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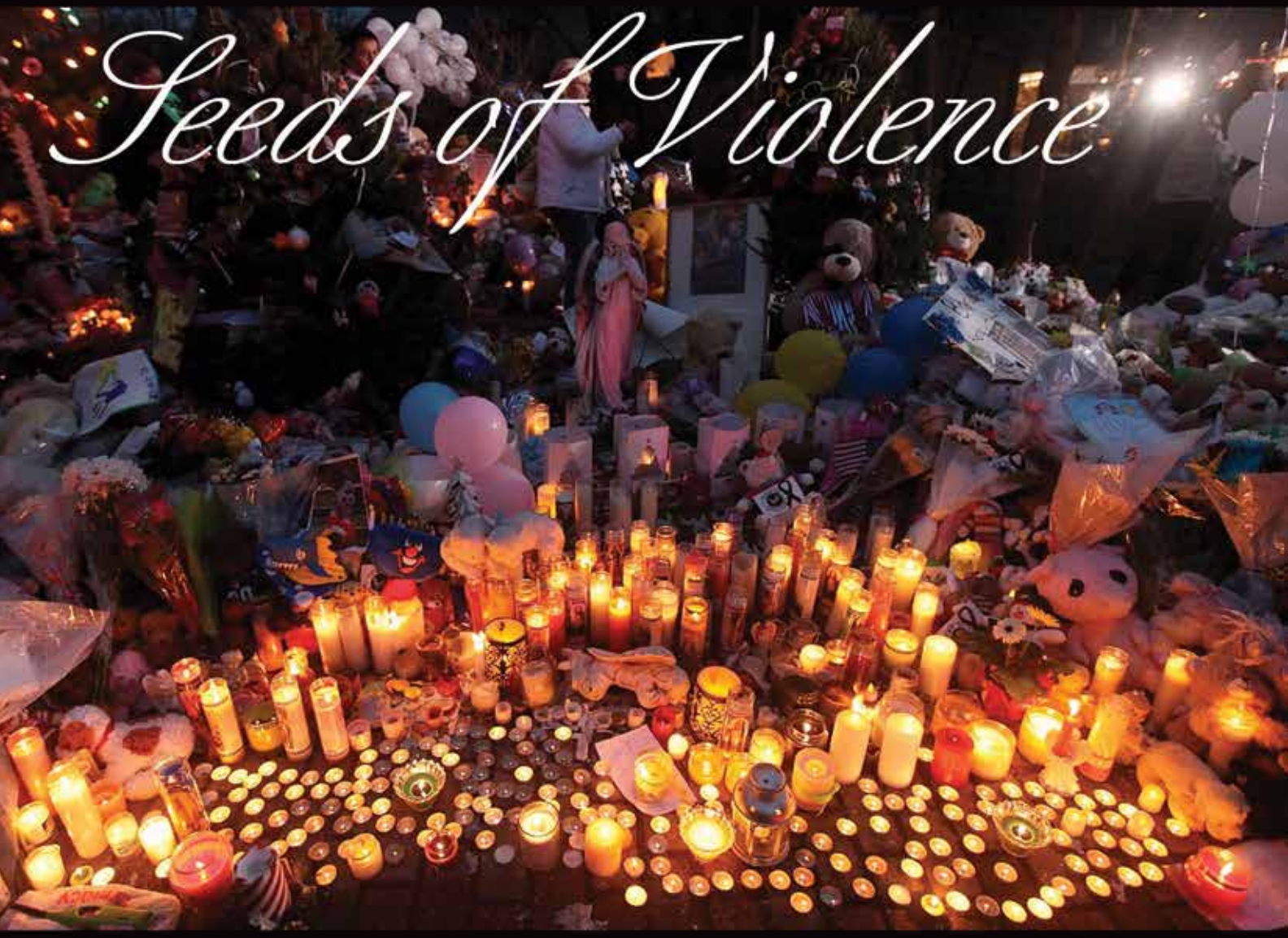

Seeds of Violence

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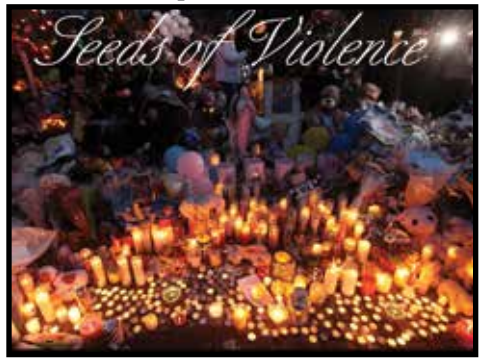

On the Cover:
Seeds of Violence
A candle vigil for the students at Sandy Hook Elementary
Photo by Mario Tama / Getty Images News / Getty Images

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Guest Editorial

This issue of Worcester Medicine was crafted as part of the response to the horrific Newtown, Conn., shootings that have revived a debate about gun policy in our country and the culture of guns that we live in here in the United States (unique in our country, as this issue will illustrate).

When the editorial board of Worcester Medicine and its editor, Dr. Jane Lochrie, offered me the opportunity to serve as the guest editor of this "Seeds of Violence" issue, I was most grateful and jumped at the chance. I have been involved with gun safety/community violence issues since the early '90s, but as many of you know, I first was touched by the problem even earlier.

On Nov. 2, 1981, I lost a dear friend and colleague, John C. Wood II, who, like I, was serving as a surgery resident in the training program at the Columbia-Presbyterian Hospital in Washington Heights in New York City to a gunshot wound perpetrated by a 15-year-old male using a "Saturday Night Special" revolver.

My chief of surgery at the time, Dr. Keith Reemstma, taught us all a tremendous lesson by having the house staff of the hospital meet with Sarah Brady, the wife of former press secretary Jim Brady, who was shot while standing at Ronald Reagan's side just a few months before. Ms. Brady convinced me that the problems in our society that lead to violence are so multi-factorial and complex that they seem insoluble to social-minded folks. But the vector of violence that elevates rage into lethal force is the firearm. I have sought ever since to try to promote responsible gun ownership and common-ground solutions to the gun violence problem. I have been the co-founder of two gun buyback programs ~ the Goods for Guns Program ~ in both Pittsburgh and in Worcester, which have contributed to diminution in the firearm injury/fatality rates in both communities. It should be noted that this year to help us promote the buyback's 11th year in Worcester, John's son, John Chase Wood III, unborn at the time of his dad's murder and currently a nursing student in New Hampshire, helped us promote the event. This contribution really felt like the program coming full circle.

