“I HAVE REGRETS”: 23 YEARS OF DICKLEY AMENDMENT

Maria G. Frank, MD; Rhea Powell, MD, MPH

I have regrets” admitted former congressman Jay Dickey (R-AR) in a 2015 interview with The Huffington Post, only five days after a shooting at a community college in Oregon left 10 dead and eight more injured, and almost two decades after the passage of the federal amendment that bears his name. The Dickey Amendment, as it is known, added language to a 1996 federal spending bill specifying that no funds could be used to “advocate or promote gun control,” effectively halting federally-funded research related to gun-violence. Mr. Dickey, who passed away in 2017, reflected “I wish we had started the proper research and kept it going all this time.” In a separate interview on National Public Radio, he explained that the intention of the legislation was to prevent government’s dollars to be used for gun control advocacy, but not to stop all research related to guns.

In 1993, three years prior to the passage of the Dickey Amendment, a Centers for Disease Control (CDC) funded study conveyed that presence of firearms in households was associated with increased risk of homicide in the home. “Gun Ownership as Risk Factor for Homicide in the Home,” an article by Kellermann, et.al., published in the New England Journal of Medicine (NEJM). A year earlier Kellerman had published a paper finding that readily available firearms increased risk of death by suicide. Kellerman’s findings drew national attention, steering the National Rifle Association (NRA) to successfully augment their lobbying in Congress.

The NRA, founded in 1871 as a non-profit organization focused on advocacy for gun rights, started informing its members about firearm-related legislation in 1934, and became an active lobbyist in 1975. In the wake of increased scientific literature emerging related to the health risks from gun injuries in the 1980s–1990s, the NRA lobbied congress to prevent federal funds from being used to support gun-related research. During a Congressional session on the matter in 1996, opponents of the Dickey amendment referenced NRA’s influence multiple times, while Rep. Jay Dickey claimed that the “NRA has nothing to do with this bill whatsoever. It has not testified.”

The spending bill that included the Dickey Amendment language ultimately passed, and in 1996, the NRA-backed amendment repurposed $2.6 million previously dedicated to the Center for Disease Control (CDC) Injury Prevention Program, towards research on traumatic brain injury; even though only 5% of the budget was dedicated to gun violence related research. The Dickey Amendment language was then extended to other federal agencies including the National Institutes of Health in 2011. When interviewed about the decision to prohibit federal funding of research related to gun violence, then-House Speaker John Boehner said “a gun is not a disease.”

In the years since it was first passed in 1996, The Dickey Amendment language has continued to be included in annual federal spending bills, despite mounting pressure to address gun violence. In 2013, and following 2012’s Sandy Hook Elementary and Aurora Theatre shootings, President Barack Obama directed the CDC to conduct research into gun violence; however, efforts were restrained to certain categories such as youth violence, continued on page 14
FROM THE EDITOR

A GUN VIOLENCE MOONSHOT

Joseph Conigliaro, MD, MPH, Editor in Chief, SGIM Forum

“But let’s be clear: At some point, we as a country will have to reckon with the fact that this type of mass violence does not happen in other advanced countries. It doesn’t happen in other places with this kind of frequency. And it is in our power to do something about it.”

—President Barack Obama, June 18, 2015, after the shooting at Emanuel AME Church in Charleston, South Carolina

C olumbine, CO, Sandy Hook, CT, Aurora, CO, Sutherland Springs, TX, Killeen, TX, Pittsburgh, PA, Las Vegas, NV, Orlando, FL, El Paso, TX. Some of these places I’ve visited and some I’ve never heard of before. At least not before they hit the news as places where mass shootings have occurred. The Gun Violence Archive, a nonprofit research group that tracks shootings in the United States, defines a mass shooting as an incident in which four or more people, excluding the shooter, are shot and/or killed in the same location, roughly at the same time. Unfortunately, gun violence as a public health issue has become a politically sensitive response from our elected leaders to prevent further injury and deaths. But unfortunately, the response to gun violence as a public health issue has become a politically

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It was during my time as health commissioner for New Orleans that I learned firsthand how smart the community is about what drives health and how we, as their public servants, should be prioritizing actions to improve health. We intended to develop strategies to improve equitable access to quality care and close gaps in healthcare outcomes. But, an intensive community-wide effort to work with the community to understand challenges and opportunities in health improvement caused us to rethink the priorities and the work ahead.

Like the famous quote from Louisiana-native and campaign strategist James Carville during the 1992 Clinton campaign, “[I]t’s the economy, stupid,” health care has lost its way in understanding the priorities of the people we serve. Zip code is a bigger driver of health than genetic code or even medical care. This concept is sometimes difficult for those of us in health care to get our head around. We went into medicine to help people and learn a special set of skills to put us in a special relationship with our patients, their families, and often our shared community. But the reality is that the non-medical determinants of health (SDOH), where we live, learn, work, and play, have a great impact on our health. According to the widely accepted medical model, it certainly does to the average person. I have shared previously that my post-Hurricane Katrina experience brought this concept forward for me. The people seeking care at our makeshift street care stations were prioritizing issues about food access, transportation, housing, and employment over acute or chronic disease needs. They wanted to know when these non-medical drivers of health would be available in their zip code. They were also concerned that historical redlining approaches that prevented people of color from living in certain zip codes would be amplified by decision makers in the rebuilding of the New Orleans community, boxing them out of their homes, communities, and the place they knew as home.

