

Megan Ranney MD, MPH, shares why gun violence is a public health issue

AMA's Moving Medicine video series amplifies physician voices and highlights developments and achievements throughout medicine.

Featured topic and speakers

In today's episode of Moving Medicine, AMA Chief Experience Officer Todd Unger talks with Megan Ranney MD, MPH, a practicing emergency physician, researcher and national advocate for innovative approaches to public health at Brown University, about gun violence and why we need to approach it as a public health issue with physicians playing an important role.

AMA resources and statements:

- "The Physician's Role in Promoting Firearm Safety" CME module
- AMA statement on Texas school shooting
- AMA renews call for gun violence prevention in wake of Tulsa shooting

Transcript

Unger: Hello, this is the American Medical Association's Moving Medicine video and podcast. Today's topic, gun violence and why we need to approach it as a public health issue. We're joined by Dr. Megan Ranney, a practicing emergency physician, researcher and national advocate for innovative approaches to public health in East Greenwich, Rhode Island. I'm Todd Unger, AMA's chief experience officer in Chicago. Dr. Ranney, thanks so much for joining us again. It's been about a year since we last spoken. Unfortunately, our nation's gun violence has only gotten worse. We've all been horrified and saddened by a recent mass shootings in a school in Texas, a supermarket in Buffalo and

a church in California, and that was just May. In our last conversation, you made the point that these are just the ones that we hear about and hear the most about. But firearm-related injuries and deaths are happening every day. Let's start by talking about the real scope of this crisis and how it's grown over time.

Dr. Ranney: Thank you. It is a joy but also so sad to be back here with you talking about this topic yet again. We know that firearm injury and deaths have been increasing in our country for over a decade, and in the last two years, that rise has only accelerated. Depending on what community that you live in, you've seen somewhere between a 10 and a 35% increase in the number of firearm deaths during the COVID pandemic. We've seen firearm death rise from being the second leading cause of death for children to the top leading cause of death for children in the United States in 2020. As you said, those are just the deaths. Right? Those are the tip of the iceberg of injuries.

Then as you read off that list of horrific mass shootings that we've experienced in our country in the month of May, as we're recording today, just yesterday, there were two shootings with deaths at hospitals in the United States, one in Ohio and one in Tulsa. These mass shootings are horrific never events. They're terrorism, essentially. But underneath them lie more than 50 to 60 suicides from guns and 40 to 50 homicides from guns and another 10 to 15 unintentional or accidental shooting deaths every single day across the United States, and each of those leaves a ripple effect beneath it.

Unger: Yeah. These statistics are horrifying and part of, of course, why the AMA first declared firearm violence to be a public health crisis back in 2016 and I know you and many others agree with that. I'm curious, as an emergency physician, how you see this playing out in your own emergency room.

Dr. Ranney: Yeah. So, here in Providence, Rhode Island, we actually saw a significant decrease in gun deaths in the early 2010s. I would actually talk about what a success story it was. We'd reduced the amount of community violence significantly through community partnerships, organizations like the Nonviolence Institute that I sit on the board of, a community organization that works with survivors of stabbings and shootings and works to decrease recurrent injury. But over the last few years, our emergency departments, like everyone's across the United States, has seen an increasing number of these shooting deaths. Not just community violence but also domestic violence shootings and suicides.

Usually, suicides by firearms don't make it to the doors of the emergency department. 90% of them are fatal. They're often declared on scene, as anyone who's worked EMS knows all too well. But we're getting an increasing number of them coming to our doors and I will tell you, Todd, again, I don't need to tell the listeners, many of whom are in the same situation that I am but it is so disheartening and difficult to do the same thing over and over. My colleagues in Philadelphia and St. Louis talk about the fact that they're basically taking care of mass shootings every day, particularly every summer weekend day, and this deserves attention and the secondary trauma on us, on nurses, paramedics and the larger community deserves attention too.

Unger: You said in a recent article in *The Atlantic* that when we look at a crisis like this that people tend to harden into two extreme positions. One is get rid of all guns or the second, give everybody a gun. You're advocating for a third approach. Tell us about that.