From left to right: Michael Hirsh, MD; Leonard Morse, MD; and Vincent Minichello

The Family of John & Diane Newton Wood

But rather than focus exclusively on my personal area of interest, with the cooperation of many of the experts in their fields that I have interacted with as a part of the WDMS and as acting commissioner for the Worcester Department of Public Health, the editorial board has been able to pull a distinguished group of authors to fill in this edition. Dr. Ron Pies covers the new focus that the psychiatric community has come under in the evaluation of troubled youth that might become "shooters." Dr. David Hemenway, perhaps the most preeminent expert on the epidemiology of gun violence in our country also contributes valuable insight into what it is that makes this problem an "American" one. Deputy Chief Ed McGinn, of the Worcester Police Department, describes our city's law enforcement response to gun violence and mass shootings like the one experienced in Newtown. Ms. Esperanza Donovan-Pendzic, a school adjustment counselor in our Worcester Public School system describes how schools recognize and treat "troubled kids" who may become isolated, like the Newtown shooter seems to have been. Dr. Kathleen Walsh, of the UMass Memorial Children's Medical Center, proffers advice to parents, kids, and teachers alike as to how to stay safe in school and how to talk to kids about Newtown-like events. Dr. Judy Schaechter, chairman of the Department of Pediatrics at the University of Miami Children's Hospital and president of the Injury Free Coalition, has submitted a thoughtful piece on the importance of physician counseling of patients regarding gun safety.

Dr. Ronald Dorris remembers Dr. Stuart Jaffee with a beautifully written memorial, and Abe Jaffe, a former UMass medical student who is now a surgical resident, looks into the biography of Dr. Jaffee, one of Worcester's most preeminent surgeons and public servants. Dr. Jaffee served the community for many years as both a practicing urologist and an adjunct medical examiner before passing way this past year. Erin McNeil and Alexis Ladd, educators and communication specialists, will discuss the importance of media literacy and preventing a susceptible young person form embracing some of the negative messaging offered by TV commercials, video games, Internet postings, movies, and Saturday morning cartoons.

I hope you will find this issue of Worcester Medicine to be informative and provocative. There will be much discussion of guns, violence, mental illness, and media influences, as the Biden Task Force tries to see its recommendations translated into policy and legislation. We can all hope that the Newtown cataclysm serves a the tipping point to bring us together as a society and a medical community to see if we can handle this firearm injury epidemic as we would with any infectious disease ~ with a "vaccination" and treatment protocol to get at the "Seeds of Violence."

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Potentially Violent Youth:
Recognition, Risk-assessment, and Remediation

By Ronald Pies, MD

Ronald Pies, MD

"Newtown concentrated the horror in one place for one hour, but the same outrage occurs daily in U.S. cities, suburbs, and rural areas."
~ Judith S. Palfrey, M.D., and Sean Palfrey, M.D.*

The tragic events in Newtown, Conn., have generated volumes of "expert" commentary from specialists in mental health, violence prevention, and many other disciplines. In truth, our expertise in the realm of so-called "targeted violence," such as well-planned school shootings, is quite limited. Fortunately, these are relatively rare events; unfortunately, this rarity has limited the development of valid assessment tools that would enhance prediction and prevention of such tragedies. Furthermore, the intense media focus on mass shootings and "crazy gunmen" diverts us from the much larger problem of endemic, gun-related violence in the U.S. ~ a slow-motion tragedy that seldom attracts the media's attention and has little to do with "mental illness."

In this brief space, I address four key issues raised by Dr. Michael Hirsh: 1) How can physicians recognize the troubled and potentially violent youth? 2) What is the role of the general physician in assisting severely troubled adolescents? 3) What is the proper role of the psychiatric community in identifying and treating potentially violent adolescents? and 4)What counsel should we provide to our children in the wake of Newtown and related mass violence?

Risk Factors in Adolescents

First, we must recognize that the rubric of "troubled youth" covers a broad territory, ranging from the impulsive and episodically aggressive adolescent to the methodical and predatory mass killer. We must also recognize that there may be fundamental differences between episodic, impulsive violence and targeted violence, such as meticulously planned and "cold-blooded" school shootings. (Forensic psychiatrists often distinguish affective violence ~ or "blowing off steam" ~ from predatory violence.) Simply put, no one can reliably predict who will become violent. However, we do have reasonably well-validated risk factors for violent behavior in adolescents, summarized in Table 1; however, it is not clear that these are directly applicable to targeted or predatory violence.

Table 1: Selected Risk Factors for Violence in Adolescents[2]
- History of prior criminal acts, including non-violent offenses. Poor parenting (abuse, neglect); antisocial biological parent.
- Delinquent peers, gang membership.
- Poor social skills.
- Poor school performance, learning disabilities, frontal lobe dysfunction.
- Psychopathology, including conduct disorder, substance abuse, mood disorder.
- School's tolerance of bullying.
- Lives in high-crime or severely disadvantaged neighborhood.

[Modified and condensed from Ash, 2008]

We know far less about the risk factors for targeted violence and the characteristics of mass shooters. Indeed, there is no validated profile that reliably distinguishes such individuals from thousands of other troubled youth. However, there is an emerging consensus that perpetrators of mass shootings often feel socially rejected, bullied by peers, and often depressed and suicidal. Some may exhibit severe narcissistic personality traits and an intense preoccupation with themes of violence, death, or firearms use. And yet, as Knoll observes, many individuals possess these traits and do not commit homicide.[3] Thus, simple profiling will likely result in many false positives. Our best hope of prevention probably lies in careful follow-up of leaks from would-be perpetrators ~ a frequent occurrence ~ and tips-offs from knowledgeable peers or family members.[4]

The Role of the Primary Care Physician

Primary care, pediatric, and family physicians are sometimes privy to information about a potentially violent adolescent, either as a result of a family member's disclosure or via direct care of the adolescent. Alas, direct referrals from the adolescent's school are probably rare. In addition to assessing risk factors for violence, the physician should document a detailed past history of the adolescent's violent acts and likely precipi-

tants; any protective factors (such as a closely involved school or family); the magnitude, intent, and pattern of the adolescent's violent acts (are they mainly affective or predatory?); and the adolescent's potential for carrying out lethal violence (e.g., easy access to firearms?).