It was during my time as health commissioner for New Orleans that I learned firsthand how smart the
The month’s theme issue is on gun violence, its devastation, and the imperatives to study and prevent it. Unfortunately, there are yet more tragedies that we don’t see as internists—those who die not only violently but also with intent to cause fatal self-harm: firearm suicides. Not an easy topic to read or talk about.

Internists routinely screen for and coordinate initial management of suicidal ideation in the outpatient setting when patients endorse depressed mood, or provide medical care to patients who survive a suicide attempt in an inpatient setting. Each of us distinctly remembers encountering inpatient cases for suicide attempt survivors. Of outpatient experiences, one of us, as a prior primary care physician (TL), encountered far fewer cases of suicidal behavior management, although in rare instances grappled with concerns about contacting police for well checks of patients in their homes or struggled with the ethical considerations and therapeutic consequences of initiating involuntary commitment of a patient to a hospital (this never happened, fortunately).

For most general internists, this pattern probably holds: patients who survive suicide attempts are seen most often in the inpatient setting and could be critically ill both psychiatrically and physically; those who are severely mentally ill in the outpatient setting are more likely to be under the care of a depressed psychiatrist, or have no affordable access to care altogether. But notably, no patients with suicide attempts that we have encountered involved firearms. It’s rare, if not impossible for an internist—or any other physician aside from a pathologist or medical examiner—to encounter a patient who presents after a firearm suicide attempt. Even emergency doctors likely don’t see such patients. They won’t survive to make it that far.

In this article, we explore essential considerations when thinking about and, more importantly, talking about firearm suicide prevention.

Language Matters
Before continuing, it’s helpful to know some basic concepts when talking about suicide prevention in general. First, there are best practice recommendations from reportingonsuicide.org to avoid describing methods of suicide death in reporting to minimize risk of sensationalization and, consequently, the risk of suicide contagion, a phenomenon involving the occurrence of multiple suicides in close proximity typically in time and geography.

Second, recommendations suggest moving away from saying that a person “committed suicide,” as though they have analogously “committed” a crime. Instead, it would be better to say a person “died by/of suicide,” which better acknowledges the complex biopsychosocial context in which suicide death occurs. Talking and writing about suicide prevention can become very difficult because of the need for sensitivity to these issues, but the intentional ending of a life, even if one’s own, is almost always controversial. But the need for this dialogue is desperately overdue, as American suicide rates are on the rise. In our view, whatever the language, as long as we talk about it openly and with respect towards the living and the dead, then we should.

Means Matter
In 2016, firearm suicides accounted for 51% of all suicide deaths in the United States, or 22,936 deaths per year. Overall, the Centers for Disease Control and Prevention reported a disturbing trend that suicide deaths increased by more than >30% in 25 states between 1999 and 2016. Viewed another way, of all the Americans who die due to firearms, 22,274 (61%) are suicides. Regarding gender, men and women are equally at increased suicide risk given access to firearms; state firearm ownership rates range from 12.2% of the state’s population (Hawaii) to 72.8% (Wyoming) with an average nationwide of 41%, and there is strong correlation between state firearm ownership and firearm suicides.

Considering best practices on reporting about suicide, discussing firearm suicide is a place where talking about the means, or method, matters. It aligns with what we observe: surviving a firearm suicide attempt is virtually impossible. Firearm suicide is quick and lethal.
BEST PRACTICES (continued from page 4)

forming a deadly combination with contextual factors that lead to death. One theory of suicidal behavior posits that three necessary and sufficient contextual factors are present in predisposing an individual to suicidal behavior: 1) thwarted belongingness, or feeling disconnected from others, 2) perceived burdensomeness, or believing that one’s death would relieve burdens on others, and 3) acquired capability, or a loss of fear response to, for example, death.

In an acute, short-term crisis, these three precursors can appear together, and when combined with access to lethal methods, the tragic outcome of suicide follows. Short-term crises that trigger suicidal ideations, if overcome, can potentially mean survival and prevention of suicide. This is where outpatient internists can be influential.

Firearm Suicide Prevention

Because of the deadly nature of firearms, prevention involves all the usual best practices for managing suicide risks and behaviors plus sensible firearm policies and outpatient harm reduction. The CDC report found that 54% of those who died by suicide had no previously diagnosed mental health condition.1 Is this due to missed opportunities for mental health and suicide risk factor screening? Or inadequate access to mental health services or insurance to cover them? Or an insufficient supply of such services? What about missed opportunities for gun safety screening and education? Yes, to all the above, with emphasis on the last one. Naturally, suicide prevention involves a multi-tiered approach, including individual, social, institutional, and health policy interventions. The largest impact is likely the development and implementation of evidence-based policy on gun violence prevention and firearm injury prevention.3 Screening and education about safe gun storage may need to go hand-in-hand with routine screening for suicidal ideation; this includes advising about the relocation or safe storage of firearms in times of acute crises and high suicide risk, according to the American Public Health Association.

