let me also indicate that within public health, this is a growing concern. Nationally, we're getting a lot of attention paid to the violence issue. And many states are beginning to get into prevention of violence as part of health.

So we're not alone, but everybody who is involved is very anxious about the lack of information that we have and the lack of evaluation and the lack of knowledge about the best way to address this very significant problem. Any questions?

MR. MASLAND: I have one question. It was the next to last graph where you had the unsubstantiated and the substantiated child abuse situation.

Were they directly related? Are you saying that somebody went to an unsubstantiated case and then later on, there was another act of violence and that was

substantiated? Was there a direct relationship?

DR. NOONAN: No. Those were two separate graphs on the same bar.

MR. MASLAND: It said re-abuse. I wasn;t sure whether that meant you had somebody that was in an unsubstantiated case that was later involved in substantiated.

DR. NOONAN: No. Previously substantiated.

MS. MILOHOV: With the National Federal Secretary of Health and other states secretaries of the health band together to have, like, television advertising campaigns to hopefully help educate the public; or are there any sort of campaigns slotted to build awareness and understanding of the issues?

DR. NOONAN: I have not seen any specific funds in that part of the activity. It's been done state by state. I'm not sure that it will be done nationally. I suspect it will be done nationally just by talking to the violence prevention nationally. I haven't seen a concrete program for that.

MS. MILOHOV: Do you have any idea how education might help resolve some of the problems?

DR. NOONAN: Do you want me to talk all afternoon? Well, Number 1, by supporting public schools. If we abandon our public schools, which I think many of us

are doing, we're going to see that these kinds of problems will get worse.

Number 2, we need more men in elementary schools. Number 3, we need to make teaching a more honored profession.

I guess I think of being a physician as the best thing you could do. But I think very close to that is teaching. I think we need to get more socially minded men into the teaching profession so that young people, especially young boys, have a male figure to deal with if there's none at home.

And have that male reality which they don't encounter until they get out of school, until they drop out of school. And then they encounter it through unsafe means. That's just the beginning.

In fact, the Department of Education has also put into place the violence prevention strategy. And I think the community strategies and the school strategies have to go hand in hand.

MR. MENDLOW: Do you see the issues of jobs and poverty tied in with this whole public health concern, or is that more of a social concern or the two were linked?

DR. NOONAN: They're linked. There's no question. I think that public health has to begin to see itself as more than just providing medical solutions,

medical preventions.

It's got to tie into homelessness. It's got to tie into jobs and unemployment, and all of knows things. And we are making efforts in various areas. For instance, a drug and alcohol program is working with homeless programs, trying to integrate strategies for the homeless.

If you look at TB, the rates of TB in some of our shelters are more than alarming. They're all tied together which makes it much more complex to come up with a successful strategy.

MS. FORRESTER STAZ: Could you please expand a little bit about what the department is doing with your sixth strategy on violence, what all is happening through the department on that one?

DR. NOONAN: Yes. I didn't hear you.

MS. FORRESTER STAZ: You said that the department had a strategy plan in one of the six areas was violence. Would you expand a little bit about what the department is doing in that area if you have some flyers or how is that violence piece working within the department? And the other is --

DR. NOONAN: I just talked about that. $400,000.00 to prevent --

MS. FORRESTER STAZ: If the 400,000 was set aside and 100,000 was used, what's going to happen with the

other 300,000? How does that come together?

DR. NOONAN: It's separate granting rounds. For the first year that we're involved in violence, our priorities community-based programs, we have $400,000.00. We've only spent 112,000 so far. But we will spend 400 this year.

MS. FORRESTER STAZ: There's going to be another rounds of grants?

DR. NOONAN: Yes.

MS. FORRESTER STAZ: And community-based or?

DR. NOONAN: Yes. Our first strategy is to go the community-based, knowing that the Department of Education is working in the schools. But the amount of the money is very small compared to the size of the problem.

MS. FORRESTER STAZ: Is there a particular person -- this is my third question. Is there a particular person at the department who's appointed as responsible person to work within the violence effort?

DR. NOONAN: Yes; Gene Boyle.

MS. FORRESTER STAZ: Thank you.

MR. RALPH KAISER: About abandoning the public school system, as legislator, I see us sinking more and more money in the public school systems.

And, you know, I don't see us abandoning people within the system. Maybe they're not focused. It's

hard to say. It's a tough call.

DR. NOONAN: I'm not an expert in education. But I have seen figures like $4.00 per -- $4.00 per day per student in rural intercity versus $15.00 to $16.00 per day per student in suburban schools.

From personal experience and from the things that I've read, I think that in poor and intercity schools, at least, the teachers largely have given up. And they've given up because one of the reasons is lack of support, lack of pats on the back that they're doing a very valuable job.

MR. KAISER: That's the problem. You know, the money is there. It's just having the right people.

DR. NOONAN: $4.00 compared to 16.

MR. KAISER: You're talking about the equity. If you look at Philadelphia and Pittsburgh, they're school districts do receive a lot of money from the Commonwealth.

You got rural areas like Green County or Somerset, those schools do not receive as much money. But one of the problems I think we have is you have administrators who don't get that pat on the back.

And a lot of teachers are thinking they're going to be in here four years and out and in for a year or two. And that's the big problem.

Like you had said earlier, by get more black

male teachers in the elementary grades maybe that would help out.

DR. NOONAN: Not just black, more men. I think we need more male representation in the elementary and junior high schools, including black men.

But, I think this sounds like the old struggle of where the problem lies. I'm not going to say that schools don't have administrative problems and spending problems.

But we see the problems in schools today. And, yet, we're talking about taking tax money and spending it on private schools.

I know, personally, a young lady who teaches in a high school who's had a gun held up, stepped between two grown men, because that was the size of them, who were fighting with knives and who then received no support from the principal or the school system in helping to keep that kind of behavior changed and modified. It's a war zone in there. And it's frightening.

MR. KAISER: If you want to place blame, I think it starts from the principal down?

DR. NOONAN: I don't want to place blame.

MR. KAISER: I think blame has to be placed from the principal down. If you want to run a tight ship, you can do it. I read a newspaper article about a

principal up in the Bronx.

Very violent school. Within one year, she cut it down in half. She made a point that violence was not going to be accepted in her school. You can do that. It doesn't take money. It's a change of attitude.

DR. NOONAN: It's very difficult. And you get these anecdotes of people who do it in a community where it's not the rule. And they stand out. And these are probably outstanding people.

But what we need to be able to do is to make that kind of capability less outstanding more than normal. And that's where the support and standardization comes into play.

MS. MILOHOV: Thank you very much. Next, I'd like to introduce Dr. James Holliman who is a practitioner and professor in emergency care.

DR. HOLLIMAN: Essentially, everything I have to present today is taken directly from a series of articles from medical journals and copies are available with the set of handouts.

The handouts I put together for this were a summary and fact sheet of what I think are some of the alarming statistics related to gunshot wounds.

Most of my comments I will try and stick pretty much just at the gunshot wound aspect of the

violence problem.

The second thing I prepared was a reference list of the key medical articles related to the gunshot wounds and the cost of taking care of these in this country. There's a brief analysis for each of those articles.

In addition, I think there's a sheet that is my personal individual opinions on some of the things that can be done about this.

And that, I think, is certainly potentially controversial. And I don't want to address that. I think more presentable are medical and statistical facts.

I'd like to make a few comments just so my personal background and training so you're aware of where I'm coming from.

I'm a member of the faculty at Penn State University at Hershey. Also a member of division of trauma of critical care at Penn State.

I served as the education coordinator for the center for emergency medicine and basically run all the training programs. We have to students residents and outside physicians.

My undergraduate training was at Duke, Washington University in Saint Louis. And I did residency training and fellowship training in burns and trauma at the

University of Utah in Salt Lake City.

I'm board-certified in emergency medicine and in practice for about 10 years. I also worked as the medical director for U.S. Health-Tec which runs all the emergency ambulance care for the City of Reading. I used to be in private practice in Reading.

In addition to running those training programs, doing research and administrative work with the pre-hospital care and developing programs, I also take care of the patients in the emergency department probably about 36 hours a week.

And because of that, I get to see, on a regular basis, patients injured by violence and by gunshot wounds in the emergency department.