Ideally, the physician assessing a potentially violent adolescent should work in consultation with appropriate school authorities, such as the school nurse or psychologist. Patient-physician confidentiality may constrain such communication; however, if an adolescent is directly threatening violence to identifiable persons or groups, Tarasoff guidelines ~ aimed at protecting others from imminent harm ~ generally override confidentiality requirements. Since Tarasoff guidelines vary from state to state, consultation with a child or forensic psychiatrist is advisable. When the PCP strongly suspects underlying psychiatric illness, a referral to a psychiatrist or other mental health professional is usually indicated. A comprehensive review of such medico-legal issues is provided by my colleague, Dr. James Knoll.[3]

For now, as the Interdisciplinary Group on Preventing School and Community Violence concluded "...the most effective way to prevent many acts of violence targeted at schools is by maintaining close communication and trust with students and others in the community, so that threats will be reported and can be investigated by responsible authorities."[5]

Direct Psychiatric Intervention to Prevent Targeted Violence

While psychosis may play a part in some mass shootings, the role of mental illness in the commission of violent acts has often been overstated in the media. In fact, patients with severe mental illness commit only about 1 in 20 violent crimes.[6] In the U.S., roughly 10 percent of all homicides are committed by individuals with schizophrenia, bipolar disorder, and other psychotic illnesses[7], most of whom are not being adequately treated and/or suffer from co-morbid substance abuse disorders.[8] Moreover, direct psychiatric intervention in preventing mass shootings and other targeted violence is constrained by 1) non-specific putative risk factors; and 2) legislative and judicial restrictions on involuntary psychiatric treatment. In general, unless a person with mental illness presents an immediate danger to self or others, most states severely limit involuntary inpatient treatment. So-called "outpatient commitment" (OC) laws, mandating psychiatric care outside the hospital, have been enacted in 44 states. The exceptions include Massachusetts, Connecticut, Maryland, New Mexico, Nevada, and Tennessee. Though their effectiveness and enforceability is controversial,[9] the Treatment Advocacy Center asserts that OC laws are "...effective in reducing the incidence and duration of hospitalization, homelessness, arrests and incarcerations, victimization, and violent episodes."[10] Notwithstanding potential infringement of civil liberties, many psychiatrists ~ including this writer ~ support carefully crafted, enforceable outpatient commitment laws. That said, greatly expanded access to voluntary mental health treatment is sorely needed.

Helping Children Cope with Targeted Violence

Most children exposed directly or indirectly to mass killings will require emotional reassurance and support, often for several weeks or longer.[11, 12] Common reactions include nightmares, intrusive recollections of the trauma, avoidance of trauma-associated places, separation anxiety, hyper vigilance, and irritability. Care and support for survivors and other affected children includes: promoting a sense of safety; using relaxation techniques, such as deep breathing; encouraging a return to normal routines as soon as possible; promoting social connectedness; and instilling a sense of hope that things will return to normal. Limiting recurrent exposure to televised "replays" of the trauma is also warranted. Fortunately, most children are quite resilient and will eventually recover even from very painful traumas.

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Ronald Pies, MD, is professor of psychiatry and lecturer on bioethics and humanities at SUNY Upstate Medical University and clinical professor of psychiatry at Tufts University School of Medicine. He is the author of several books on philosophy and ethics, as well as several collections of poems and short stories.

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One Cheer for the National Shooting Sports Foundation

David Hemenway, Ph.D.


David Hemenway, Ph.D.

The National Shooting Sports Foundation (NSSF) is a trade association for the firearms industry (e.g., gun manufacturers, distributors, retailers, and shooting ranges). It is headquartered in Newtown, Conn., only a few miles from where the Sandy Hook shooting occurred. After the Biden Commission recommendations for dealing with the United States' gun problem were reported in the press, the NSSF issued a short statement.

The NSSF stated that the central gun problem in the United States is unauthorized access to firearms, and it proposed two action steps. The first was support for immediate improvements to the National Instant Criminal Background Check System (NICS) to ensure that all appropriate mental health and other records (e.g., restraining orders) be brought into the NICS system. The second was to initiate "an expanded safety campaign to promote the secure and responsible storage of all firearms and ammunition when not in use. We believe the personal responsibility of gun owners, especially if there are children or at-risk individuals in the home, is central to any meaningful discussion of the issues." For the full statement, visit www.nssf.org/newsroom/news/Jan16_statement.cfm.

The NSSF is to be applauded, for each of these two steps is important in reducing firearm access for the wrong people. Compared to the response of the National Rifle Association (NRA) to the horrific Newtown shootings ~ intransigence about gun policy, trying to arm even more citizens, claiming that it is really gun owners who are the victims, and vilifying the president of the United States for the Secret Service protection of his own children ~ the NSSF response was a model of decorum and responsibility. The difference between the NRA and the NSSF responses to the Newtown tragedy was the difference between night and day.

I especially like the second step, for it is something the NSSF itself can do. The scientific evidence is clear that proper gun storage can reduce both gun accidents and gun suicide. Proper storage can also reduce gun theft. It is estimated that perhaps some 500,000 firearms are stolen each year, and many end up being used in crime. The NSSF can make a renewed and stronger effort to change social norms about safe storage. Responsibilities come with rights, and while most gun owners accept these responsibilities, far too many do not and impose costs, not only on their own families and friends, but on society at large. Gun owners, for example, should be alert to signs of suicide and crisis among their family members and temporarily store their firearms outside the home if a family member is at risk of self-harm or harming others ~ a simple step that may have averted the Newtown disaster.

On the other hand, I can only give the NSSF one cheer rather than three ~ even on the sole issue of limiting unauthorized access to firearms. In the first step, for example, the NSSF avoided any support for new laws ~ which is the position of the NRA. Thus, there was no mention of a central Biden legislative proposal: universal background checks. It is estimated that up to 40% of gun transfers are made without any background check ~ an easy way for criminals to obtain guns. A national requirement for universal background checks ~ a law already working in California and Rhode Island ~ is supported by the vast majority of the U.S. population, including gun owners and NRA members. Universal

background checks are crucial for keeping guns out of the wrong hands. Universal background checks would also financially benefit licensed dealers by making all sales go through these dealers. Yet the NSSF was silent on this issue.

The NSSF was also silent on anything that gun manufacturers and gun dealers might do to reduce America's firearms problem. Yet this is whom it represents, and these groups can make an enormous contribution to reducing our gun problem. For example, gun manufacturers can help reduce accidental injuries by making guns that are child safer, that never go off when they are dropped, and by making semi-automatics with magazine safeties that ensure the gun will not fire when the clip is removed. Manufacturers can help criminal investigations by making guns with serial numbers that are difficult to obliterate and guns that permit ballistic fingerprinting. Manufacturers can help reduce gun theft by making smart guns that will not allow use by unauthorized people. Instead of focusing on selling more lethal and more concealable weapons, manufacturers could focus their efforts on producing weapons that are more likely to promote, rather than reduce, public health and safety.

Dealers can also do more. Virtually all guns begin as legal guns sold by licensed gun dealers. Gun tracing shows that a huge percentage of guns used in crimes were sold by a tiny percentage of licensed dealers, and studies find that this percentage is not explained by sales volume or dealer location. Sting operations in Chicago and Detroit and by Mayors Against Illegal Guns have shown that such dealers will sell illegally to straw purchasers and even directly to felons. Studies by public health researchers have found that a sizeable minority of all dealers are willing to sell to someone who is clearly an illegal purchaser. Most dealers are not "bad apples," and NSSF could be doing more to identify and hold accountable those who are.