Unfortunately, some special subpopulations are disproportionately at higher risk for firearm suicide. They may have a higher risk of developing the three contextual precursors for suicidal behavior, easier access to lethal methods, or other unique population characteristics. For one of us (SP), this hits close to home, having lost a resident colleague to firearm suicide. Physicians and health professionals may be more likely to experience short-term crises, one of the risk factors for suicide. Additionally, they may have more specialized knowledge of and access to more lethal means of self-harm,4 which could include the use of firearms. Other occupations may have more ready access to firearms, such as farmers and police officers, who may be at increased risk of firearm suicide.6

Those who die by firearm suicide will never re-present to our routine outpatient or inpatient medicine practices as internists. Last month was National Suicide Prevention Awareness month, where September 17th was the second annual National Physician Suicide Awareness Day. Our powerful clinical voices can advocate for gun violence prevention to improve our population’s health, including our peers as current and future patients. But we can also intervene to help individual patients, helping them manage key moments during acute crisis to reduce suicide risk. After all, gun violence prevention is firearm suicide prevention.

If you are in crisis and need emergency help, call 911 immediately or the National Suicide Prevention Lifeline (1-800-273-TALK or 1-800-273-8255) if in the United States. If you are in another country, find a 24/7 hotline at www.iasp.info/resources/Crises_Centres.

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References
Seventy-three years had passed since the Declaration of Independence, when the first woman physician graduated from a US Medical School in 1849—Elizabeth Blackwell. It only took one year following the Emancipation Proclamation for the first African-American woman to become a physician in 1864—Dr. Rebeccia Lee Crumpler.

Being a physician and a woman in the late 19th and early 20th century was a rarity. Despite Elizabeth Blackwell’s pioneering women’s presence in Medicine, by 1880 only 2.8% of US physicians were women. Not surprisingly, the percentage of female physicians doubled by 1900 reaching 5.6%. In Colorado, the first licensed woman doctor was Edith A. Root in 1881, soon joined by Mary H. Bates and Aida Avery. All three were admitted to the Denver Medical Association in 1881.

“It’s too bad you are not a boy. You would have made a good doctor”.
—Grandmother Sabin to Dr. Sabin.

In 1881, Florence Sabin (1871-1953) was 10 years old and lived outside Chicago, Illinois. Born in Central City, Colorado, in November 1871, she served a very successful medical career and was a role model and advocate for patients and communities. She completed medical school in 1900 at John Hopkins University. After graduation, she held an internship under Sir William Osler’s supervision and a research fellowship under Dr. (first name) Mall’s mentorship. In 1917, Florence was the first woman to hold a full professor appointment at John Hopkins University. Dr. Sabin was the first woman to be a department head at the Rockefeller Institute for Medical Research; in 1924, she was the first woman to be elected president of the American Association of Anatomists; and became the first lifetime female member of the National Academy of Sciences. She retired at the age of 67 (1938) and moved home to Colorado to spend time with her older sister, Mary. After enjoying a short retirement in 1944, at the age of 72, she was recruited to chair the Colorado Governor’s Health Committee. Her work resulted in the “Sabin Health Laws,” ground-breaking health laws contributing to a modernization of the public health system in Colorado and other states.

Through the Sabin Health Reform, Florence proposed eight different pieces of legislature. Five of them focused on establishing and funding health services and the remaining three focused on the control of specific diseases. Seven of those passed (the “cow health bill,” aimed at controlling Brucellosis was defeated) and led to the Sabin Health Laws.

As a result of the Sabin Health Reform, Colorado experienced a significant increase (from 4 to 18) in the number of counties receiving services from the local and state health departments. Laboratory services were accessible to physicians, dentists and health officials at no charge; the State Health department emphasized immunization against diphtheria and smallpox and worked to reduce death from measles and whooping cough; new regulations for production of milk and dairy products were set in place; and milk pasteurization became mandatory in 1949. Other accomplishments of the reform included the beginning of research efforts focused on studying “stream pollution” resulting in the setting of standards for sewage treatment; development of new codes for water supply to assure quality of drinking water; novel laboratory testing for 22 pre-natal and pre-marital screenings in 1948; and subsequently, the mandate for restaurant inspections by health officials for food safety.