Dr. Ranney: So, both of those are reactions that are, in some ways, extremes. Sure, if we got rid of all guns, we would have no gun deaths. Sure, if we armed everyone, then anytime someone pulls out a gun, there's someone next to them who's going to shoot them. But the reality is neither of those are feasible and both will cause their own forms of harm to our society. Instead, we can approach this from a middle position, which is actually where somewhere around 80% of Americans are, which is approaching firearm injury is something that no one wants their loved one, their kid, their parent, to ever experience or be exposed to and where we talk about the very real health effects of firearm injury and then address firearm injury in death the same way that we talk about every other form of injury and illness as a health problem.

We talk about using data to identify where hotspots are, who's most at risk. We talk about examining what protects some people. Right? There are about 400 million firearms in private hands in the United States right now, and that's a rough estimate. There are around 40,000 deaths every year. That means that the vast majority of firearm owners never use a firearm to hurt themselves or someone else. So, what differentiates those who own a firearm or multiple firearms and are perfectly safe for their entire life from those who aren't? How do we distinguish that? How do we use that to inform better policies but also to inform culture change? Then once we develop interventions on the individual level, the family level, the neighborhood or community level and the societal level, how do we get them out into practice? Todd, you and I have talked about this before but this is the strategy that we use to decrease car crash deaths by more than 70%, since their peak.

We did it not by banning cars but by making cars themselves much safer, putting in three point seat belts, airbags, changing the way that windshield glass is manufactured. We did it by changing roads, sometimes by changing licensing standards. Graduated driver's licenses are a great example. But we also did it through education, education around drunk driving, educating families about proper use of a car seat and the ages. There are policies but there are also community norms. We have clinics at my hospital to get new parents the right size car seat for their kid and to get it installed correctly. It's that type of full-spectrum public health approach that will actually move the needle. Yes, policies matter. But over the last 10 years, while we have been fighting exclusively about policy since Sandy Hook, we've seen gun deaths increase by, again, about 40%, which is just on a nationwide basis and again, there are some communities that have been harder hit. That's just not acceptable to me and that's not the way we would approach any health problem as physicians.

Unger: So, using that lens, which you just talked about, that's employed successfully in car safety and other examples. To use that lens and that approach when we look at the issue of firearm violence, that would require us to look at the root causes and I think maybe folks would think about different ones

that you're going to talk about here. What are those and how do we address them?

Dr. Ranney: Absolutely. So, there's a few root causes of firearm injury and death, and I will say, sometimes I talk about gun violence when I'm talking to the media because it's the term that's most colloquially used. But as a physician, as a public health professional, I actually prefer to talk about firearm injury and death because it's so much bigger and wider than just violence. There are some root causes that are common across all types of firearm injury and death. The first, of course, is access. Access to a gun by someone who has intent to harm themselves or others or who doesn't have sufficient training. One of the best things that we can do as communities, as physicians is to advocate for safe storage, to talk to our patients, to parents about safe storage and to talk to folks who are at particularly high risk to them or their families about making sure that a firearm is not accessible.

I'll say as a parent, a lot of homes have firearms in them. Most kids who shoot themselves or others do so with a friend's or family member's gun. There's study after study showing that our kids know where our firearms are stored and know how to access them. So, one of that biggest first root causes to address is access and making it a community norm to store your firearm safely. The second root cause is isolation. It's one of the reasons that we've seen gun injuries and deaths increase so dramatically over the past two years. We know that organizations like Big Brothers, Big Sisters or Boys and Girls Club are actually some of the biggest protective factors against firearm injury. When we've all been separated, sitting on social media, we get hopeless, we're not looking out for each other and we see firearm injury and death, both self-directed and other directed, increase.

The third root cause that we can address is actually the need for data and research. You and I have talked before about how for about 24 years, there were no appropriations to the CDC for research on firearm injury prevention. We've started to address that but we are years and years behind in terms of our understanding of these root causes and our ability to deliver evidence-based interventions. We wouldn't accept that for heart disease. We sure as heck didn't accept that for COVID. We invested billions into fighting COVID. We don't accept it for HIV, for cancer. We shouldn't accept it for a firearm injury either.