Now, on the personal side, I actually own a number of firearms. I enjoy target shooting. I used to hunt ground hogs. My father is an avid NRA member and a licensed gun dealer. And I know his views are in considerable variance with my own.

The other physicians that are here today in include Dr. Richard McDowell. He's the former state director of the emergency medical services. He's currently the president of the Pennsylvania chapter of the American College of Emergency Physicians.

Dr. McDowell is a theme as president for

physicians to deal with violence and try to reduce the level of violence as a public health issue in this country.

In addition, Dr. J. Smith, who's an associate professor of surgery at critical care in Hershey. He's also here. He's the founder and director of the trauma program at Penn State, Hershey.

Dr. Salness, who is the new director of the center for emergency medicine who moved here from California is also here. And these other physicians after Dr. McDowell speaks, we're going to sit up front and the panel will have a question and answer session and additional comments could be addressed. And they can present their views on the same problems.

The first set of things I'd like to talk about are sort of a general scope of gunshot wounds in this country in terms of statistics.

Currently, there are almost 40,000 deaths per year in this country from gunshot wounds and about 300,00 non-fatal gunshot injuries.

The exact figures for '93 haven't been compiled or made available. Everyone expects that these totals will exceed the record set in the year 1992.

As of December 29th, 1993, 22 major U.S. cities had set new homicide records for the year. I won't read the entire list. The most noticeably is Pittsburgh.

Closer to us, Washington D.C., the murder capital of the country set another record.

Baltimore, Maryland is in this top 22 list. New Orleans, Saint Louis, which used to be the murder capital when I was in medical school. And a bunch of other cities all across the country.

Now, a breakdown of the causes of firearm deaths from 1991 data is kind of summed up like this. Total firearm deaths for that year were over 38,000. Of these 18,000, were suicide. 17,000 were due to homicide. And accident or unknown causes, a little over 2,000.

In 1992, there were 22,540 homicides throughout the country with 12,489 of these due to handguns. So that handguns constituted 55 percent then of all the homicides.

Total firearm homicides then in 1992, the same year, were a little over 15,000. So handguns then represent about 80 percent of all firearm homicides. In addition, handguns also caused 80 percent of all firearm deaths because of the percentage of handguns are used in suicides.

In 1992, over a thousand people were shot to death at the place they work. This constituted 17 percent of all work-related deaths throughout the country that year.

The current sort of sum data, you might say, there is one death for every 6,500 people in this country per year or 15 per 100,000 per year.

Of the firearm homicides that occur each year only about 300 throughout the country are so-called justifiable homicide by people defending themselves or the police. That represents less than 2 percent of the firearm homicides.

Most firearm homicides victims are of young age. This represents a tremendous number of years of life lost. A lot of different diseases that we deal with medicine are dealt with on calculated how many years of life lost.

Gunshot wounds that adds up to 700,000 years of life lost per year in this country. Gunshot wounds are now the leading cause of death in teen-age boys in the U.S.

Suicide is now the third leading among children and adolescents in the United States. This rate has doubled in the past 30 years. And almost all of this doubling is directly due to firearms use.

From 1960 to 1980, the population of the country increased by 26 percent. But the firearm homicide rate increased 160 percent.

Currently, every 1 1/2 years in the United States, the same number of people are killed or wounded by

firearms as were killed and wounded in the entire Vietnam War.

In the 1980s, when you figure up over the whole decade of '80s, three times the people died in the United States from gunshot wounds as died with AIDS.

During the course of the Persian Gulf War, the Martin Luther King Center in Los Angeles admitted more gunshot victims, over 800, than the number of Americans killed or wounded during the war, which was about 600.

L.A. currently has more gunshot wound in any time period than Beirut. In about 60 percent of the trauma deaths that concern urban trauma centers are due to gunshots.

In 1990, Texas passed a new milestone. The number of deaths due to gunshots, over 3,400, exceeded the number due to auto accidents that year which was about 3,300. Louisiana has also crossed this threshold.

If current trends continue, it's projected that the number of deaths from gunshots to the entire U.S. will be more than the number of deaths from car accidents perhaps as early as this year, certainly, by the year 2004. And I have a reference in the reference list that shows you the graph and statistics for that.

Now, Pennsylvania, unfortunately, I think Dr. Noonan alluded to some of these is just as effected by

gunshot wound injuries as anywhere else in the country.

In 1992, there were 1,431 cases of gunshot wounds admitted to the state's trauma centers. This number does not include the number of people throughout the state that were killed by gunshots and never reached the hospital as well as patients that were treated at the state's numerous non-trauma center hospitals.

For instance, Harrisburg, I think, actually sees more gunshot wounds than we do at Hershey a few miles away.

Dr. Jay Smith has the breakdown of all these reported cases if you're interested. And we can extend that as part of a panel discussion.

The highest percentage of firearm injuries due to deliberate assault with firearms occurs from the Philadelphia reporting region.

Of the total 1,400 gunshot cases that we've seen in trauma centers, over a thousand were due to assaults with firearms, deliberate intent.

The next series of comments I'd like to make are about international comparison. Dr. Noonan presented in data related to this the overall homicide rate in the United States is at least 6 to 10 times that of most European countries and other developed nations homicide of the males 15 to 24. He had a nice graph.

Currently, about 9 times higher or 37 for 100,000. And the closest which is only 4 for 100,000. The U.S. rate is 40 to 80 times higher for that age group, 15 to 24 than for, say, any of the other western countries and Japan.

Another source of telling statistics in the nation of Sweden with a hundred million people. They had two gunshot wounds in the entire nation in four years. And both of these were hunting accidents.

Some other statistics. In 1990, handguns killed 22 people in Great Britain, 68 in Canada and 87 in Japan. And 10,507 in the U.S.

A comparative study of homicide rates in Seattle and Vancouver, two cities in fairly close degree graphics proximity, and I have this reference in the reference list. It showed that the homicide rate in Seattle overall was twice that of Vancouver.

And virtually, all that was due to handguns. And, in fact, that difference is even more prominent. At that time the homicide rate in Seattle is half that of most other cities and the homicide of Vancouver and twice that of other Canadian cities.

The reason for much less rates are in the western European countries, Japan, are clearly multi-factorial.

A major component is clearly the fact that firearms are much more restricted in all of these countries than the United States.

All these countries have a much lower total number of firearms as well as number of firearms per persons than we do in the United States.

Currently, there are over 200 million guns in circulation in the U.S. And about 3 million are produced domestically and have between 2 and 3 million imported each year.

The next section I have on the medical effects of gunshots and I think separate from the consideration of human tragedy and the large number of deaths, they cause tremendous tissue damage and severe medical effects.

Gunshots are now the third leading cause of spinal cord injuries after motor vehicle accidents and falls.

In Detroit, it's the leading cause of spinal cord injury. High velocity bullet injuries from assault type weapons and hunting weapons can cause huge areas of tissue damage and often can cause such shattering of bone that injuries to the arm or left leg may have to be amputated.

A single chest wound from these type of

bullets very often is fatal. It blows out all the blood vessels in the chest.

The trauma centers of the University of Pennsylvania in Philadelphia, and an additional trauma center in Washington D.C. have documented that the average number of gunshot wounds per patient that's increased in the last few years. This is apparently directly due to the increasing use of the semiautomatic multi-round clip 9 millimeter semiautomatic.

The average number of gunshots wounds has increased from 1.6 to about 2.7, and that was as of 1990. And there's been a further increase since then.

1988 report from Chicago reported that 20 percent of their gunshot victims had been shot more than once. And that percentage has also increased.

Another effective of this has been the death rate at the scene from being shot with these guns is three times of that of being shot with other types.

An additional medical effect of these kinds of shooting is that the first bullet that hits the victim tends to spin them. The subsequent bullets hit at different angles. This tends to injure more organs and body structures and it makes it more difficult to figure out what structures have been injured.

This contributes to the tremendous increase

of expense of taking care of these injuries because of the greater number of pre-operative tests that we have to do to figure out what has been injured by the bullets.

Now, in addition to the spinal cord injuries, gunshot wounds also cause severe adverse long-term effects in other ways. These include nerve and muscle damages with result to poor use of an arm and leg, severe cosmetic problems with the wounds to the face and head, lead poisoning from bullets in the body.