To help reduce our enormous firearm problem, the NSSF needs to look to improve the practices of its own members. We are going to have lots of guns in the United States. If we want to live safely with them, everyone needs to step up and do their part. This includes not only citizens and gun owners, but also gun manufacturers and gun sellers. Otherwise, it is largely "business as usual" ~ which means a lot of death.

David Hemenway, Ph.D., is Professor of Health Policy at Harvard School of Public Health and Director of the Harvard Injury Control Research Center.

School Violence: A Pediatrician's Perspective

Kathleen E. Walsh, MD, MSc

Kathleen E. Walsh, MD, MSc

The recent school shooting in Newtown, Conn., has caused parents, politicians, and other public safety officials to reconsider gun control, mental health, and school violence. For the practicing pediatrician, school violence more commonly involves children with behavioral problems, school failure, or bullying. This article seeks to describe, based on available information from the American Academy of Pediatrics (AAP) and others, what parents, pediatricians, and schools can do to address school behavioral problems, gun safety, and mental health care for children.

What can parents do to help children and teens stay safe in school?

Parents should encourage open dialogue with their children at all times, so that they will identify problems early. Parents can do this by showing interest in their child's activities and friends and by talking about things that make the child happy. Parents should remember that adolescents are primarily interested in the present and often behave childishly or impulsively when stressed. Parents of children of any age can encourage honest, open, and respectful conversations by being aware of their own reactions, giving the child all of their attention, and offering opinions without lecturing.

For adolescents, frequent check-ins on the teen's location is essential, particularly between 2 and 6 p.m., when teens often get into trouble. Parents can directly teach their teen how to safely avoid violence by reminding them that it takes more courage to walk away than to fight. Concerned parents can also speak directly to their teens about the dangers of carrying a weapon, informing them that it gives false sense of protection and makes you less safe.

If a child gets into a fight, parents should use the opportunity to listen to the whole story, pay attention to the child's feelings, and find out what caused the fight. Understanding the cause gives parents a tool to help children avoid future fights. Was it an argument, an insult, revenge? Parents should ask children how they are feeling now. Are they still afraid? Thinking about getting even? Interested parents will find more detailed materials from the AAP at healthychildren.org

What should schools do to address problem behavior in students?

The AAP provides guidelines for schools on the management of behavioral problems. These guidelines encourage early identification of problem behaviors and early intervention to mitigate severity and duration of problems. Clinicians should remember that schools provide the largest amount of mental health care to children. As such, clinicians and community mental health agencies must coordinate and integrate with school health and educational resources.

What can clinicians do to address mental healthcare for children with problem school behaviors?

For children, mental health problems exist within the child but also are intertwined with the family, school, the neighborhood, and the community. Successful pediatric mental health care harnesses community resources in collaboration with the school. Clinicians should be aware of the inventory of available early intervention and mental health resources in the community. This may, in some communities, include a community resource telephone number. There are also several family and consumer advocacy groups, such as the National Alliance on Mental Illness, Mental Health America, and Children and Adults with ADHD (CHADD). Clinicians should consider risk factors for mental health problems, such as developmental disabilities, academic problems, foster care, parent military service, social/familial stress, family mental health problems. For younger children with risk factors, programs which enhance parent-child attach-

ment, such as parent mentors, parenting programs, or nurse visits, can help.

How can pediatricians advocate for gun safety in community?

A recent JAMA editorial entitled "Curbing Gun Violence: Lessons from Public Health Success" enumerates a public health approach with several changes that can be made by clinicians, parents, policy makers, and gun manufacturers to reduce gun violence. The authors endorse the AAP recommendation that primary care clinicians should address firearms as part of anticipatory guidance for all children. Almost 40% of homes with a child younger than 18 have a gun. More than half of accidental deaths from firearms happen at a friend's home. Specifically, clinicians are advised to counsel families to store guns unloaded in a locked case and to store ammunition separately. Families should also be advised to remove guns from homes where any household member is depressed; this is especially important for clinicians to discuss during urgent mental health visits. Families may need to be educated that suicide with a gun is much more likely to be fatal than other methods. Clinicians seeking to do more may access the AAP position on firearms at federaladvocacy.aap.org under "media resources," which includes a draft email for your legislator and speaking points.

On a day to day basis, clinicians collaborate with schools to identify and care for children with mental health and behavioral problems. In a larger dialogue on school safety, mental health, and gun violence, clinicians are one of many stakeholder groups. Collaboration between these many groups will be needed to develop the legislative, public safety, and cultural changes which are necessary to improve the safety of our children.

Kathleen E. Walsh, MD, MSc, is Associate Professor of Pediatrics, UMass Medical School.

Media Literacy and Health

Alexis Ladd, MPH, and Erin McNeill

Alexis Ladd, MPH

Erin McNeill

In entertainment media today, the celebration of violent masculinity, sexualization of females of all ages, and the depiction of sexual violence are common fare. In a typical snippet of dialogue ~ this one from *Family Guy*, a popular, animated, prime-time television show ~ a news announcer appears on the screen, saying "…where the remains of three college students were found near a local nightclub. Reports suggest that all three were violated sexually before being brutally murdered." Peter Griffin, the main character, sitting at a table in a bar says, "Aw man, see that? Everybody's getting laid but me."

Some adults may have chuckled at Peter's lament with little connection made to how this kind of "comic relief" sends the message that we should laugh about rape and violence against women. Such messages, repeated over and over, normalize this violent behavior in our culture. The message, and the attitude, is particularly harmful to the children and youth who are watching, as they become desensitized to violence, including acts of violence directed against women.

And they are watching ~ on average more 7½ hours a day, according to a recent Kaiser Family Foundation study.[1] Kaiser found that exposure to media has increased exponentially over the past two decades. The quantity of media is certainly problematic ~ it takes the place of other activities, such as playing actively outdoors. But the content is a concern, as well, and it goes well beyond the junk food marketing that is linked to important health issues like childhood obesity and diabetes. The normalization of sexism, racism, violence, misogyny, gender stereotypes, unrealistic body expectations, an unhealthy and pornified sexuality, and general disrespect for parents and others is continually promoted to children in all the forms of media they use.

The Center on Media and Child Health at Children's Hospital Boston cites numerous studies that indicate children and adolescents are strongly influenced by images and messages they see in mass media. There is a growing body of research explaining the impact of such exposure ~ in video games and apps, music, social media, magazines, movies, TV and advertising ~ on children's physical and mental health.