The last root cause, Todd, that I hope that we can all address as physicians and other health care professionals is the sense that it's us against them. Whichever side of this debate you sit on, this idea that we can't come together as Americans to combat this scourge is, to me, one of the most disappointing and frustrating drivers that continues to make the epidemic worse. Same thing as we saw with COVID. Right? When I think about the work that I've done around distributing COVID vaccines and that others across the country have done where the greatest successes we're seeing were where community partnerships were created with trusted messengers to talk about the safety of the vaccine, its efficacy, we can do the same thing for firearms and firearm injury prevention. I and others are doing that work but it takes more of us.

Unger: There's a lot of fuel for a big problem. To one of your earlier points in that part of the discussion, you have spoken about the dangers of linking firearm violence to mental illness. It's something, it's discussed. It's particularly in the context of these major incidents that we've seen over the past several years and certainly last month. But tell us more about how you think about this.

Dr. Ranney: Yeah. So, to be very clear, although people with mental illness are up to 10 times more likely to hurt themselves with a firearm, mental illness is not a predictor of hurting others. Hatred is. Antisocial personality disorder is. That is not mental illness. As any of us who've gone through med school or any other form of health professional training know, this is not ... The trouble becomes when we say that it's mental illness, first it further stigmatizes those who are suffering mental illness, keeping them from getting help. Second, it distracts us from talking about those root causes, which are reducing access to lethal means by someone who has intent to hurt themselves or others. It is a red herring. Now, do we need better treatment with mental illness in this country? Absolutely, all day long and we can talk about that separately. But to label our firearm injury and death epidemic as the result of mental illness is baloney. We are no more mentally ill in this country than in any other country and yet we have one of the highest firearm death rates of anywhere in the world.

Unger: I also, I thought it was interesting what you said before about the lack of data, for instance, and with COVID, we obviously invested a lot of time and effort in getting that data, which is how a physician approaches it, like a disease, through that lens. How do we get the information that we need to approach this problem?

Dr. Ranney: So, great question. There's a lot of ways that we can get the information that we need. Again, I will give that parallel to COVID where right now, some of the most reliable data actually comes from citizen science efforts, just like it did in the early days of the COVID pandemic, where organizations like Get Us PPE. We had the best data on PPE access. The Atlantic had some of the best data on COVID demo- ... the demographics of cases and hospitalizations. Well, right now, you want to know where I go to find out about injuries and patterns of mass shootings? I go to an organization called The Gun Violence Archive, which has some of the most comprehensive tracking of shootings across the United States. It is, however, not complete and the CDC itself is unable right now to accurately track the number of firearm injuries that happen across the United States, much less to accurately track demographics or risk factors, even our counts of deaths.

Although, if you die by a gun, it's going to be recorded as dying from a gun, we don't know actually exactly what causes some of those deaths. There have been some inquiries into errors that coroners or poorly trained medical examiners have made in assigning the cause of death. Without that basic data, can you imagine setting up an initiative, whether it's in a business or in medicine, without being able to measure your outcome? That's just not acceptable. So, how do we get there? Funding, empowerment of the CDC. Honestly, the DOJ and ATF are also huge potential partners in terms of accurate de-identified data around firearm injury and death. We need to be all hands on deck in ways

that both protect privacy, which we always do with clinical research, and that help us move the data conversation forward so that we can design better interventions that actually work. And so that we can identify those hotspots and help those areas to avoid these types of tragedies.

Unger: Seems like there's no shortage of opportunities in this day and age for, or I say, that require physicians to participate and lead. How do you advise your fellow physicians about the role that they should be playing in this particular public health effort and to make a difference in a situation that might seem insurmountable right now?

Dr. Ranney: So, I think the first and most important thing is to share our stories. Every one of us as physicians has taken care of either a victim of firearm injury or a family member of a victim. And many of us have personal stories ourselves. There's actually a study that more than 95% of Americans know someone who's been shot. So, starting by sharing those stories, our clinical, protecting HIPAA but also those personal stories is the first part. The second is to know the data, to know these facts around how common ... that firearm suicide is somewhere between 55% and 60% of gun deaths in a year, to understand the risk factors for firearm suicide, to understand the epidemiology of firearm, domestic violence and homicide and what actually drives mass shootings.