Between 1947 and 1951, she served as chair of the Board of Health and Hospitals of Denver and later as the manager of Denver Department of Health and Welfare. Dr. Sabin died at the age of 82, in October 1953 in her home in Denver, while listening to the Baseball World Series (Dodgers vs. Yankees). Dr. Sabin’s legacy is very much alive.
“I feel dishonest taking a fee from you. You’ve got 2 strikes against you to begin with. First of all, you are a lady; and second, you’re colored.”
—Colorado Medical License Examiner to Dr. Ford

Justina Warren (1871-1952) was 10 years old in 1881 and she lived in Knoxville, Illinois. Born in the same city on January 22, 1871, to freed slaves, Justina’s mother was a practicing nurse exposing her daughter to the importance of caring for the sick at a young age. Her compassion and enthusiasm for health sciences led her to attend Herring School in Chicago, obtaining her medical diploma in 1899. Justina married John Ford, a Baptist reverend, in 1892. After finishing medical school in 1899, she opened her own practice in Chicago and shortly thereafter moved to Alabama in 1900 to be the director at the State Normal and Agricultural College in Normal-Huntsville, Alabama. Two years later, Dr. Warren-Ford moved to Denver to join her husband who opened the Zion Baptists Church, after completing her two-year contract in Alabama. After living in diverse places like Chicago and the South, arriving in Denver was a cultural shock, she imagined Denver would be a more open-minded place to call home.

By 1902, Denver’s African-American population was barely at 2%. Dr. Warren-Ford became the first black woman physician in Colorado and the only female African-American practicing physician until 1952. She started a private practice in her own house, where she cared mostly for underserved communities.

The Lady Doctor, as her patients called her, practiced Gynecology, Obstetrics, and Pediatrics for over 50 years. She exchanged goods for services and consultations, brought groceries bags to patients and learned to speak five languages. After 49 years of applying, in 1950, she was allowed to join the Colorado and Denver Medical Associations. Dr. Warren-Ford died in October 1952, and she is remembered as a Medical Pioneer of Colorado. Her house, which was relocated, was converted into the Black American West Museum and Heritage Center in the historic Five Points neighborhood. 5

During her professional practice, she was honored with the Human Relations Award by Cosmopolitan Club of Denver, 1951. Although, most of her recognition occurred after she passed. In 1973, the League of Women voters named one of their units, Justina Ford Unit. She was inducted to the Colorado Women’s Hall of Fame in 1975; and recognized as Colorado Medical Pioneer by Colorado Medical Society in 1989. In 1998, sculptor Jess E. Dubois created a statue celebrating Dr. Warren-Ford that is currently located in the Five Points Neighborhood. Denver Public Library honored Justina by naming Ford-Warren to one of the branches in 1973. The University of Colorado, School of Medicine offers the Justina Ford Scholarship for her Commitment to the Underserved.

Despite the significant differences in available opportunities, both Florence Sabin and Justina Warren Ford were pioneers and crusaders. They advocated for patients and communities and shaped generations to come. This summary is designed to honor those who were not demeaned by the challenges but instead became role models for later generations.

References
Several months ago, you said we “anti-gun” doctors should stay in our lane when it comes to gun control. Today, I’d like to invite you into my lane—I want you to come to the table with ideas and funding, and I’ll share with you why.

My wife called me in tears to tell me that she was outside our sons’ school, STEM Academy in Highlands Ranch, Colorado, in May watching SWAT snipers move in to deal with an active shooting in progress. My sons were locked inside, and there was nothing we could do but wait and pray. Here was something I’d proven mathematically to my children to be such a rare occurrence as to be wholly unlikely (number of school shootings divided by number schools equals zero, when using significant digits). And now, here I was facing the 100% likelihood of a school shooting, an anomaly that had come to us.

A favorite aphorism of the NRA is guns are necessary because only a person with a gun can stop a person with a gun. Well, it turns out a bunch of unarmed high school students stood up to both gunmen until police arrived. Wielding only their minds and bodies, they defended themselves and their community.

One student—Kendrick Castillo—died, at least seven others were injured, and we’re talking about the 30th+ mass shooting since we kicked off 2019, many occurring in schools, largely by white men native to the United States.

That day, two students wanted to kill my children. Hell, everyone’s children, at my sons’ school. And the means to do so was via firepower.

I’m not going to argue the Second Amendment, yet, I seem to remember it was written right after we seceded from a king who subjugated his colonists and, without a well-armed militia, we, the burgeoning United States, would not have been able to win this war of attrition. The arguments about gun ownership and what the right to bear arms means now was really settled by the Supreme Court in 2008 (D.C. v Heller decision, an interesting case).2

What I’d like your help with is to open funding to research the cause of these huge spikes in gun violence. You’ve lobbied very successfully to bar the CDC and NIH from researching this—depriving federal funds for reasons I can’t imagine. The Dickey Amendment may have been stripped of some of its teeth, now allowing gun research, but with the caveat that the CDC and NIH cannot use any government funding to accomplish that research. Put another way, the CDC and NIH can do all the free research it wants, but no funding is allowed, especially if it might advocate for any measure of gun control.3

While the House of Representatives appears poised to pass funding for gun violence research ($25 million each for the CDC and NIH) as of August, 2019, any funding requests would still have to pass the Republican-controlled Senate where passage seems less certain.4

Instead of helping us physicians and researchers understand how the issues that happened in May continue to play out again and again, you’ve simply thrown your arms up (pun intended) and tell me it’s not the guns’ faults that people are people.