For example, the American Psychological Association (APA) reports that viewing mass media violence leads to increases in aggressive attitudes, values, and behavior, particularly in children, and has a long-lasting effect on behavior and personality. The APA also says that girls' exposure to sexualization and objectification can lead to mental health problems such as eating disorders, low self-esteem, and depression, among other negative consequences. Other problems with the sexualization and sexist content of media include precocious sexual behavior, out of balance relationships between girls and boys, and rising sexism among the young.[2]

That such media fare appears at all is regrettable, but even worse, some of the highest levels of sexualization, violence, and stereotyping in media have been found in programming for children and teens.[3, 4] Even bullying is a major source of entertainment material for children. A study published this year found that nearly all popular children's programs portray some social aggression.[5] On average, there were 14 different incidents of social aggression per hour in these shows ~ frequently featured in a humorous context and resulting in no consequences. While educators struggle to confront bullying in schools and online, researchers note the risk that children are being trained in bullying behavior by the shows they watch.

In the face of this media onslaught, are we doing our job as a society to protect children? Media today surrounds children like the air they breathe. When so many children are spending nearly all their free time with such a powerful force that has so much influence over their lives, behaviors, and health, they need to be given the tools necessary to make their way in this world. They need help to explore, study, talk about, analyze, and investigate the media, not just passively consume the images and stories presented to them. One powerful tool is media literacy education, which helps to create critical thinkers and producers of media within a cultural framework.

Media literacy education has proven results.[6] Comprehensive media literacy education is quite common in many western countries, but not in the United States. Some passionate individual teachers are introducing it in their classrooms in this country because they see how media impacts the development of their students. These educators know that media literacy has positive outcomes in critical thinking, positive social behavior, tolerance, positive self-image, and improved academic performance. The American Academy of Pediatrics and the APA both strongly advocate for media literacy education programs in schools.

One of the foundations of being media literate is applying deconstruction skills. Media literacy educators practice deconstruction with their students by asking a series of questions some of which include: Who produced the media and why? Who is the target audience? What persuasive techniques are being used? What messages are being promoted, and what parts of the story are left out? These questions can be applied to any media example. Honest responses will leave children and adults with a better understanding of how media affects them. Ultimately, it's empowering to understand where these messages are coming from and that everyone has a choice about whether to accept them or not. Once children become more engaged, they can advocate for better media and produce pro-social media themselves.

The Massachusetts Media Literacy Coalition (MMLC) was formed last year in a grassroots effort to advocate for urgently needed media literacy education in public schools across the Commonwealth. We are currently exploring opportunities to support media literacy curriculum in schools, to pass legislation that provides the initiative to do so, and to educate the public about the importance of media literacy education. We encourage you to get involved. Please visit our website, www.MassMediaLiteracyConsortium.com, to become a member and to support the legislation. Join us as we support students to be critical thinkers and producers of their own positive media messages.

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Alexis Ladd, MPH, teaches media literacy at Wheelock College and started Medialit4U, an educational media literacy resource for teachers, parents, and students. Erin McNeill is a journalist who publishes the website MarketingMediaChildhood.com. Ladd and McNeill are members of the Steering Committee of the Massachusetts Media Literacy Consortium.

Living with Guns in our Society

Deputy Chief Edward J. McGinn, Jr.

As compared to other cities its size on the east coast of the United States, Worcester is a very safe city. While gun-related and other violence does occur, the simple truth is that if one steers clear of gangs and the drug trade, the chance of being the victim of a gun offense in Worcester is slim. That said, there is occasional collateral gun violence injury that comes unto the truly innocents.

Guns and the people that would use guns unlawfully are of special interest to the Worcester Police Department. Like no other crime category, the incidences of shootings, fatal and non-fatal, are vigorously investigated by a specialized unit called the Shooting Response Team. This unit is made up of experienced Major Crime, Gang, and Vice detectives, and the suspects that they pursue are haunted by these detectives' incessant investigatory scrutiny. Even if we cannot arrest and prosecute these suspects, by calling this investigatory attention onto themselves and their associates, they are effectively "shut down" in their subsequent criminal activities. This, in and of itself, has a deterrent effect.

The Worcester Police Department (WPD) is also responsible to administer and otherwise deal with guns on a number of other levels. As the local issuers of individual gun licenses, it is our job, within the established legal provisions, to evaluate and discern those that may be lawfully granted gun licenses from those that are simply too dangerous or irresponsible. As part of the licensure process, we provide these licensees with top notch training in the safe handling and storage of firearms. The vast majority of those that apply for gun licenses in Worcester are ultimately successful in receiving those licenses. As Worcester is home to a number of gun manufacturers, it is the WPD's obligation to examine these operations to ensure that weapons produced at these facilities are properly handled and stored.

Here in Worcester, the police department has worked extensively with school officials in the development and annual refinement of disaster and emergency plans to include lockdowns and evacuations. These discussions involve a myriad of "what ifs" to include active shooter intruders and school personnel response thereto. Moreover, Worcester's police officers have undergone training in their response to active shooter scenarios.

In addition to these measures, the Worcester is fortunate to have a cadre of uniformed police officers that work exclusively within the schools on a daily basis. While much of these officers' day is spent in the city's five public high schools, these officers are visible in the middle and elementary schools regularly. This recurrent presence in all our schools carries a deterrent effect, but more importantly, it espouses relationships and confidences where problematic students like Eric Harris and Dylan Klebold (of Columbine, Colo., infamy) perhaps can be identified and looked at before tragedy strikes.

In other initiatives, Worcester police have partnered with UMass Memorial and a number of other local organizations to hold an annual gun buyback program. This has gone on each year since 2002. Under the passionate leadership of Dr. Michael Hirsh, Worcester's commissioner of public health, we have taken a proactive approach vis-à-vis guns in the household. This approach focuses on public health and safety objectives, rather than on investigatory or punitive objectives.

Through these annual programs, more than 2,200 firearms have been taken out of circulation. Because of their removal from circulation, these turned-in weapons will nevermore become the subject of theft, will not be the weapon with which a child accidentally harms himself, and will not become the weapon a despondent or mentally ill individual will use on himself or others.

A program known as the Jail Diversion Program is funded by a grant from the Department of Public Health. It is the objective of this program to proactively identity members of our community that are in need of mental health evaluation and treatment and connecting them with that treatment. Rather than arresting and incarcerating these individuals, which likely exacerbates their mental health conditions, we seek to get them into continued and monitored treatment before they commit crimes or victimize someone.

We are hopeful that these programs will give rise to a safer community, and we remain vigilant in our continued effort to maintain ~ and indeed increase ~ the safety and security of our community.

Edward J. McGinn, Jr., is a deputy chief of police in Worcester, in charge of the Uniformed Services section and oversees the Community Impact, Traffic, and Court Liaison and Service divisions of the Worcester Police Department. He has been with the Worcester Police Department for 28 years. He can be reached at mcginne@worcesterma.gov.

Let's Lock Up Guns, Instead of Child Victims and Young Shooters

Judy Schaechter, MD, MBA

Judy Schaechter, MD, MBA

It is accepted as common sense that if a mail carrier slips on an iced-over, unsalted step, the homeowner is liable; if a child drowns in an unfenced pool, the pool owner is responsible. If an aggressive dog gets loose and bites someone, the dog's owner is responsible.