One study from Los Angeles showed that victims of firearms have about a 20 percent mortally when they survive long enough to reach a center.

If a patient was injured in a chest or abdomen, mortally was about 20 percent. 49 percent chance of significant long-term disability and 11 percent being made paraplegic.

The complication for abdominal wound was 38 percent. 17 percent of the patients required a colostomy bag and 31 percent required long-term care for a large open wound.

Late deaths far after the gunshot itself occurred from rupture of the heart and complications of subsequent surgery.

In studies of police officers, it was found that they were off duty in an average 143 days after the

gunshot and had an additional period of limited subsequent duty time of about 70 days. 20 percent of the officers had permanent disabilities related to this gunshot injury.

Another international comparison is that each year in this country about a hundred law enforcement officers are killed. About 90 percent of those by gunshot.

In contrast, in Britain, they only have one or two police officers killed per year. That includes some of the spill-over from Northern Ireland.

The next section I want to address is the effects of the U.S. gunshot wounds directly on health care personnel.

Health care workers are now directly at risk of being a victim even working within a health care facility. This was dramatically demonstrated by the shooting of three physicians at Los Angeles County Hospital last year by a person in the Emergency Department.

In addition, an increased number of health care workers have been injured by gang activity in emergency departments. One of the references I have is about a hospital emergency department that was sprayed by a machine gun waiting room because the gang members were waiting on somebody who had been admitted.

And everybody in the waiting room was injured by flying glass. I have a scar from a knife attack when I

was an E.M.T. working in North Carolina before I went to medical school.

Now, the profuse and sometimes uncontrolled bleeding that results from gunshot wounds and the need to do major surgery, actually, there's a tremendous increase of the likelihood you are going to be directly exposed to blood contaminated with hepatitis or HIV virus that causes AIDS.

The HIV positivity rates is at least 10 percent and probably pushing to 20. In San Francisco, their data is like 30 or 40 percent.

Gunshot wounds that cause open fractures with bone splinters in the wounds as well as wounds due to the sharp-edged bullets such as the super talon pose a direct risk to health care workers.

Now, because of the direct risk of being wounded by gunfire, most urban prehospital personnel, E.M.T.s and paramedics now wear protective body armor. I strongly recommend this to all of my paramedics in the City of Reading.

Wearing flak jackets is actually required now in Los Angeles for certain specific type of ambulance responses.

The care of gunshot wound victims is so time-consuming, resource and personnel intensive that it

often directly interferes with other hospital patients and other trauma victims. This is documented in the list.

We've had occasions where they received so many gunshot wounds that they've been totally unable to care for other patients.

One of the trauma centers in Washington D.C. have shut down entirely because the trauma staff were so completely tired out from working 'round the clock for a number of days in a row that they don't take care of anyone else.

Now, dealing with the steady and seemingly unending flow can cause severe psychological problems and burnout in health care personnel.

Part of the frustration in caring for these people is a feeling of powerlessness to prevent or reduce the carnage that we are all seeing on a regular basis.

The additional stress is that some of the victims are young in age and maybe entirely innocent victims. The tragic cases of small children accidentally shooting themselves have also a psychological stress when hospital personnel take care of them.

The next section I have on effects of keeping firearms in the home. Dr. Art Kellerman, who is now the director of the Emory University Center of Injury Prevention in Atlanta, has published a series of articles

which study the effect of firearm related deaths in the home.

His first study was from Seattle, Washington published in 1986. And this showed that of the 398 deaths due to firearms that occurred in a home in Seattle, 333 or 84 percent were suicide.

41 or 10 percent were criminal homicides. And 12 or 3 percent were accidental. And only 2 cases were of a homeowner shooting an intruder. An analysis of the homicide cases that 37 percent of the homicides were committed by a friend of the victim. 17 percent by a relative. 14 percent by a spouse, and 9 percent by a roommate.

This same point has been found in a lot of the other studies which is; namely, that the victim is much more likely to be shot by a friend or a close relative usually in a domestic argument or altercation.

The second study of his series was published last year and showed that the mere presence of the gun increased the risk of suicide in the home about 5 times.

The third study was published in October of '93 and showed that the presence of a gun in the home was associated with an overall three-fold increased risk of homicide.

This study was done in three separate county

locations throughout the country. Virtually all the homicides in this study were committed by a family member or an intimate acquaintance.

The relative risk ratio was ten-fold when any household member had had any problem with alcohol and the risk was twenty-fold when the shooter or the victim had a problem with alcohol.

The risk factor was ten-fold increased when any family member had required medical attention because of a fight within the home and was nine-fold increase when there was any use of illicit use of drugs.

It study also identified several other factors that also showed increased risk of homicide. Conversely, it showed, however, that the use of the protective devices on the house of security does not lessen the homicide risk. And their quote was most homicides in the home come from within the home.

So this series of studies clearly showed that rather than being protective, the presence of firearms within a home, in fact, make the occupants of the home at a much greater risk of committing suicide or being victims of a homicide.

The next section of the cost of the medical care for gunshots. There's no question that gunshot wounds are an expensive form of trauma. They are estimated as

being the second or third most costly form of injuries in the United States following motor vehicles and accidents and falls.

The Center for Disease Control has estimated nationwide gunshot care cost in 1988 as $16.2 billion. Now, the cost of the care for gunshot wounds need to be considered.

One significant difference between the U.S. health care system and the health care of Japan and others is that these countries don't have to care for 300,000 gunshot victims per year.

Much criticism has been leveled at the U.S. for accounting for the expenditure of 14 percent of the U.S. gross national product.

This percentage is typically only 8 percent for Japan and a portion of this difference is health care spending based on the percentage of the GNP and could be explained by the expense of having to care for the huge number of gunshot wound victims.

Another way of looking at this involves the following calculations: In '87, Germany spent 8.2 percent of the its GNP on health care, which represents 165 billion U.S. dollars.

If the Germans had to spend $16 billion on gunshots as we did, that would have raised their GNP to 9

percent.

Now, for the year 1990, the U.S. gross national product was 5 trillion, 454 billion dollars. And the total health care spending that year was about $600 billion or 11 percent of the GNP.

If you assume that gunshot wound care that year cost $18 billion which represents only a 12 percent increase from the GNP of $16 billion, then that means that 3 percent for entire health care that year 1990 was for gunshot wound treatment.

Now, there had been a number of studies with the direct cost of firearm injuries from several U.S. trauma centers. These studies show that the average direct cost varies between 7,000 and $20,000.00.

Now, that $7,000 figure is from 1984. That's almost a decade old. And I think, you know, how much inflation has occurred since then.

These costs aren't the true picture. That's the hospital cost. These don't include the physician fees, cost if autopsies, cost for ambulance transports, cost for rehabilitation care and follow-up care and surgery.

And in addition. these costs don't represent the even larger indirect costs of gunshot wounds which include lost time from work, cost for funerals, cost for law enforcement, cost for security measures and court

costs.

Gunshot wound deaths result in $373,000 per death which makes it the most expensive form of injury-related death.

Dr. Smith analyzed the cost of caring for trauma victims in our trauma center in Hershey. We found the average cost in 1992 to be over $27,000.00 per case. And in 1993, $23,000.00 per case.

Again, this is hospital charges only. Doesn't include the physician fees and follow-up fees. Patients who spend a long time in intensive care can readily rack up bills of several hundred thousand dollars.

In a number of the studies, you will see a typical number is the cost of caring for gunshot wounds per individual trauma centers is about $10 million per year.

Patients with spinal cord injuries and gunshot wounds can easily have lifetime cost over a million dollars.

Something I must admit I neglected to put is the who's paying for this. And studies done in different places show that 68 percent of the cost of this is done by tax money. And the patients themselves pay less than 1 percent of the treatment cost.

This is the final section I have on discussion and summary. I think the current level of

firearm violence in the United States ought to be regarded as a national embarrassment.

Our nation's capital city has had the highest murder rate in the country for the past several years. Emergency meds projected to invite physicians from other countries to come over here to visit our medical centers because of its particular problem.

The occurrence of all types of violence and especially live firearms related violence in this country are huge orders of magnitude than the other developed countries.

The current gunshot problem in the U.S., I think, must be recognized through one of the massive epidemic proportions and should be treated as a public health problem as Dr. Noonan stated.

