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The Phony 'Public-Health Crisis' of Gun Violence

Academic medical professionals are increasingly perverting the language of the field to justify cracking down on Second Amendment rights.

By Vik Khanna — January 16, 2017

Two major medical journals have decided to renew the academic medical establishment's assault on gun owners.

The first shot across the bow appeared in the November 8 *Journal of the American Medical Association*, where esteemed Stanford University health economist Victor Fuchs published a paper on the problem of life expectancy in the black community. Near the end of his lamentation, Fuchs asserts that increasing life expectancy in the black community "depends more on public health measures such as gun control than on medical care." The second shot came with the release of the January issue of *JAMA Internal Medicine*, which has four papers and an editorial devoted to firearms violence, with a heavy emphasis on suicide prevention, which would benefit whites much more than it would the black community.

It should go without saying that Dr. Fuchs and his fellow public-health avengers have made critical analytical errors that belie their actual goal: a creeping vine of restrictions on access to firearms that, in their most lurid dreams, would eventually make gun ownership illegal. Unfortunately for them, the inconvenient truth is that the right to bear arms is in the Bill of Rights. There is no cross-cultural argument that can trump this right; it exists in the Constitution of no other modern, industrialized democracy, and no other modern, industrialized democracy resembles ours. Democratic and demographic differences matter.

But though the law is against them in their aims, these writers can still do real damage. Their mixing of apples and oranges in order to arrive at a preordained conclusion — guns are bad, and this "public health crisis" of "epidemic" gun violence is sufficient cause to reconsider their place in society — is part of an ominous trend in the way the medical community thinks about social ills. The words "public-health crisis" and "epidemic" have become a pretext for restricting perfectly legal individual choices and behaviors in the marketplace.

When the government deems the actions of individuals a public-health crisis, mandates can't be far behind. Insufficient health insurance was a public-health crisis; Obamacare gave us a mandate. Heart disease, diabetes, and obesity are public-health crises; Obamacare mandates coverage of clinical prevention services that almost never save lives but increase spending. Sugar consumption is a public-health crisis; the government tries to limit soda sizes and gives us sugar taxes, both effectively mandates to consume less. Cigarette smoking is a public-health crisis, so the government mandates reduced consumption through extravagant taxation, which creates both a thriving black market and a bizarre paradox in which the health-care industry needs people to continue smoking (to pay the tax and fund the tobacco settlement) even while it implores them to stop.

Historically, the field of public health focused on improving the health of populations through strategies that reduced the risk of harm to individuals without requiring much if any participation by end-users. This is important when the policy objective (e.g., safe food and water supplies) or risk elements (e.g., how fast or recklessly is someone else driving) are difficult for individuals to control.

Well-known and well-documented public-health success stories include vaccinations, food safety, building codes that require lead-free paint, food fortification, hospital infection-control protocols, and clean-air and -water laws. In each of these cases, an agent (most often the government), acts to affect *the environment* so that citizens can go about their lives with relative security in the public square.

In other words, the theory behind most public-health successes has hitherto been that big-picture strategies provide passive protection against harm. The end-user, you or I, needn't do anything special to benefit. Active protection requires an action by the end-user. For example, designing and building safer roads and more crashworthy cars, which better absorb energy and thus prevent injury or death in an accident, is a passive way to protect drivers. Requiring a driver or passenger to buckle a seat belt is an active protection. Punishing a driver who is impaired or distracted and causes harm is a criminal matter, because we as a society have rightly recognized that not all harms are preventable and that both negligence and malicious intent should be punished under the law.

Under the guise of beneficence, public-health elites, who have fewer and fewer problems they can address via the passive route, have begun to make a broad range of false allegations when it comes to guns, employing deceptive but politically motivated and appealing analogies while ignoring the direction in which the data actually point. Their reluctance to follow the evidence gives us a third kind of purported protection in which the code words "public-health crisis" and "epidemic" form the tip of a spear intruding into the lives of individuals to restrict lawful

activities that the academy simply finds distasteful. They have, in other words, co-opted language previously reserved for describing problems that require passive protections in order to agitate for active protections that infringe upon Americans' constitutional rights.

This insidious shift in public-health strategy dates back to epidemiology pioneer Abraham Lilienfeld, who teamed with D.A. Henderson to address the scourge of infectious disease in the middle of the 20th century. Lilienfeld, whose epidemiology text is still considered a classic, eventually turned his attention to non-infectious and non-environmental threats to health, claiming that the one could apply the same methods used in the fight against infectious disease to problems such as heart disease and cancer. In retrospect, Lilienfeld was the first to make the apples-to-oranges mistake made by anti-gun public-health professionals today; cancer, heart disease, and other such maladies are non-transmissible. Some of their major risk factors are non-modifiable and unique (family history, age, and gender) and others are modifiable (exercise, diet, smoking, and alcohol consumption).