So, it seems reasonable that when it comes to firearms, gun owners ought to be responsible for their property and the prevention of the injuries those firearms may cause.

The massacre at Newtown, Conn., focused the nation on the issue of access to firearms like never before. The debate extends to assault weapons, ammunition capacity, background checks, mental health screening, treatment, research on prevention, and school safety.

Where the national discourse runs thin is recognition that keeping guns out of the hands of children, adolescents, persons with mental health issues, and anyone for whom they are not intended is the responsibility of gun owners. Guns need to either be securely locked or removed from the premises where such persons may gain access.

We don't know a lot about Adam Lanza or his mother, Nancy Lanza. Both are now dead. Nancy Lanza, widely reported in the media as a "gun enthusiast," probably believed herself to be a responsible gun owner.[1] Most gun owners do; maybe most are. Yet, it is fair to question if a gun owner who allows someone to gain access to his or her handgun or high-powered weapon is responsible enough. Based on brain development and cultural norms, adolescence continues into the mid-20s. Adolescence is a period of impulsivity, risk-taking, and mood changes, even in those without mental health issues. Mrs. Lanza may or may not have understood that. Yet, if Mrs. Lanza and all gun owners were fully responsible for securing their guns from others, deaths like this might be substantially reduced. There is solid evidence that children and adolescents are safest in homes without guns.[2, 3, 4]

Just three weeks prior to the shootings in Newtown, a 13-year-old girl was fatally shot on a school bus in my own town of Miami.[5,6] Lourdes Guzman DeJesus was on her way to school with her younger sister. There was no altercation or intent to harm, just a 15-year old showing off. Jordyn Alexander Howe had brought his stepfather's .40 caliber handgun in his book bag, a gun he found on a closet shelf.[6, 7]

Jordyn Howe's mother reportedly didn't know there was a gun in her home. But her teenage son did. He knew exactly where his stepfather kept the apparently loaded and unlocked firearm. In my own practice, it is not at all uncommon that adolescents know where the family gun is kept, even when their parents say their children don't know there is a gun in the home. Though parents may believe their kids would never dare touch a gun ~ that they know better ~ unfortunately, that doesn't always pan out. Many ~ most ~ kids, even those taught not to, reach for guns when given a chance.[8, 9]

If a doctor had asked Jordyn if there was a gun in his home, he might have said, "Yes," perhaps triggering a life-saving conversation with his mother. Jordyn's doctor could have facilitated an important revelation to Ms. Howe and helped her discuss with her husband how to prevent a potential tragedy. Perhaps they would have agreed to remove the gun from the home ~ the safest option. Or, if the stepfather was determined to keep his gun at home, she could have guided him to ensure the weapon was stored locked and/or unloaded, which, in a home with children, substantially reduces the risk of gun death and suicide.

However, just about the time that Jordyn would have been due for his 14-year-old checkup, the Florida legislature passed the nation's first law banning doctors from asking questions about access to firearms, a law which has fortunately been overruled.[10] Nonetheless, Florida is appealing that ruling.

Nationally, in most unintentional shootings, the shooter is a minor; the victim is usually even younger.[11] The gun usually comes from the home of a family member or friend. In this case, 15-year-old Howe has been charged ~ as an adult ~ for manslaughter, carrying a concealed weapon, and illegal possession of a firearm by a minor. The real adult, the gun owner, has not been charged and likely won't be, even though Florida has a child access to firearms prevention law, which is rarely enforced. It has been reported that the authorities believe leaving a gun on a closet shelf is a "reasonable" attempt to secure it.[6]

I don't believe that ~ not as a pediatrician advising parents, not as someone who has taken gun safety courses, not as an American with common sense. The many high-velocity assault weapons in the Lanza home did not belong in that home. At a minimum, the gun in the Howe home should have been locked in a safe. Gun owners should keep guns secure. It is not enough to hide them. It is not enough to tell children and young people not to touch them. Not when the risk is to one's own child or someone else's.

We need to love children enough to get serious about securely separating youth and guns.

We also need to love adolescents enough to stop thinking that all young people "know better" all the time, that they always use good judgment, that they will resist the temptation, impulse, anger, and urge. Some might, but many don't. Not always. Not reliably. Their brains are still developing, and the ability to think through consequences is still forming. By their very nature, they are impulsive, risk-taking, and emotional. They yearn to be adult-like, sometimes in all the wrong ways. They want to show off and impress. They sometimes do stupid things. They make mistakes; it is how they learn ~ but making a lethal mistake with a gun is an eternal tragedy, for the shooters, the people they shoot, and their families.

Americans want guns, lots of guns. It is clear that we will keep the guns. But let's recognize that we have a problem with children, youth, and people on the edge accessing firearms and deadly ammunition.

Is it really so hard to keep a gun locked?

Isn't it better to keep a gun in a locked box than forever bury a child in a box?

Isn't it better to lock up a gun than lock up a child, even a young teen, in a cell?

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Recognizing Potentially Troubled Youth and How to Counsel Kids Who Witness or Overhear Violence

Esperanza Donovan-Pendzic, M.Ed., CAGS

Recognizing troubled youth is not easy. It takes training, skills, and the determination to not dismiss what even society has under-graded and devalued: young people with mental illness issues. It seems that today's cultural violence reflects in our society ~ it is obvious when one sees the devastation and the neglect that our communities are facing. Our families are looking for resources that are too scarce in our communities. These resources include the need for mental health services that can help families, students, and educators to recognize the symptoms of violence, suicidal tendencies, and mental illness in our youth. The ability to receive counseling in schools has taken second place to standardized testing. Sadly, our society's devastating violence and the easy access to guns is targeting our youth.

Spotting young troubled people like Adam Lanza takes resources, competence, and acceptance to work with all students and families within our communities. Every potential victim can be a potential perpetrator. Most children who suffer from mental illness, violence, neglect, or abuse can be affected in many ways. Adam Lanza's rage and mental illness was known by his mother before he became a young man capable of gunning down 20 children and six adults at the Sandy Hook Elementary School in Newton, Conn. According to many news reports, Lanza's mother knew that her son was mentally ill. Also, it was reported that Lanza did not attend Sandy Hook Elementary School. What seems to be clear is that the family was not receiving the mental health services they needed. We will never know why.

Many educators have concerns that the negative aspects of our culture and its devastating violence are being acted out in our schools. "All schools are a reflection of our society," commented Dr. Kathleen Lynch, one of five guest presenters at an educational forum held at Worcester State University last April. "Our schools are simply a mirror that reflects our communities," she went on to say. The sad truth is that perhaps nothing could have protected those 20 children and their teachers at Sandy Hook Elementary.