The application of criminal justice measures alone to deal with this problem has clearly not proved to be sufficient in dealing with this as a public health problem.

The current epidemic of gunshot wounds is only part of the even broader epidemic as violence and violent behavior in this country. Strong measures to reduce other forms of violence are clearly necessary along with reducing firearm-related violence.

There appears to be very broad public support

to control this epidemic of violence and particularly for controlled gunshot injuries. And I'm sure everyone is aware.

A large amount of the attention is focused on this around the country. I brought USA Today from last week. The entire issue was devoted to the firearm problems and measures for gun control. I don't usually watch the evening news, but I have been recently.

And almost every evening on each of the major networks, there's been a feature presentation on violence and gunshot wounds.

Now, the urgency in dealing with this is important as it also directly affects efforts to undertake health care reform in the United States as you are considering health care reform.

I think it's critically important to observe this relationship and inter-relationship with the problem of violence. Because the magnitude, as Dr. Noonan stated, is seen greater than that of gunshot wounds. The efforts to control and reduce violence in this country ought to result in huge savings in money that we could put to better use.

A huge amount of human tragedy could be prevented. As different health care reform measures are considered, the interrelated effects of violence on the

health care system and on health car spending need to be appreciated and considered.

And I'd like to thank Chairman Caltagirone and the Judiciary Committee for the opportunity to present this information.

Why don't we hold questions or comments from my presentation for the panel that we'll have after Dr. McDowell's speech.

DR. MCDOWELL: My name is Richard McDowell, and I'm going speak only for 15 minutes. I was given 15 minutes. And I'll try to keep it short and sweet.

When I found out I was going to be able to speak with two distinguished physicians from the Commonwealth, Dr. Noonan and Holliman, I decided to grow a beard. But I found out about this about a week ago, so I haven't started it too long ago.

Emergency medicine is a safety net for the health care system. We catch all the patients who fall through the cracks and always there to treat everybody, 24 hours a day, regardless of what they're problem is or what their ability to pay is.

We also provide medical direction for the paramedics that provide care in the streets and at your homes and car accidents.

Emergency physicians also direct patients as

they pass through the gates of the health care system. We occupy a unique position and interact with the entire health care system.

Emergency departments admit 35 to 50 percent of all the patients in hospitals. And the other patients that are discharged get sent into the health care system by referrals. We're on the front lines of delivery of health care.

What I've done today for you is a handout which I'm going to follow. But we're got not going to get to all parts of the handout. We don't have time. I think some of the information would be helpful to you. I would like to sort of use that for the guide for the next 15 minutes.

Just to let you know. I'm director of the emergency department at Chester Medical Center which is outside of Philadelphia. And I'm president of the Pennsylvania Chapter of Physicians. We're the second largest chapter in the country with over a thousand emergency physicians.

If you'll refer to page 2 of my handout -- excuse me, to page 1, I want to tell you what we're going to go through today quickly.

There are four sections. First is emergency medicine and how it relates to interpersonal violence.

Second is violence is a public health issue. Third is Pennsylvania resources and some initiatives, which I think we'll focus on. And the final section will be very brief on specific interventions. And you'll have to read those for yourselves because we don't have time to do that.

If you turn to page 2, item number 3, in the United States in 1990, there were 100 million visits to emergency departments in this country.

In Pennsylvania, in 1990, I think there were about 5.4 millions visits per year to the 250 departments in the state.

Emergency physicians see all the victims of abuse that Secretary Noonan talked about. Child abuse, spouse abuse, elderly abuse, sexual assault, other assaulted violence, suicidal and homicidal, crazy patients.

And, typically, emergency docs patch them up and send them home. This is referred to treating them and streeting them.

But emergency physicians are learning more and more that there are other things we can and should be doing. We talk about secondary prevention where if we have victims of violence in our emergency departments, we are not only treating them but try to prevent secondary episodes of violence.

For example, the patient that comes in as a

victim and is a perpetrator. This guy beat me up. I'm going to go get him. Is there any way to break that cycle?

I think emergency physicians are more interested in primary prevention which is the purview of public health. And we're more interested in trying to get into that.

Item 5 is just a reference that Secretary Noonan talked about from a study by Health Policy International on the cost of violence in Pennsylvania. Those numbers are reproduced for you.

I want to mention a book that is very instrumental to me by Deborah Prothrow-Stith it's referenced as item number 6 called Deadly Consequences.

I think it's important because, in her book, she really is the person who convinced me to appoint a special task force on personal violence this year.

Because she is a public health physician, assistant dean of the Harvard School of Public Health. And she's written a violence prevention curriculum for public high schools.

If you read this, you'll find out the reasons you she got interested in this is that when she was a third-year medical student at Harvard and she was doing a rotation in the emergency department at the Boston City Hospital.

And she realized if she were taking care of the patient who was a victim of child abuse or spouse abuse, there was some mandatory reporting requirements. There was some resources to refer these people.

But she would take a young patient who was beat up and the patient would say, Look Doc, don't go to bed tonight. I'm going to get the guy who did this.

And, of course, there's no mechanism or precedent for us doing anything than sewing him up and sending him out. So that book is full of statistics and also an important reference for me.

Point 7, I wanted to let you know if you're really interested in seeing emergency medicine firsthand, call your local emergency department or contact Pennsylvania ACEP and we'll have you shown around in your local emergency departments. That's where the rubber meets the road in health care.

Section B is violence is a public health issue. And we don't have time to talk about that. I do want to tell you that I'm going to use as a reference this book written by Mark Rosenburg, edited by Mark Rosenburg, Violence in America, a Public Health Approach.

The CDC in 1985, set up a whole section on violence as a public health problem. And Rosenburg has been the guru in the CDC for that effort.

Point 2, on page 2, mentions that although the CDC has studied years of life lost before 65 for injury, they've compared that to years of life lost before 65 for heart disease and cancer.

And although the years of loss of life are comparable, the research dollars for injury are only 7 percent of those spent for the research for heart disease and cancer.

The rest of this section on violence is a public health issue we'll skip except for point 5 on page 3.

Violence in society is an incredibly complicated problem. And there are no simple solutions. If there were, we might have solved it by now. We have a interdisciplinary approach to this problem.

I think it's important that you all who write the laws and make the policy do understand that there is some science that can be brought to bear on this problem.

And that people like Dr. Noonan, who is such a phenomenal example and a greet resource for this Commonwealth and people like Jim Holliman at Hershey, can provide some data and some information that can help you as policymakers help everybody else who's involved in this solve the problems.

What's important that we try to use science

and not rhetoric for some of these problems. I think we need physicians, legislators, social service people, law enforcement specialists and people involved in the judicial systems to solve the problem.

Let's move to section 3, which is Pennsylvania resources and initiatives. Item 1 is the Chapter of American College of Emergency Physicians has two special task forces that I appointed this year to deal with these issues that we've talked about today.

The first is the task force and interpersonal violence. And the second is the task force on health care policy.

We're very concerned with community responsive medicine and prevention. That's not traditionally the purview of the emergency medicine. But more and more are interested in that, and think it's important.

We're also are concerned with preserving access to care for patients, particularly those with no other access or options like poor patients, inner city patients, patients in rural areas.

We think it's important that U.S. policymakers focus on subsets of the problem since we can't solve of whole problem all at once. But there are certain subsets that are very important.

For example, in Pennsylvania, there's no law that prohibits possession of a handgun by a minor. But recently, North Carolina passed a law prohibiting possession of a handgun by a minor.

Even though we have lots of concerns about gun control and lot of questions about where's the science and rhetoric, clearly a lot of us believe that minors have no reason to possess handguns. That's at least one area where we can focus on certain subsets to try to solve problems.

Other subsets where we can focus our efforts on youth violence, violence in the schools, and particularly what people call fatality of violence.

That is, there are many cases of violence. We talked about elder abuse, child abuse, and domestic abuse. But certain types of violence are more lethal than others.

Secretary Noonan put up a slide that talked about an increasing homicide rate in the United States from 1985 to the present.

What he didn't put up was that if you factored out the method of homicide, that increase is almost completely accounted for by handguns.

So that focusing on the fatality can be an important way to help nibble away at this huge problem of

violence. Pennsylvania ACEP also feels that preserving EMS systems and trauma center funding is a critical element that we think is at some risk at the health care policy debate currently in Pennsylvania and in the nation.