The modern cult of public health uses manipulation, conditioning, and contrivance to replace data, logic, and integrity. In the *JAMA Internal Medicine* papers and subsequent media coverage, study authors and advocates have blithely conflated firearm deaths in the U.S. (almost 33,000 in 2013) with automobile deaths (38,000 in 2015).

This comparison is deceptive in the extreme.

All auto deaths, other than the occasional murderer driving into a crowd, are by definition accidents, and thus unintentional and unpredictable. Hence, the academic injury-prevention industry, which cut its teeth on the issue of automotive safety in the 1970s and 1980s, has typically (and logically) encouraged better road design and more passive injury-prevention improvements in car design, such as energy-absorbing materials and air bags. The industry's own reasoning is that drivers and passengers may not have control over what happens to them on the road, so building a safer environment can save lives. It doesn't push to restrict the rights of individuals to drive or to dictate what cars people can buy, because its members cherish those rights as much as anyone else.

Of the 32,279 firearms deaths in the US in 2014, 586, or just 1.8 percent, were unintentional discharges. You are nearly six times more likely to die by accidental drowning and 54 times more likely to die in an accidental fall than you are to be accidentally killed by a gun. While accidental firearm deaths are tragic, they are exceedingly rare, and are best reduced through education about responsible gun ownership and use. The vast majority of gun deaths — more than 98 percent of them — are intentional, whether they be suicide or homicide.

Intentionality is the vital but completely ignored difference in the lie that connects automobile deaths and shooting deaths. To acknowledge its importance in firearms deaths undoes the argument of the public-health avengers that guns, per se, are the problem, because intent is personal. It requires examination of individuals and why they kill themselves or another person. In all likelihood the circumstantial drivers are as unique as the individuals involved, making it nearly impossible to craft environmental solutions that would not be so broad as to intersect with the rights of law-abiding individuals who pose a threat to no one.

The public-health community never discusses the fact that the violent-crime rate in the U.S. has dropped by half since 1990. The total number of fatal and non-fatal firearms events in the U.S. fell by 69 percent from 1993 to 2011. The firearm-death rate, too, is down over that time, by nearly 40 percent.

Why aren't these massive improvements in public safety celebrated as public-health victories? Well, mostly because the public-health community had nothing to do with them. You cannot attract new grant money by pointing out a decline in the problem that you've so emotionally labeled as a public-health crisis and an epidemic. No one can say for sure why the U.S. is much less violent now than it was 25 years ago, but we can all be thankful that it is.

There are now more than 300 million guns in circulation in the U.S., with nearly a million new guns sold each month. The proportion of households owning a firearm has hovered between 40 percent and 50 percent since 1993; it is now at 47 percent, according to Gallup. But there are 25 million more households in the U.S. today than there were in 1993. This means that one of the great public-health achievements of the past 20 years can't be credited to anyone in the public-health industry: There are more guns than ever in the U.S., but as a population, we are also safer than ever. That's the very definition of improved public health.

The irony of the academy's zeal to trample the rights of Americans is rich. Take Johns Hopkins as an example. Baltimore is one of the most violent cities in the U.S. In 1988, Maryland passed a ban on the sale of so-called Saturday-night specials — small, cheap handguns often favored by criminals — that took effect in 1990. Unfortunately, in 1993, 353 Baltimoreans were murdered, mostly by guns. Fast-forward to 2016, and more than 100,000 people have fled Charm City. The ban remains intact, but 318 Baltimoreans were murdered last year anyway, again mostly by guns. Criminals will always find a way to get a weapon. Always.

So, I'll ask the question that the academics won't ask: What is it about urban America that perpetuates such flagrant disregard for life? And what strategies does Johns Hopkins have to restore schools, jobs, churches, social institutions, and, most importantly, self-respect and

respect for life and the rule of law in Baltimore? If they can't do it there, how can anyone take seriously their sticking their fingers in the eyes of law-abiding gun owners elsewhere?

Is this a problem that academics will solve by restricting the right of people like me to buy any firearm we wish for recreation or protection or just because we think it's cool? No. The answer lies in vigorous prosecution and no-parole sentencing for *all* violent crime, and in a search for the meaningful expansion of individual opportunities for the urban poor so they can reclaim their communities and their lives. That so many public-health academics think otherwise is telling and profoundly worrisome. Here's hoping President Trump and the 115th Congress don't listen to them.

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