I’ll also excuse your very specious reasoning that if guns were regulated mass killings would continue anyway since people have knives, bombs, etc. We’d be a lot farther along if you had the courage to help us understand the mindset that drives people to it, and ways we could prevent that from happening. Maybe the solution isn’t gun control. Honestly, I just don’t know. But you’re making it hard to get to that point.

Before everyone starts sending me hate mail claiming I want to take everyone’s guns away, let me be clear here: I don’t like that guns are everywhere, I don’t want a gun in my house, but I respect the laws of the land as they are now. What I want is a way out. I have two boys whose normal lives were just ripped out of existence. One fellow classmate is dead, and we’re sitting here confused and so very sad for the shooters’ families and the victims and their families.

Join us physicians in ending gun violence. Open research at the CDC—you’re a lobbyist organization, so lobby for this. Stop thinking everyone who wants gun violence to end wants your guns. We don’t...Help untether the Dickey Amendment.

Join us physicians in ending gun violence. Open research at the CDC—you’re a lobbyist organization, so...
AFFIRM holds that eliminating gun rights is not a solution. Using public health solutions, AFFIRM aims to reduce the number of gun-associated school shootings by 50% in the next five years. Rigorous study, rollout of protocols, and follow up of outcomes will help end this epidemic scientifically. The goal of a toolkit available to all physicians to bring science to bear on this issue is not only noble, but doable. Without dependence upon government funding, AFFIRM believes it can accomplish this through philanthropic support.

But it takes a village. The NRA can join us in ending this epidemic. They could advocate for government funding to research violence prevention. Let’s merge lanes. Let’s stop this now. Everyone can win.

References

FROM THE EDITOR (continued from page 2)

charged one whereby gun advocates argue that restricting guns equates to restricting personal freedoms and constitutional rights. This has even affected the ability of the scientific community to study it. Drs. Frank and Powell outline in their article the untoward effect of the Dickey Amendment on preventing any federal funding to support research on the causes of gun violence or how to alleviate its effects. It seems that the only thing that can stop a good person with an idea to curb gun violence and its effects is a misguided lobbyist and an amendment.

The National Rifle Association (NRA) unintentionally inspired a new rallying cry when it admonished the American College of Physicians (ACP) to “stay in their lane” after it published a position paper calling for more research on gun violence and its causes. The entire medical community denounced the NRA’s admonition and SGIM members were among its most energetic voices. More recently, after even more recent mass shootings, Michael Dowling, CEO of Northwell Health, urged healthcare CEOs to take a stand and take the necessary steps to deal with guns in our patients and to hold our elected officials accountable.

I hate to think that the most recent momentum after the most recent mass shooting (no need to specify since when we go to press it may already have been supplanted) will be for naught. We have an opportunity as individual healthcare providers, and collectively as organizations, to have an impact by asking our patients about guns in the home, studying the drivers of the current epidemic, and learning how to intervene. If we devoted the same amount of energy and resources that we do to cancer or heart disease, then maybe, just maybe, we may save lives. In 1962, President John Kennedy simply stated, “We choose to go to the Moon.” That same conviction and determination is needed now.

Also in this issue, Drs. Leung and Pendharkar discuss the role of the internists in preventing gun related suicide deaths, a book review of Trauma-Informed Healthcare Approaches: A Guide for Primary Care, the remarkable story of the pioneering lives and work of Drs. Sabin and Ford, and a Morning Report of a not-so-typical fever.

References
Traumatic experiences, ranging in scope from individual to interpersonal to community, are highly prevalent and can have long-lasting negative impacts on health. Early adversity has been shown to have a striking dose-response effect on the prevalence of diseases, ranging from depression to cardiovascular disease to lung cancer. Because aspects of health care can retraumatize survivors, a history of trauma can also impact the ability to engage in healthcare.

Trauma-Informed Healthcare Approaches: A Guide for Primary Care, edited by Dr. Megan Gerber, provides a valuable framework for understanding how to meet the needs of trauma survivors by providing thoughtful and compassionate trauma-informed care (TIC).

Dr. Gerber's book is a collection of chapters authored by a multidisciplinary group of clinicians, researchers, and educators that provide a foundation in TIC that is immediately relevant and useful for primary care clinicians and administrators. The book includes a number of important contributions to the field, particularly in its exploration of trauma in special populations: African-American men, sexual and gender minority patients, and veterans. The book defines trauma to include a broad range of experiences, including childhood adversity, intimate partner violence and sexual assault, human trafficking, and historical and community violence. It also emphasizes the need for cultural humility in working with patients who have experienced trauma, as well as the need for self-reflection and self-care on the part of providers. With an approach of cultural humility, and an acknowledgment of trauma's role as a social determinant of health, trauma-informed care can be seen as an integral component of health equity.