On page 4, there are a couple other Pennsylvania resources in initiatives. We have about five more minutes here.

The Center for Injury Reduction and Control is a multidisciplinary program at the University of Pittsburgh Medical Center which by coincident is directed by an emergency physician and also associate director is an emergency physician.

The purpose is to reduce the mortality and to control the morbidity associated with acute traumatic injuries using primary prevention, public health, and improve technique and treatment.

An example is that CIRCL is working with Allegheny County Health Department thanks to state funding to get data from the emergency departments on the magnitude of the problem of violence as seen in emergency departments.

A lot of the data you saw today deals with morbidity; that is, people's mortality. People who die from these problems. What needs to be studied further in many parts of the country, including Pennsylvania, is the

morbidity. That is, the patients are injured and treated but don't die. We have don't collect that data. And. of course, there are some estimates.

I think Jim mentioned that 6 to 10 times the number of patients that are injured versus are killed in a lot of these settings.

If we have no data, we really can't have any solutions that are going to work. We feel that funding of these public health projects are needed.

Item 3 is the Pennsylvania Trauma Systems Foundation. And they do superb data collection and outcome analysis on victims of trauma that are seen at Pennsylvania trauma centers.

But they need funding to expand their studies to non-trauma center and emergency departments. We're missing a lot of information that could broaden the database in our understanding of violence.

Four is the Pennsylvania Coalition Against Domestic Violence. More funding is required for county domestic abuse programs and for shelters for abused women and their children. The same is true for child and elder abuse and sexual assault problems.

One of the problems we have in the emergency departments is if we do a job and identify victims of abuse, which sometimes we don't do as well as we perhaps

could, the problem is where do we refer those victims for follow-up?

And in many areas of the Commonwealth, the resources just aren't there. And at 2 in the morning, the shelters that are required so that a woman can leave an abusive situation with her children are just not available. That sort of funding is critical.

Point 5 here is violence prevention programs like SAVE in Philadelphia. Secretary Noonan talked about the $400,000.00 available from the Commonwealth. And that's incredibly important.

This concept of community-based or school-based primary prevention programs is critical. Julie Good is director of student anti-violence education program in Philadelphia that directs an anti-violence curriculum at children in grade school.

It's amazing to think that there's data from social studies that say if you want the most bang from your buck, you should start in the 5th grade.

Because by the 8th or 9th grade, it may be too late to teach children conflict resolution. That's kind of a scary thought.

But those sorts of studies, these curriculum that talk about conflict resolution and the fact that it's okay to be angry but you don't have to have fights to solve

it, that whole movement which is really well-described by Prothrow-Stith in her book, needs to be studied, validated and funded.

The final point that I mentioned at 6, the centers for the study of violence at Albert Einstein Medical Center in Philadelphia was formed in the department of the psychiatry in 1992, again, to work with a multidisciplinary approach to the problem of interpersonal violence.

Since my time is about up, I want to tell you that the last three pages of my handout I think are worth reading. We're not going to be able to go through them now.

But I've taken them almost verbatim and unashamedly from Mark Rosenburg in his book on violence. Let me explain to you what those last few pages are.

Rosenburg has suggested some specific interventions to prevent assaulted violence and divided them into four areas, social and cultural changes, health and related social, etc., etc.

And I want to give you an example from each one to them to wet your appetite a little bit. On page 5 under social and cultural changes, Item 1, decrease the cultural acceptance of violence.

You know, many people feel this is such a big

problem that can't be solved. But one of the first things that public health does is redefine the unacceptable.

And if we believe that it can be solved, then we need to look at creative and proven ways to decrease our acceptance of violence in this culture.

Obviously, what we see in the media is a critical piece of this, what we see on television every night.

Under 2, Roman Numeral 2, Item 1, develop educational programs to teach conflict resolution skills. We talked about these being school-based, community-based, etc. That's incredibly important.

Also under health and related social services, many of us in our own emergency departments don't identify and refer victims of violence as well as we could.

There have been studies that show that even though we do it every day, we can do it better. And there are ways we can improve our own identification referral of victims.

On page 7, under criminal justice changes, item 4 says to initiate informal citizens surveillance and silent witness programs. Town watches have been studied. Although they may focus on burglary and disorderly conduct and robbery, they are effective.

They can be expanded to include violence,

drug activity and homicide. A rand study of detectives found that most crimes, including homicides, are solved because someone witnessed the event or an informant told police or the victim identified the offender.

Finally, under environmental and other changes, Number 1, there is developed strategies to reduce injuries associated with firearms. We need to avoid rhetoric and adopt a scientific perspective.

I think it's important for us all to understand. We talked about in Pennsylvania that there is no law that prohibits possession of handguns by minors.

Hopefully, you'll have time to read some of those specific proposals. My time is up. I appreciate the opportunity to present a couple of perspectives from emergency physicians, and thanks very much.

MS. MILOHOV: What I'd like to do is call our four sitting physicians forward and have the two doctors that haven't been formally introduced to the audience, introduce themselves and give a brief description of their work and interest. And then we'll open it for further discussion or questioning.

DR. SMITH: My name is Jay Smith. I'm the director of trauma at the Hershey Medical Center. And I think all of the statistics have already been covered. I have a couple things I'd like to show on some overheads to

give you some idea of where we're heading here.

Pennsylvania is a fairly diverse state. And looking at things, we actually have broken the state into three areas.

I'll explain what the three areas are. Philadelphia is the Philadelphia area and the five counties of Southeastern Pennsylvania. Central Pennsylvania also includes Lehigh Valley and the northeastern part. So it's more than Central Pennsylvania.

Looking at the different trauma centers, these come from the trauma centers of these particular areas.

In Western Pennsylvania, it's Erie, Pittsburgh and Johnstown. These are all trauma centers that you have been instrumental in authorizing through the Pennsylvania Trauma Foundation.

This is some of the data that we can identify for you from the database of the trauma registry of the Pennsylvania Trauma Systems Foundation.

Looking at a few things here, if you look at accidental and mechanisms, and these are probably approximately equal population areas.

But if you look at accidentals, they're pretty much the same for the three different areas. It's interesting that Philadelphia actually has the least number

total of accidental gunshot wounds.

Suicides, again, Western Pennsylvania is somewhat higher. Philadelphia is less than Western Pennsylvania. Central Pennsylvania is about the same.

Where we see a marked difference or in the purposeful category and we see that Central Pennsylvania is much different than western. And by the time that you get to Philadelphia, there's a tremendous increase in purposeful types of injuries.

And what I'd like to show you is a few other things if we look at on a graph. The purposeful and the accidental are almost the same level in a graph like this.

And as you go toward the Philadelphia area, you get to Western Pennsylvania. The purposeful is higher. And as you get down to Philadelphia, although the scales change and sheets fly away, you can see what's happened now that we've gone from 50 at the top to 100 at the top to a thousand at the top. And suddenly, the accidentals and suicides pale in comparison to a number of purposeful gunshot wounds.

One of the most important aspects of this from your standpoint is if we're going to look at who's going to pay the bill or, at this point, who's not paying the bill, it's certainly not the patient.

If you look at the payer class, self-pay in

Central Pennsylvania and medical assistance, you can see the numbers in this strategy is generally people who do not have resources to pay their own bills.

And unfortunately, it doesn't get any better as we go across the state. Ä tremendous number of medical assistance in Western Pennsylvania and self-pay.

As we go further down, Philadelphia area, there are a lot not known. But the self-pay is way out on a scale.

So as you consider health care reform, just remember that these are things that if you're going to have universal coverage, these are things that aren't covered right now.

DR. MCDOWELL: And in our experience is equivalent to no pay. The hospital eats that bill. The self-pay part of that does not come out as much pay.

DR. SMITH: Back down to Philadelphia. Since there's a difference in scale, I'll show some Western Pennsylvania at the same time.

You are look at this and say, Well, what types of guns are being used? And this second bar is handgun purposeful, otherwise intentional. And as you can see, the way that this is increased across the graph.

And the other bar that sticks up rather high which is the gray bar is other firearm purposeful, and this

other firearm really is where your semiautomatic weapons would be fitting in.