The question that remains is: How can we prevent young men or women from hurting themselves and others? As a school adjustment counselor, counseling young students to cope with reactive emotions, impulsivity, and anger are important skills to teach our students in schools. These skills are beneficial to all children, as well as teens. To address different issues, there is a need to learn and teach conflict resolution skills, self-awareness, and managing anxiety and to establish trusting relationships between students, teachers, parents, and school administrators.

Students who witness brutalities and have experienced trauma need some specific attention. For example, the procedures that are generally used are the following: 1) listen to the student without judgment; 2) acknowledge the child's feelings as to whether they feel afraid or guilty about what happened.; 3) find out if the children have a sense of responsibility for the violent act (many children feel responsible for creating the violence, even though they had no role in causing it); 4) Reassure them that they did not cause the violence; 5) Support the child (ask them "How can I make this situation better for you?")

After identifying the emotional needs of our students, the next step is to report the information to the administrative staff and also to share it with the parent if it is appropriate. At times, different agencies that protect children, such as the Department of Children and Families or the Department of Mental Health, need to be contacted. The school adjustment counselor begins the process of matching and referring the student and his or her family to a counseling agency in the area.

The counseling referral process has to be thoughtful, and the adjustment counselor needs to understand the underlying issues that may be aggravating the pupil's situation. A match is then

made by accessing the emotional needs of the student and his or her family. For example, many of our students and their families might not speak English. These families need to communicate in their native language. Unfortunately, many counseling agencies do not have clinicians or therapists who speak different languages available to serve specific populations. Another issue that hinders receiving counseling is that many traumatized students do not have the required insurance coverage to pay for the services unless the family pays privately. These are difficult situations that prevent mental health services from reaching students and families in need of psychological and emotional support.

The reality is that most of our families whose children attend public schools cannot afford costly counseling services unless they are involved with the Department of Children and Family or the Worcester Juvenile Court. This means that the child and his or her family may have a negative perception about being involved with "the system." Finally, another problem is the long and painful waiting list of at least six months ~ and sometimes more ~ to see a therapist or a counselor. Counseling services should be available to all our students, especially those who suffer from trauma or mental health issues. If parents are supported, then students will be better served. Public and private educational institutions, as well as the community, have to create some helpful and progressive strategies if they want to help troubled youth avoid violence.

Policing and arming schools is not the answer. The solution is complex, but we need to start somewhere. This requires a new way of thinking and creating opportunities to stop violence in our communities, and therefore, stop the violence against our youth.

Esperanza Donovan-Pendzic, M.Ed., CAGS, is a school adjustment counselor for the Worcester Public Schools and an adjunct professor at Quinsigamond Community College. She is the creator and founder of the Latino T.V. show,* Esperanza Y Su Exito, *in affiliation with Worcester State University.

To the Editor,

Reflecting upon my review of *The Quest for Cortisone* by Thom Rooke in the November/December issue, I wish to correct a major imbalance in emphasis I made regarding Philip Hench. While the book does address post-Nobel changes in Hench's personality, I erred in not emphasizing that the author had painted a more complete picture throughout the book, one that described Hench's intellectual breadth, charismatic personality, generosity, and intense loyalty to his colleagues and concern for his patients. While I endeavored to accurately portray the author's incisive account of the cortisone discovery, my review was inappropriately narrow and selective as regards Hench's full dimensions, and for this shortcoming, I wish to apologize to readers.

Sincerely,
Thoru Pederson, Ph.D.

Report from a Free Medical Clinic

By Sidney P. Kadish, MD

In November, 2012, I began attending at the free clinic held weekly at the Epworth Methodist Church in Worcester. This is a summary of my experiences and impressions.

The clinic is held in the church basement from 6-8 p.m. Mondays. It is staffed by church volunteers who provide clerical service, coffee and pastries. Medical professional volunteers include UMass medical students who see the patients and report to a licensed physician who reviews the history and physical exam and provides a disposition.

The patients are always people without medical insurance. They may be students, recent immigrants, people who have lost their jobs, or homeless people. Some visitors come to the clinic because they need a physical exam to secure employment. Some have mild or moderate ailments requiring further diagnostic tests or need prescriptions for known diagnoses, such as hypertension or Type II diabetes. Prescription renewal is a common request.

The experience of attending in this free clinic contrasts sharply with my usual duties as a staff radiation oncologist at UMass. There, I have a complete repertoire of laboratory and X-ray services at my disposal, as well as a complete panel of medical and surgical specialists and consultants. At the free clinic, we have a very limited laboratory menu, no access to X-ray services, and no formal consultative resources. It is the contrast between the Haves and Have-Nots.

Despite these drawbacks and deficiencies, there is an admirable esprit-de-corps among the volunteers, both professional and non-professional. A sense of the "healing mission" pervades, inspired by both a religious sense of charity and sacred duty and a secular attitude of social justice. Everyone is served cheerfully.

For me, this is the actualization of the two-tier system that some have predicted. A Canadian once explained to me that in his country, fire and police protection are for all the people and so is health care. A part of me wishes that these uninsured unfortunates would also have full health care access, as they do with fire and police.

This is an issue for health care policy. But health care policy is a complex and difficult subject, complicated by politics and the desires of established stakeholders, like insurance, medical and drug companies. But as practicing physicians, we have to face the fact that not all patients can afford insurance or drugs. Volunteer to serve in this no-insurance medical environment by contacting Dr Eric Dickson (eric.dickson@umassmemorial.org) and see for yourself. Of course, at a minimum, you can contribute to the Worcester District Medical Society Rx Fund, which helps people who cannot afford their medicine.

Sidney P. Kadish, MD, FACR, is a professor and clinical director of the Department of Radiation Oncology at University of Massachusetts Medical School/Center.

Spoken History Project
Stuart Jaffe, MD Interview, August 2001

By Abraham Jaffe, MD

In 2001, Stuart Jaffee and other area physicians were interviewed by students from the University of Massachusetts Medical School (UMMS) for the Spoken History Project. The interviews were videotaped and, in some cases, transcribed; video recordings and transcribed interviews are available through the WDMS.

Stuart Jaffee, MD, passed away Nov. 5, 2012, leaving behind family and many adoring colleagues and grateful patients. Although I never did get a chance to meet him in person, I feel a connection to him through the same last name. When I first began rotating through the operating rooms at UMass as a medical student and would introduce myself to the nurses, I often was greeted with the remark, "Jaffe? Any relation to Dr. Stuart Jaffee, the urologist?" I got tired of seeing the disappointment in people's faces when I said no, so began answering, "No . . . but I wish I was." After hearing so many adoring stories from colleagues, I had the pleasure and privilege of watching a video interview with Dr. Jaffee from August 2001, gathered as part of the WDMS Spoken History Project.

During the hour-long videotaped interview, Dr. Jaffee appeared relaxed, reclining comfortably on a couch in his Worcester home, speaking with a sparkle in his eye and an obvious appreciation for the path he has traveled. He answered questions thoughtfully, with waving hand gestures, frequent historical references, and a quick smile.