Trauma-Informed Healthcare Approaches begins with an overview of the prevalence and effects of trauma. For those of us without much exposure to this field, the effects are shocking: people who have experienced six or more adverse childhood experiences (ACEs) have nearly a twenty-year shorter life span compared with those who have not had any ACEs. This finding, and others described in the book, raises important questions for healthcare providers:

- how can we help patients engage in their health care and mitigate those effects of life traumas?
- should we screen all patients for trauma?
- how should we respond to disclosures?
- are there effective interventions to offer?
- how might learning about patients' stories of trauma impact providers, especially knowing that we are likely to have our own stories as well?

The authors in this book address each of these questions as they offer a framework for moving towards a trauma-informed approach to health care.

What is trauma-informed care? Often using specific examples juxtaposed with cogent summarizes of the research literature, Trauma-Informed Healthcare Approaches effectively communicates the broad principles and necessary components of the TIC approach at both an individual and systems level. I find Leigh Kimberg's 4 Cs (Calm, Contain, Care and Cope) particular useful as a mnemonic for how to apply trauma-informed principles to clinical care. Kimberg describes the ways in which using these 4C techniques can improve care for patients and mitigate the barriers to medical care faced by patients with trauma histories.

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Among the chapters on special populations, I was particularly struck by chapter 4, “Trauma-Informed Care: A Focus on African American Men,” by Marshall Fleurant, that walks through a case to illustrate the ways in which racism, violence, and trauma impact African-American men, and these experiences intersect with masculine gender norms to impact health and health-seeking behavior. A discussion of societal and neighborhood effects describes ways in which the patterns of trauma exposure and response to trauma differ between men and women, and particular impact African-American men. In addition to this cogent discussion of trauma in African-American men, Fleurant briefly summarizes the components of effective interventions.

Dr. Megan Gerber’s chapter on “Trauma-Informed Care of Veterans” likewise delves into the particularities of trauma exposure and response in a population. This chapter offers valuable information on the prevalence and types of trauma experienced by both male and female Veterans. She summarizes each of the combats in which US soldiers have participated over the past century, describing the key factors impacting the types of trauma experienced by veterans. Noting that many veterans choose to access care outside the VA system, she also provides useful information for non-VA providers regarding the resources that are available for their veteran patients for treatment of combat-related trauma.

The final section of the book is addressed to strategies to support clinician resiliency and utilize a trauma-informed approach to help healthcare teams and organizations thrive. The book notes that healthcare workers are more likely than other professionals to have experienced trauma, to experience workplace violence; we also can experience vicarious traumatization through listening to our patients’ stories. As we are experiencing a nationwide torrent of physician burnout, this book offers tools that we can use to decrease our own stress responses, mitigate vicarious trauma, and work towards a system that supports our well-being.

Throughout the book, case studies clearly illustrate the effects of trauma on health and on interactions with the health care system, as well as the possibilities for meaningful engagement and trauma-informed practice. These stories pulled me in—I eagerly read the chapters, and went back and forth between the theories and research findings, and the gripping individual stories.

As internal medicine begins to acknowledge the prevalence and impact of trauma—and as we are seeing a wave of enthusiasm from medical students and trainees about this topic—this book is invaluable as a practical and wide-ranging guide to understand trauma’s role on overall health and well-being. Reading each chapter in this book offers strategies to clinicians to help patients engage in care, mitigate the health effects of trauma, and avoid retraumatizing our patients.

*Trauma-Informed Healthcare Approaches: A Guide for Primary Care* belongs in the hands of physicians and clinicians at all levels of training. It offers crucial information and actionable strategies to improve the care we provide for the many survivors of trauma in our patient populations, as well as tools to support our own resiliency as healers.

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community is about what drives health and how we, as their public servants, should be prioritizing actions to improve their health. I walked into my role as health commissioner in 2011 with a goal of improving the health of our city. The leading drivers of morbidity and mortality were cardiovascular disease, cancer, and infant mortality, and we intended to develop strategies to improve equitable access to quality care and close gaps in healthcare outcomes. But, an intensive community-wide effort to work with the community to understand challenges and opportunities in health improvement caused us to rethink the priorities and the work ahead. New Orleanians told us that their priorities were more aligned with the social determinants of health including areas such as community violence.

Unfortunately, sometimes the nation mistakenly presumes that the social determinants are a challenge only to low-income individuals, including those served by the Medicaid program or communities of color. The reality is that social needs can impact people from all walks of life at many points along the life span. This recognition is essential for building policy, payment, and public health systems to address health needs of all people and also eliminate disparities in health outcomes. It is also essential for general internists to understand that our patients may have social needs that do not seem obvious to us on the surface.