This is your 9 millimeter, semiautomatic weapon. And you can see a sudden increase in this. And actually, what's happening as well is Philadelphia is peaked perhaps a little bit. And it's now spreading westward throughout the rest of the state.

So it hasn't been to Pittsburgh as yet. But as you heard from the homicide records, it's get to Pittsburgh now. And looking at all this, this also parallels the manufacture of the 9 millimeter handgun that the manufacture or the number of 9 millimeter handguns that have been manufactured in this country that's has gone sky-high in the last decade. Thank you.

DR. SALNESS: I'm Dr. Kym Salness. I'm the physician director of the center for emergency medicine at Penn State. I'm newly arrived in Pennsylvania. I have a similar position for 10 years in the State of California and just recently recruited to Penn State.

I'm primarily going to add some national perspective to the panel also to see presentation being a form like all of you. I thought I would flip out a very short and brief comment.

I might interest and amuse some of you regarding the California experience that I've had.

University of California Irvine is relatively a tame part of Southern California. It's near Disneyland.

In that part of the country, we do have now quite frequent drive-by shootings in many parts of Orange County with quite a high death rate, not quite as high as some we have here. We are setting some records.

We are famous for our freeway-related shootings a few years ago. Thankfully, they seem to have come and gone.

In our increasingly violent society, emergency physicians and caregivers have been stunned by this epidemic of violence across the country. I speak for primary emergency physicians and emergency nursing.

We are stunned, and this has been contributed to a high rate of burnout and stress amongst health care providers that see all this kind of carnage on this basis.

I personally think that this kind of violence seen in your emergency department is adversely affecting career choices. People are not choosing to go in those specialties because of the violence they're going likely see and witness and perhaps the risk for nurses also.

You couple of people mentioned a real point that I'd like to emphasize and their risk of exposure to hepatitis and HIV or AIDS-related diseases. Getting it from your patients that you are forced to care for.

Also, health care provider across the countries really fear some substantial amounts of harm from some of their patients or some of the visitors or guests related to their patients.

This is a substantially costly measure to enhance the security of these emergency departments. Every emergency department that I know of either in California or in Pennsylvania are beefing up security measures.

They are putting bulletproof glass areas to separate the patients from the visitors or be it metal detectors. This is a real common theme all across the country for emergency departments and trauma centers.

As I said before, emergency medical care providers fears some of their patients and the activities around them. I can affirm for you that paramedics wear body armor in many places of California and Pennsylvania routinely in fairly tame areas of Orange County.

The point that I'm especially expert in is the cost of this care as Dr. Smith mentioned. Much of these patients that are involved in gunshots and other such injuries are so-called self-pay.

It really translates into no pay. And in California, because of the health care mess that that state is in, really the Medicaid is in trouble all across the state, the financing and funding of health care is in

serious trouble. I can tell you that there are definitely trauma centers that have closed because of the huge financial burdens occurred by the trauma center of uncompensated care.

They would choose as administrative decisions despite the protest of the physicians and other caregivers. Caregivers don't want to provide care and the business decision would be made to eliminate the service.

Doesn't make the problem go away. It just goes down the street. Then further adds to the magnitude of their original problem. And now it's somebody else's problem.

Just a lost couple of comments. Perhaps my own philosophy. We know that guns don't kill people. People kill people. And furthermore, I personally presume that most gun owners are law-abiding, honest, constructive and really productive citizens.

Furthermore, I don't think that guns are the root of the problem. We heard the roots of the problems, and I'm sure they have the family unit and the same thing that contribute to be drug use and failure of intercity problems.

However, the answer is tied up in other problems that we have heard, like violence prevention programs involved in schools, businesses, churches,

lawmakers, law enforcement agencies and health care providers.

However, I feel that really some increasing controls on gun access will be coming across our country and will be helpful and hopefully without limiting the rights of honest citizens that we have.

But, here's my punch line to my perspective. I think this is really somewhat an analogous to other legislation that we have.

We have the rights of smokers versus the rights of non-smokers. And in California the pool owners, they all have to put up 6-foot high fence around their pools. Really, we've seen unfortunate restraints and restrictions to be placed not because of the behavior of the most conscientious, honest or well-intentioned citizens but rather these restrictions and restraints are placed because of the actions associated with the behavior of the least conscientious, competitive or ill-intentioned citizens. That's my closing statements.

MS. MILOHOV: I have a question. I think I'll direct it at Dr. Mcdowell. And if anyone else has something to add. Could you please explain how gathering more data would help physicians and trauma centers be a secondary prevention mode, and if there's anything that legislators can do to promote that?

DR. MCDOWELL: If you believe that violence is a public health issue, which I think is well-documented, what is the public health approach to a problem? The public health approach is a scientific method to collect data.

Analyze the data and suggest some interventions. Try the interventions. Study the results of those interventions. And see if, you know, how to continue in that cycle to improve the problem. So that anything starts with data is a collection.

We feel -- many of us feel that the problems that we've talked about today like gun ownership, who should have guns, who should be allowed to have them, can escalate into a rhetoric that is counterproductive that you need to look at.

And so that's really we feel a a cornerstone of any action that's going to show some reasonable results and be convincing to people that have to pay for it.

In emergency departments, particularly, I'll give you an example. In Pennsylvania, if a person comes into the emergency department with a gunshot wound, you're supposed to report that to the local police department.

Some people do that and some don't. Even if every gunshot wound would be reported, there would be no way for you, the policymakers, to go and get that data.

I may make the call, but there's no coordination of where that information goes. There's no uniform collection of that information.

Now, if a person is shot dead, there's some way to get that information. But there's no way for you to find out in the states the incidents of how many people come into my emergency departments in this state with gunshot wounds.

How can we study the problem? How can we identify where the money should go to solve this issue? I think data collection in emergency departments and other places, not just emergency departments, is, you know, the first step in solving some parts of the problem.

MS. MILOHOV: So you're suggesting that the legislature could pass a law that would allow some agency with the state to collect the data. And that there might be a task force previous to that to decide what data is necessary?

DR. MCDOWELL: Yeah. The example that I gave in my handout with CIRCL and the Allegheny County Health, they took some money from a block grant and said we're going to do that. They're working together in Allegheny County. That's a good start.

And I think, perhaps, if we're able to look at the information we get, it looks worthwhile, then money

like that can be allocated through projects like that to set up together at least enough information to see if that's something that can be done on a statewide basis.

If you're talking about mandatory reporting in a system of surveillance, it sounds kind of sinister, but the surveillance is it. Maybe that should be something done throughout the state. It's going to cost money to do that.

MS. MILOHOV: What about the case that was cited Deborah Prothrow-Stith saying that we treat them and street them. And in the meantime, that mandate should get less rest because they she know there would be more violence. How can physicians intervene in that?

DR. MCDOWELL: Well, again, trying to be specific because it is a huge problem. Right now, there's not way that in most emergency departments in the country where if you see a person like that -- I'll give you a better example.

In a personal assault and violence, if somebody comes in and says I got into a fight with my brother, we've never fought before. We had this terrible argument. They identified the brother for a person at risk for escalating violence, a problem with drugs or alcohol with the gun in the house, there is no place we can refer that patient after we stitch them up.

There's no place we can send them for mediation. No place for follow-up. We call the police they say we'll do what we can. We have plenty of homicides to take care of.

That whole problem is unaddressed. Even more specifically, a woman comes into the emergency department, abusive situation. Has to get out of the situation. We have 20 patients waiting to be seen in the emergency department. It's 2 in the morning.

Where can that person go for help? Where is the shelter that person can take her children? We don't even have that. That's not just a problem in Pennsylvania. That's a problem in many parts of the country.

So we can't even practice secondary prevention which is kind of what that is without the resources which have to be made available.

MS. MILOHOV: Would there be an ethical or moral or constitutional problem with having an intermediary agency that could intervene and/or cool down or whatever, work with those people that needed the intervention on the secondary level?

DR. MCDOWELL: No. And what emergency departments are doing in the Commonwealth and in the country are developing better relationships with their county domestic violence programs.

For example, I practice in Delaware County. The domestic abuse project in Delaware County, the administrators of that program meet with me and my staff on a regular basis to try to improve identification victims and referral. But they have limited resources.

MR. JERE STRATTMATTER: One bill we passed was an anti-stalking law. I know it's too soon to tell the effect. I think that would be one of the answers that now you don't have to wait until after the fact, that you can lock these people up and put them away before the fact if you feel endangered. All you do is feel endangered.