Dr. Jaffee grew up in Worcester and graduated magna cum laude from Tufts University. He described how an early interest in engineering morphed into a fascination with biology, leading him to medicine. He attended Tufts Medical School and then went to Bellevue Hospital in New York City for a general surgery internship. He decided to specialize in urology, largely because "the urologists who I met were such nice guys that it was automatic. I wanted to work with them. . . Overall, urologists tend to be pretty nice people ~ there probably are reasons for that," he said with a slight smile. He returned to the Bay State for a urology residency at the Peter Brent Brigham Hospital and then returned to his hometown of Worcester to work at St. Vincent Hospital.

During the interview, Dr. Jaffee fondly remembered his many joyous years working as a urologist at St. Vincent and said that it was the people that he most enjoyed. He spoke gratefully of the people that he interacted and worked with at the hospital ~ during his time in the OR especially ~ and of the many patients that he helped. He called medicine a "holy field" and spoke of the magic in the doctor-patient relationship. Tears welled up in his eyes as he spoke of the "love affair" between a doctor and patient. He seemed deeply fulfilled by his career. "I've loved every minute of it."

When asked about changes in the field of urology over the years, he replied, "The most striking change is in treatment of cancer of the testicle. When I started 40 years ago and I was a resident, the cancer had very frequently affected young men in their 20s, just starting life being married with a little kid. It was a horrible and dreadful thing; there were a lot of fatalities. Then, treatment was discovered; radiation for one type, chemotherapy and radical surgery for another type. The cure rates went up to 100% in many of them." During his long career, he was witness to many advances in the field of urology and was an early promoter of the use of transurethral resection of the prostate (TURP), which greatly decreased morbidity in the surgical treatment of prostate cancer.

Stuart Jaffee was fully invested in his profession in every sense. At one point during the hour-long interview, he paused to listen to a phone message being left on the answering machine. "This is a lady who is calling me about a briss, the Jewish ritual circumcision. I'm also a Moyel, so I conduct these rituals." He then launched with wonder into a description of the thousands-of-years-old rules for circumcision in the Talmud, the Jewish book of tradition and rules.

"The Talmud was full of medical information, as well, and 2,000 years ago, they wrote of different medical conditions where you would not conduct the ritual on a child. If one child in the family dies of bleeding, you don't do the others' circumcisions. That was 2,000 years before anyone understood hemophilia. … I think it's remarkable that we have these texts to work with."

Dr. Jaffee also served as a medical examiner and told the story of how prostate specific antigen (PSA) was discovered in Japan as a means for medical examiners to prove rape and later became a life-saver for many men in the early detection of prostate cancer.

Regarding advice for medical students and young doctors, he stated, "Well, that's easy because we have four sons and we encourage them to go their own way. … Follow your bent and do it only because you love it." It is obvious that Stuart Jaffee epitomized this ethic and will be missed greatly.

Abraham Jaffe, MD, is a first-year general surgery resident at UMass Medical School.

Stuart R. Jaffee, MD
1929-2012

Stuart Jaffee died Nov. 5, 2012. He was a kind man, a caring physician, and a down-to-earth student of everything about life. At social gatherings, he was the cynosure, and his charisma gathered others whenever he spoke.

Stu was born and schooled in Worcester until he went to Tufts, first as an undergraduate and then as a medical student. He had the achievement gene, and it showed early. He joined the prestigious program in urology at Harvard's Peter Bent Brigham Hospital. There, he witnessed medical history, including the first use of topical lidocaine to control arrhythmias and Manitol to reduce hypovolemec renal shutdown. He worked with many of the leading physicians of his time. He made his contribution when he invented an illuminated catheter that outlined the ureter during surgery.

He started his urology practice at Saint Vincent Hospital in an era when the bishop, the monsignor and the nuns were a major presence in the hospital. Stu knew the nuns, and he made a traditional Passover Seder for them, sharing the history behind each ritual. Stu was proud of his own religion, and he wore a large neckpiece of Moses carrying the 10 Commandments. After special training, Stu became a Moyel and turned every ritual circumcision into a festive occasion. Indeed, his automobile license plate read "Moyel." When he was staff president, he worked to advance St. Vincent Hospital as a teaching institution and to unify urological care citywide.

Stu was a trivia buff and a raconteur with a great memory for humor and anecdotes. He was frequently the master of ceremonies at hospital, Medical Society and temple gatherings. Each successful presentation brought accolades and fresh requests to perform. He enjoyed it for a while, until colleagues complimented him, saying "Stu, you missed your profession. You should have become an entertainer." Then, he turned down MC offers and said he just wanted to be a good urologist.

He was active in the Worcester District Medical Society and a Worcester booster. Once he arranged a citywide bus tour for members of the Medical Society. As the bus moved about the city, he told tales of which old buildings were the sites of Worcester's leadership in industrialization. At the shores of Lake Quinsigamond, he located the beach and the amusement park that had been thronged with visitors every summer. The tour was so popular, he was asked to repeat it several times.

Stu practiced urology for more than 40 years but found time to be a pioneer in the new bureaucracy of utilization review. He traveled across the country teaching others about the subject, and he became a local UR guru. In addition, he loved to interact with local police and forensic specialists, and he was a Worcester County medical examiner for many years. He was liked and respected by the Worcester police.

However, these accomplishments give an incomplete picture of the essence of Stuart Jaffee. Stu was a solid family man. He had one wife, four sons and 12 grandchildren. He was proud of them all, and they were all "good people." The rock in his life was his wife, Sylvia. He shared his profession, his religion, his family, his politics, and his soul with her. She was his helpmate at home and his office secretary. He also doted on his four sons, their wives, and his many grandchildren, who reciprocated with adoration and affection. He was especially proud of the close relationships between his sons, their families, and each other.

Stu loved to travel. Sylvia was always with him. They visited all 50 states between frequent travels abroad. They visited both famous and obscure corners of the world. Everywhere they went, they made friends; if there was a wedding, they would congratulate the wedding party and often be invited to the wedding. Random encounters led to invitations to dinner and invites to foreign homes. They were never dismayed if old traveling companions turned up on their doorstep to accept long-ago offered hospitality. Sometimes, they traveled first class, and sometimes, they went baggage class, but every trip was recorded by quality photos and memorable anecdotes. These were proudly recounted at gatherings of colleagues and friends in their house. Stu was proud of his photography.

Stu did many things well. Always, he was modest about what he did, and he skillfully deflected praise about himself to another subject. In truth, he was an excellent leader, but he wanted to join more than lead; he wanted his friends and colleagues to be a part of his world and to share his experiences with them. That is what made him a joy to know.

Stu Jaffee, we will remember you and miss you.

Ronald Dorris, MD

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