Survey data from McKinsey showed that of over 2,000 people covered by Medicare, Medicaid, or an ACA marketplace or individual plan, more than half of those surveyed indicated that they had at least one social need. The majority of respondents with multiple unmet social needs reported that they would be interested in help from their health insurer in addressing the need. The most common issue, in one third of respondents, was food insecurity, followed by community safety, housing, social support, and transportation. Eighty-five percent of respondents reported they would use a social program offered by their health insurer to address a social need. A survey of smaller size found similar results including that SDOH impacts are common, irrespective of payer category, indicating that we need policy and practice in health care that transcends a single population and can serve everyone. In this survey, consumers preferred discussing their SDOH issues with their doctors and providers rather than health plans, suggesting our patients are looking to us for solutions. This finding is a reminder that consumers are expecting us to be engaged in efforts to understand and address their social determinants.

The National Partnership for Women and Families (NPWF), a consumer advocacy organization, conducted focus groups to inform policymakers and the private sector, including the care system, about consumer perspectives on SDOH. What they learned is in keeping with what I have heard from my own patients and the community:

1. People want to be treated as a whole person, which means understanding the social determinants because they are the reality of the day-to-day texture and atmosphere of people’s lives.
2. Consumers in these focus groups expressed strong concerns about motivations, opportunity for misuse, and unintended consequences of asking about and intervening in social needs.
3. They emphasized the importance of health care, public health and social services collaborating, in lieu of medicalizing social services or having health care entities providing those services.
4. And finally, they expressed a strong desire to partner in development of policies and programs.

Based on these focus groups, the NPWF worked with others to lay out a consumer-focused framework for policymakers and the private sector to use when approaching work around the social determinants of health. The framework is grounded in the recognition that efforts to address the social determinants must have equity as an explicit goal. Second, they recommend working in multi-sectorial partnerships to share responsibility and accountability, including with consumers and communities. NPWF also recommended a person-centered approach that “reflect[s] the perspectives, preferences, and decision-making of individuals and communities most affected.”

“It’s the zip code” is a dramatic over-simplification of the challenge our patients and communities are facing related to social determinants of health, just as Carville’s words were an over-simplification of the challenges voters were facing in 1992. However, the complexity should not scare us off. Just the opposite. Academic general internists are experts at complexity of any sort and the challenges around understanding, impacting and mitigating against future social determinants driving inequity are just the sort of issue that our members should and are working on in the clinical, educational, research and policy environment.

This work has never been more important. We are in a race that is high stakes like that of a presidential election. To reverse the distressing decline in life expectancy, the rise in infant mortality, the scourge of multiple, burdensome chronic diseases worsening daily quality of life, and to find our way to improving the public’s health, we must work with partners to address all determinants. It will take more than addressing medical and genetic determinants, but also the zip code drivers where our patients live, learn, work and play. Our patients continued on page 13
understand that their health is impacted by more than medical care. It is time for medicine to catch up with what consumers want.

References
domestic and sexual violence, and suicide. Active and unsuccessful negotiations continued through March 2018 when Congress agreed on a budget that, while still including the Dickey Amendment language, offered clarification on the intent of the amendment. A report accompanying the bill stated that “[w]hile appropriations language prohibits the CDC and other agencies from using appropriated funding to advocate or promote gun control, the Secretary of Health and Human Services has stated the CDC has the authority to conduct research on the causes of gun violence.”

Physicians and the research community are important voices in the discussion about need for federally funded research related to gun violence. Many professional physician associations have published position papers on the imperative need for gun-violence prevention and research, including the American College of Physicians (ACP), American College of Emergency Medicine (ACEP) and American College of Surgeons (ACS). The ACEP proposed more than 60 specific research questions needed to be addressed. The ACP’s report not only supported gun violence research but also expressed the College’s position in relation to firearm ownership policy. The ACS paper reflects on the polarity between perceived “freedom control vs. violence control” and calls for collaborative approach to engage both poles to re-write the “narrative.”

Meanwhile, gun violence kills more people in the United States than in any other developed country. An average of 645 people die per week in the United States to gun-violence, and it’s estimated that nearly 2.5 times as many people present to emergency departments with non-fatal firearm injuries. Gun-related fatalities affect people from all races, ages and neighborhoods, yet the nature and factors contributing to these fatalities differ, and significant health disparities exist. The vast majority of gun deaths are among men, and fatal gun injuries disproportionately affecting young, non-Hispanic black males. Young people are most likely to die from fatal gun-related injuries; however, rates of gun deaths by suicide increase with age. Mass shootings shake communities far too often. Lives are lost both intentionally and accidentally to firearms, and physicians are first-hand witnesses to this public health crisis. Gun violence demands the national attention, and like any health crisis the nation’s response must include robust and adequately-funded research. Repeal of the Dickey Amendment is a necessary, but not sufficient, step to the path to reducing gun violence.