Have you been referring your patients or are you familiar with the anti-stalking law that you refer them to police to be able to lock those people up?

DR. MCDOWELL: Yes. I think not just my own opinion but the opinion of many people in the public health aspect think that those sorts of measures are very important.

MR. STRATTMATTER: What kind of confidentiality we should have? Those in mental health field, psychiatrist, psychologist with sharing information that I would presume most of these things don't just happen.

I presume every once in a while there is an instance where the neighbors say, Oh, my gosh, I'm totally

surprised. Most of the times, it can be predicted. It can be predicted six months. This is a time bomb. For 10 years, I knew this person was crazy doing that.

What kind of confidentiality problems do you see or what do you think the medical profession should be doing to try to tighten up where you know that you have a ticking time bomb that maybe should be getting some type of help. But it seems that are mental health laws is such now that it leans the other way to let them out. What are your thoughts?

DR. MCDOWELL: Clearly, I do think that confidentiality is critically important. And we're very cognitive of a patient that comes to our department. We have to take care of them. But you all can also protect health care workers and report. It's done for child abuse.

Our risk of reporting potential child abuse is acceptable. In other words, if I have to tell a parent. I have to call and report you as a possible -- report the situation as possible abuse situation, I have to prove it. I just report it, and I'm protected. I think that's important.

DR. HOLLIMAN: It's technically any time you report to anybody else anything that was said in a doctor/patient relationship, we're violating our oath in violating patient confidentiality.

So we need specific state law that says in this particular kind of situation or suspicion as is the case with child abuse, that we are required by law to advocate our hypothetical oath to report this information to the appropriate state agency or the police or whoever.

For instance, that applies to gunshots. We have a specific thing we're supposed to do. Technically, someone walks with a gunshot wound and we tell somebody, that's a violation of patient/physician confidentiality.

We need kind of a specific release from you all in order to be able to do these things. And we're perfectly agreeable to release this information as appropriate. Again, we recognize the public health benefits of doing it. We got to be specifically allowed to do that other, or we're going to get sued by the patients for violation of confidentiality.

MR. STRITTMATTER: What we need is, you know, we need your help in order to work with the other members of the medical family that deal with mental illness and the fact that, you know, you could advocate to us or write that where we don't overstep our bounds.

I think the intended good is far outweighing by the unintended bad and goes too far the other way. I certainly appreciate your help. If you can explore that with the other allied health and report back to the

chairman what you think the best way to go about in doing this.

I know we got from the school teachers. They're there to help. Just like yourself, you're there to help people not to act as a police officer.

You always feel I could help you. The teachers, they witness violence. They're subjected to violence. They won't report it for the fact they can help this person. By reporting, it's not going to be helping. I can work it through.

Now they've been working rewarded for bad behavior. The more they're rewarded, the more it escalates. I know it's a fine line. But I'm not one -- people know me in this room. I'm not one to be writing laws.

So I would be one of the conservative side of wanting to get your advice. I think you pointed out a very good point. I would like to go slow and work with you to find out what the mental health people would like to have as a law.

I know as emergency room people how you'd feel. If you could sort of know the right questions to ask for the psychiatrist and psychologist and I would appreciate that.

DR. HOLLIMAN: I think this is a problem

where the public health approach and problem. For society is good physicians should violate their patient confidentiality to report these things so we can fix them on a public health society level.

That, of course, violates the individual's relationship with the physician. It's important from the overall public health aspect, and that's why the public approach is such an important program.

DR. MCDOWELL: There is some areas where things can be pretty easy. Again, this concept is subsets. There is some others areas that are, for example, a guy comes to the emergency, I need to talk to somebody. I think I'm going to go out and shoot Mr. Smith.

I think I'm going to go kill him. I say, fine. Glad you came to the emergency department. The guy is a paranoid schizophrenic and hasn't taken his medicine. Obviously, he is asking for a bad problem.

And then he decides to leave. I try to restrain him. He runs out the door. Clearly, in Pennsylvania, I report that. I call Mr. Smith and call the police.

There are some things that are simple and that's not a problem in Pennsylvania. But there are some things like a patient comes and wants some help and then refuses to continue in a therapeutic plan. Then clearly,

that breach of confidentiality that the patient doctor relationship takes on a broader significance for other people that can get hurt.

For example, if someone is impaired by drugs or alcohol or medical condition, gets in a car. We have reporting requirements in Pennsylvania that we have to report that incident to PennDOT in writing.

So there are areas where, you know, you can do some good without causing a lot of consequence.

DR. SMITH: What happens when it is reported, somebody has to follow up with it. A lot of times I think that certain things are reported but nothing is ever is followed up on it.

For example, drinking alcohol while driving, somebody comes in with a very high blood alcohol and nearly been in a couple of accidents. She needs to record that to the Department of Transportation. What's going to happen to them?

And, you know, is it you that is really bound to report that and assuming the police will catch up with that person. But oftentimes, is the case when they're injured.

MS. MILOHOV: Dr. Smith, could you extrapolate for us using your figures on trauma cases and collating with self-pay as to what the general cost is for

a health care to the individual.

I mean, how it escalated? How it might work with the current health care plan, ways that we could save money and better utilize our funding and our resources of doctors and trauma care.

DR. SMITH: Well, first off, the inflation has gone from, perhaps, about $7,000.00 per gunshot wound care of a surviving gunshot wound. The cheap ones are the ones that are killed.

Frankly, I hate to say that. But the cheap ones are the ones that are killed. The survivors and the cost of inflation, the cost has gone from 7,000 to approximately $20,000.00. 23,000 is some of the figures that Jim brought.

If we look at that, most of the these people are uninsured. If we're going to go into cover that, universal insurance, it means that that cost is going to have to be covered from somewhere.

If there is less cost shifting, in other words, now, in order to cover that cost, there has to be some cost shifting. So that some of that cost is going to be born by cost shifting.

Otherwise, there are places in Pennsylvania in the Philadelphia area and so on who are absolutely inundated and financially are very strapped because of

trying to take care of these gunshot wound victims.

There have been institutions in the Philadelphia area that have either wanted to give up taking care of the gunshot wounds and taking care of trauma or have sought other means and other support through Pennsylvania legislature or through separate grants to help try to take care of this tremendous problem.

The losses that they're incurring are then going to be transferred over through cost shifting to other things that are paying items. So at some point, this whole cost is still going to have born through universal coverage.

I think the more important thing is we don't want to have to pay the cost of taking care of these victims.

We'd rather prevent the wounds and the injuries in the first place because if the increase in the number of gunshot wounds and the increase in violence continues, it's soon going to consume all of our health care dollars. And we won't be able to take care of normal diseases when we talk about health care reform.

If we're sinking all this money to taking care of things and aren't paying for themselves, where are we going to get the money to take care of people that are sick from diseases?

DR. MCDOWELL: When he brought that up at a forum in a national discussion about health care costs, the fact that all the other countries that talk about what percent of their gross domestic product that pay for health care don't have the violence problems that we have. That cost is part of it.

And, clearly, we've tried to cut down on drunk driving. We've had some success. We've had public health approaches to that and public health approaches to smoking and some success with that.

And, clearly, this is another area where we might have some success. Having a trauma center is important. I've got to drive home tonight. And if I'm in an accident on the freeway, I would like to go to a trauma center.

The point is that the trauma centers in our urban areas are being overwhelmed by kids shooting other kids. And that's something we should be able to prevent and cut down.

It's amazing when you think about the dollar cost and what it's doing for us try to deliver health care it, you know, all the other situations that we need trauma centers.

DR. SMITH: I have a good friend, actually, who is one of the authors of the articles that Jim passed

out Dr. Schwabb. He became director of trauma at the University of Pennsylvania. They were seeing a few cases of trauma over the past five years.

They're now averaging at least four gunshots a day at the University of Pennsylvania. It's a state Ivy League Institution. It is not previously been associated with a lot of intercity/urban type violence. This is now what they see as part of the trauma department.

This goes on more and more. As you can see in the figures, it has spread. It's not just in Philadelphia as far as Pennsylvania. It is spreading to Central Pennsylvania much more slowly than it is to Western Pennsylvania.