Then the third thing is to do the work. I think that there are so many actions that we can take in the clinical space, which have been shown to be effective, screening for risk factors, counseling when appropriate. But there are also actions that we can take and lead, that we are in a truly unique position to lead within our hospitals, within our community and on the larger national stage.

Unger: Gosh, Dr. Ranney. When you were talking before about PPE, I had just the memory pop into mind about one of our prior discussions about Get Us PPE, which is an organization that you co-founded back when hospitals and physicians didn't have access to the PPE that they needed. They seemed very disparate in terms of problems but both of them have one thing in common, which is physicians coming together to solve a big problem. Do you have any other kind of piece of advice about the collective of physicians and how together, they can make a difference?

Dr. Ranney: Yeah. I think that those are two examples that I frequently call on to demonstrate the power of the physician voice and that collective power of us when we join together. I'll say it's one of the reasons that I'm an AMA member, as well as a member of my specialty societies, is because I think that these types of organizations also help to unify us. But it's also really around finding those groups, whether it's on Facebook, on Twitter, on TikTok and I could cite countless examples of where coming together, we have made a difference, whether baby formula, getting patients enrolled in voting or registered to vote. There's so many examples of ways that we've created new organizations. I will say, of course, one of the organizations that I'm involved in is a group called AFFIRM, now AFFIRM at the Aspen Institute, which came out of this collective movement and is continuing. But there are so many others as well. Again, just to reiterate that prior point, it is that our voices do make a difference, particularly when amplified by our peers and colleagues.

Unger: That issue around a unified voice, so important as part of the AMA, and the AMA does have extensive policy on firearm violence, including calling for background checks, waiting period to purchase firearms and a ban on assault-type weapons, bump stocks, high capacity magazines and armor-piercing bullets, just to name a few. We've also developed resources to help physicians address firearm injuries and assist them in recognizing risk factors and communicating with patients to reduce injury and death. In fact, you and your colleagues were instrumental in the development of AMA CME module, "The Physician's Role in Firearm Safety." So, thank you for that. Beyond that, how can organizations like the AMA support this effort going forward? Do you have any final thoughts to share?

Dr. Ranney: Yeah. I think that advocacy for evidence-based policies is certainly critically important. We've never solved a public health problem in the United States without policy. But we've also never solved a public health problem in the United States with only policy. We have to talk about not just policy but also all those factors that lead up to the point where someone misuses a gun. That is about creating spaces for firearm owners and non-firearm owners to work in collaboration to move this discussion forward. This is about recognizing the hundreds to thousands of other physicians across the country that are doing this work. You mentioned that CME module. Dr. Emmy Betz at the University of Colorado and Dr. Garen Wintemute at UC Davis were my co-developers, and I think creating that space for us to acknowledge and create connections between each other is critically important.

Then the last thing is to hold space for each other and for our patients. We as a nation are grieving right now. We are grieving COVID, we are grieving the loss of two years and now we are grieving these just horrific tragedies. I'm from Buffalo originally. So, the Buffalo shooting hit close to home, and I've got kids, so Uvalde just gutted me. But whether you've got kids or not, whether you're from one of the towns where one of these shootings has happened or not, there are also a hundred other deaths a day and each of these kids, each of these people deserves to not be forgotten. I have seen over and over again the power of the physician voice in creating change and I just hope that we keep standing up for the health and safety of our communities. We keep holding space for each other and for our patients to experience this grief and we keep working to create hope because if we don't, who will?

Unger: Dr. Ranney, thank you so much for being here today and for all of the important work that you continue to do in addressing gun violence. The AMA will also continue to elevate voices like yours, support policies and advocate for initiatives that are aimed at encouraging firearm safety and preventing firearm-related injuries and deaths. A link to our statement on the recent Texas shooting, which also contains details on AMA policy and resources for physicians, can be found in the description of this episode. We'll be back soon with another Moving Medicine video and podcast. You can find all our videos and podcasts at [ama-assn.org/podcasts](https://www.ama-assn.org/podcasts). Thanks for joining us today. Please take care.



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