References
When a Fever Turns Deadly: Herpes Simplex Encephalitis in the Elderly

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A n 89-year-old female presented to clinic with a sore throat and weakness for one day. She was incidentally found to have a fever of 101.3°F. She denied confusion or urinary symptoms. Past medical history included atrial fibrillation, hypertension, hypothyroidism, cholecodolithiasis, and mild cognitive impairment. Patient denied sick contacts. She had traveled to Connecticut one day prior to presentation. Physical exam revealed a well appearing older woman with a slow, wide-based gait; euthymic, non-anxious affect, and tangential speech. Labs included: white blood cell count (WBC) 8.1 (WBC 4.5-11 x10E3/uL) with 59.5% neutrophils (neutrophils % 40-78%), platelets 141 (platelets 150-450 x10E3/uL), potassium 3.1 (potassium 3.5-5.2 MEQ/L), and sodium 132 (sodium 135-145 MEQ/L). Chest X-ray was unremarkable. The patient’s weakness and fever persisted the next day. She was admitted to a hospital at home program for intravenous fluids with presumed upper viral respiratory infection and dehydration. Using an interdisciplinary team approach, our urban academic center’s hospital at home program cares for patients with acute illnesses, such as pneumonia, cellulitis, congestive heart failure exacerbations, in their home by providing intravenous support, oxygen, X-rays, labs, and daily medical visits. This program has decreased readmission rates, caregiver burden, costs, and improved clinical outcomes.

Serious illnesses in older patients often present atypically. Due to homeostasis, treatable infections in older adults with complex medical problems or frailty can become sentinel health events. When evaluating older adults with fever, it is critically important to consider a broad differential diagnosis, including meningitis and encephalitis, while investigating the cause of presenting symptoms.

On day three, the patient was referred to the emergency department (ED) for ongoing fever and altered mental status (AMS). In the ED, she was awake but not alert, did not follow simple commands, and had nuchal rigidity. Labs included: WBC 12.6 with 87.3% neutrophils, platelets 131, potassium 3.2, and sodium 136. CT head showed chronic microvascular changes and parenchymal volume loss without hemorrhage or infarct. Multiple attempts for bedside lumbar puncture (LP) were unsuccessful. She was started on acyclovir, vancomycin, cefepime, and ampicillin for presumed meningitis. On day four, the patient became more altered and agitated with 101.5°F fever and WBC count of 13. Urgent Interventional Radiology (IR) guided LP showed clear cerebrospinal fluid (CSF), glucose 66mg/dL (glucose 40-70 mg/dL), protein 108.2 mg/dL (protein 15-45 mg/dL), RBC 280/uL (RBC 0/uL), and WBC 12/uL (WBC 0-5/uL) with 59% lymphocytes (lymphocytes ≥ 70%). Suspicion was high for Herpes Simplex Encephalitis (HSE); acyclovir was continued at 10mg/kg q12 hours.

Approximately 2-4 cases per million of HSE are reported worldwide annually. HSE can cause significant morbidity and, without treatment, mortality rates are as high as 70%. HSE diagnosis can be challenging, particularly in older patients, resulting in potentially dangerous treatment delay. HSV PCR is a rapid CSF test that can quickly identify HSE; however, it has low sensitivity and specificity. CSF HSV culture is the gold standard diagnostic test, but the time requirement can delay diagnosis. Brain MRI is non-invasive and helpful as it can show hyperintensity in the temporal lobes, but is also limited by its low specificity.

On day five, the patient’s mental status worsened. She was no longer responsive to verbal or tactile stimuli. Her respiratory status declined. She was intubated and admitted to the Intensive Care Unit (ICU). On day five, CT head showed a left middle cerebral artery (MCA) territory hyperintensity, depicting an acute infarct. On day seven, MRI brain showed hyperintensity signals along left insular cortex, anterior and medial left temporal lobes, and left cingulate gyrus. This MRI suggested HSE as well as an evolving left MCA infarct. On day eight, CSF polymerase chain reaction (PCR) detected HSV1-5,400 copies/mL (HSV1 not detected <50 copies/mL), confirming the diagnosis of HSE.

HSE case reports are associated with ischemic strokes, intracerebral hemorrhage, and cerebral venous sinus thrombosis. Often originating as cerebral hematomas, cerebral hemorrhages due to temporal lobe vessel disruption occurred more in HSV-1 cases. HSV-2 cases were more frequently associated with infarcts and multifocal ischemia caused by large vessel vasculitis and continued on page 16.
related occlusions. The patient’s initial CT head did not show an infarct. However, repeat imaging supported a diagnosis of acute MCA infarct, further complicating the clinical diagnosis. Cerebral hemorrhages and infarcts on imaging are not always seen initially and can have a radiographic delay of up to 10 days on average.

Due to worsening prognosis, goals of care were readdressed on day nine. Code status was updated to Do Not Resuscitate (DNR)/Do Not Intubate (DNI) on day 12. She was transferred to the palliative care unit for palliative extubation and died on day 20.

When older adults present with a fever, weakness, and AMS, a broad differential diagnosis should be considered, including encephalitis. If a workup is negative and a patient remains symptomatic despite empiric treatment, clinicians should maintain a heightened index of suspicion and avoid any anchoring biases because decompensation can occur rapidly.

References