But it's certainly affecting Pittsburgh at this point in time. And where's it going to go from there? And it's eventually going to consume the rest of the state.

DR. HOLLIMAN: Two traumas can tie up a surgical team for a day in terms of operating on them and then taking care of them in ICU.

DR. SMITH: In places where they are very active with penetrating stab wounds or gunshot wounds, people end up lying in hallways waiting to be taking care of.

It's almost a MASH hospital-type situation where the sickest are taken care of first. And who aren't

quite as sick, wait for their opportunity to get into the operating room because we don't have enough people in the medical care side to take care of the number of victims that are being brought to us.

It's not necessarily true here in Central Pennsylvania. People who are representatives from the rural and suburban parts of Pennsylvania aren't going to see this as much. But it's definitely true in Philadelphia and the other major cities in this country.

MR. DAVID KRANTZ: Do you think that's partly because a lot of the people use emergency wards just as the first place of physicians instead of having one?

DR. SMITH: I think some of that's true. But I don't think that's the problem with violence. It's an expensive form of primary care for violence. But people aren't going to -- back in the old days, you see the gangster movies where he went to the local doc and he pulled out a bullet.

But the bullets now are such you can't pull them out with a pair of tweezers. You've got to open somebody up to take care of the injuries caused by them.

MS. FORRESTER STAZ: Could you speak for a moment about Dr. Stan Carroll's article in the general of trauma about baseball bat injuries.

DR. SMITH: Yes. The other aspect of

violence is not just in guns but more recently, people who don't have guns so much in Philadelphia, which is where this is experience is from, there's been a tremendous increase in a number of people using baseball bats for weapons rather than for baseball.

And so that this has become another problem on the horizon. Perhaps, the control of guns could get such that baseball bats become the next thing. And how are you going to control baseball bats? We only use them inside of baseball.

Do you have to give your license to get a baseball bat or sign out a baseball bat? We need to address the societal problem. Why are we so violent? Why are people in this country so violent and the people in the rest of the world aren't necessarily?

We look at the news every night and see the violence in the Middle East and Ireland. Ireland is way down on the list of homicides and gunshot injuries compared to many other countries. It didn't appear on Dr. Noonan's graph. But it's well below Great Britain.

And the places that we think about as having tremendous violence problems and that make the national news every evening, their violence problem is not near what we accept. We don't accept their problems. We accept this problem every day in our own state to a greater magnitude

than what we see on the news.

MS. MILOHOV: Could this partly be because we don't sunshine, for lack of a better word, or broadcast the figures of violence throughout our society and talk about the number of lost days of life and the cost to the public for these things?

Or is it because we overemphasize those very aspects of how it is bleeding society dry to have this kind of violence go on?

DR. SMITH: I don't think that we see that. But when we see that favored movies among our teen-agers are the Terminator, Dirty Harry movies, Clint Eastwood as a figure, the type of things that portray the Sylvester Stallone movies, Rambo, etc., this is an image that we're portraying to our society that this is okay.

MS. MILOHOV: What I guess I'm saying is, I understand how the media and popular movies and so on is emphasizing it and making it more acceptable. But I'm wondering if we had fallen down on the job of letting people know the reality of the consequences.

DR. SMITH: We haven't presented the other side of the consequences. We really haven't. And we should.

MS. MILOHOV: Just like when the Surgeon General started his campaign for anti-smoking 20 some years

ago, suddenly, we have now, you know, non-smokers rights and so on. It seems suddenly to me because there was an awareness of the cause and effect.

And right now, kids that are playing with guns and using them for one-upmanship or what they consider protection, don't really have a full concept of what the consequences of their acts would be if they follow through and use the gun on someone.

DR. MCDOWELL: Why is that?

MS. MILOHOV: Because they think it's playacting just like the movies.

DR. MCDOWELL: That's correct. That's one of the points. There's no consequences associated with the violence that we see on television. When we see somebody in the emergency department that's been hit in the head with the baseball bat, we see the consequences.

When you see Terminator 2 and all these other movies, you don't see the consequences of the violence. That's clearly a problem that the media perpetrates.

MS. MILOHOV: It would be appropriate to develop a stronger message of what the consequences are?

DR. SMITH: Absolutely. When you're used to running around, and now your whole life in every single way has changed in a terrible tragic way.

I read in USA Today one of these articles of

the kids were kind of getting into, well, if I get shot on the way home from school, they were planning their funerals and planning what songs they were going to play.

Very glorified. They were having fun talking about what it would be like if they were dead because of the songs that they were going to pick. They didn't realize that they would be dead. They would also be dead. Besides having good music and not really getting to go on with life.

It was a glorious moment for them rather than the reality. It was preposterous how they were looking at it. And through lack of publication, this is how to get tied up in all the violence.

MR. STRITTMATTER: It seems to be going, well, if we do public health, more public programs and more government consequences, but we've had all these government rules. With smoking, the example that you gave, you have young ladies that are smoking at a greater rate now than ever before. Obviously, it didn't work.

The stairways, many kids point out that you can win every event until you're 25 and then you're going to die.

Well, yes, I'm going to do it. I want to look and feel good. It still goes back to what the family is and consequences to people having a conscious. And that

is something that the government cannot instill by executive or by legislative laws. You just can't do that.

But not to give it as a panacea to think that that's going to happen, I want to get my point.

MS. MILOHOV: I don't mean to be argumentative, but I do that think that government has a role. That's why we have polio vaccinations and mumps and measles vaccinations and why we know that alcohol and nicotine are deadly to people.

It's because government said it's important for the public to know what the consequences are of their actions.

And I think that it's very important for government to suddenly realize that they can have a relationship with the public and they can say what the risks are so that people are better informed. And I think better information means better actions.

DR. HOLLIMAN: I think the government can't do it directly. But through supporting the indirect measures, that would be our idea of how the government could support dealing with those in sort of general society.

DR. MCDOWELL: We can't do it alone. In terms of numbers, I don't have them in front of me. The polio vaccine had been invented for sometime.

In the mid '70s, in 1977, immunization rates for polio were only 65 percent even though it was a perfectly safe and effective vaccine. It's the same thing today.

If you look at the rate of immunization of our children, the vaccines are available. They may be inaccessible or too expensive.

You can get them free. But that doesn't mean that you don't have to wait for hours at a public health clinic in a bad area that's dangerous.

But the point I was going to make was the rates for 65 percent and only increased after public and private agency support.

I think the problem is it's not the government can't solve it, public health can't solve it, the police can't, the court systems can't solve it. It's we all have to.

But in response to your question in particular, one thing we can all do in society is say this is now unacceptable. Polio used to be a fact of life in the summer.

Once we developed a good vaccine, we decided it was not acceptable. And likewise we said that the carnage from drunk driving is not acceptable. We haven't solved it but cut it down.

I think we have to say that the violence in our society is unacceptable. There are some things we need to do to cut it down.

Simon from Illinois was talking during an interview and mentioned that the recent President of the United States used the phrase, Make my day. And it drew a big laugh. And that sort of surprised me.

The more I thought about it, that's exactly the sort of thing that I think we policymakers and public health people and social workers and everybody needs to look at. And it's a big problem and needs many years to change.

We have to identify the problem first and move towards solving it. It's not going to happen over night.

MR. CALTAGIRONE: I might as well wrap it up and thank the doctors for participating today and share your knowledge. And we are certainly groping with this problem.

And this year's budget is going to be difficult at best and one of the outbreaks of the topic that we're talking about here today, the end results are the prisons.

And the exorbitant cost are incurring as a state and even our counties for the increasing tax dollars

that are being poured into it. Whether it's a co-relation or direct result or indirect result of our society and the violence that we're seeing and all of these other issues that we're talking about.

But I think that the approach has to be multifaceted. We are not going to be able to solve this problem over night. I also agree and I agree with you, Jere, it's not going to be government completely coming up with the answer. I don't think we can.

And we don't have enough money to either. But I think it's got to be a total unified effort from everybody in our society if we're going to continue in our society as it is. Thank you.

(Whereupon, at 3:50 p.m., the hearing was concluded.)

I hereby certify that the proceedings and evidence are contained fully and accurately in the notes taken by me during the hearing of the within cause, and that this is a true and correct transcript of the same.

JANET E. SMITH
Court Reporter

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