

doms, Gloria Steinem noted that Sanger was not immune to political expediency.<sup>5</sup> While refuting claims that Sanger was a eugenicist, Steinem notes that for tactical reasons, Sanger adopted the “mainstream eugenics language of the day” and used soft phrases like “family planning,” rather than voice her belief that the poor were being “manipulated into producing an endless supply of cheap labor.” Steinem notes, “Her misjudgments should cause us to wonder what parallel errors we are making now and to question any tactics that fail to embody the ends we hope to achieve.”

If the provision of safe and affordable health services to all women is what we hope to achieve, are we using the right tactics? I wonder how Albert Lasker might have used his powers of persuasion to broaden the social appeal of Planned Parenthood today. Would he invoke the argument that abortion reduces crime and poverty, or that contraception

fosters more enduring marriages and better family life? Would he suggest another strategic name change? Would he turn to evidence?

And yet perhaps the misjudgment of our day lies in the impulse to use persuasion at all. Lasker seems to have succeeded in advertising largely because he first sought to understand the reasons for people’s behavior. He talked to people, listened to them, paid attention to how they felt and why. Opportunities for such interactions are rare in today’s tribally riven society. The Lasker Foundation honors and sustains outstanding contributions to human health, but to extend the benefits of these advances to as many people as possible, we may have to begin to approach the conflict between science and belief with curiosity rather than disdain. Perhaps a future Lasker award will be granted to those who teach us, as a society, to move beyond seeking confirma-

tion of what we already believe toward better understanding what we don’t.

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1. Cruikshank JL, Schultz AW. The man who sold America: the amazing (but true!) story of Albert D. Lasker and the creation of the advertising century. Boston: Harvard Business Review Press, 2010.
2. Secura GM, Madden T, McNicholas C, et al. Provision of no-cost, long-acting contraception and teenage pregnancy. *N Engl J Med* 2014;371:1316-23.
3. Stevenson AJ, Flores-Vazquez IM, Allgeyer RL, Schenkkan P, Potter JE. Effect of removal of planned parenthood from the Texas Women’s Health Program. *N Engl J Med* 2016;374:853-60.
4. Lu Y, Slusky DJG. The impact of women’s health clinic closures on preventive care. *Am Econ J Appl Econ* 2016;8:100-24.
5. Steinem G. Margaret Sanger: her crusade to legalize birth control spurred the movement for women’s liberation. *Time*. April 13, 1998.

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## The Quiet Room

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At the end of an inconspicuous hallway and strategically placed far from the controlled chaos of the trauma room lies a dimly lit waiting area that we in the medical field call “the quiet room.” It is a bland spot; a few soft chairs surround a table that holds a box of crisp institutional tissues. There may be a picture or two on the wall, but generally it is an unassuming room where we physicians tell mothers about the deaths of their children, far too often because of firearm violence.

As we make our way to this room, we recite a careful script; we use words intended to ease this painful first-and-only meeting. The reality is that over the years, we have found that there is no good way to tell a mother that her child has died, especially when the unexpected death might have been avoidable.

We introduce ourselves as the doctor who took care of their child. We take a deep breath, look into their eyes, and quickly break the devastating news — there is

no reason to delay. What follows is the visceral, piercing shriek of a mother’s wailing, “Please God, not my baby!” We often weep with these mothers, we sometimes quietly blame ourselves for not being able to do more to save their baby’s life — and when they are alone, as is often the case, we hold them up while they cry.

We walk away from the encounter, our stomachs churning from the stale, metallic scent of a child’s blood barely dried on our clogs, our faces streaked with

tears, and our hearts gripped in a vise as we tell ourselves that this senseless dying must end. But it doesn't end. Another child is shot, and another mother is heartbroken.

There is nothing quiet about this room.

In the month since the mass shooting in Las Vegas, over 1300 more Americans have been killed, and more than twice that number have been injured, by firearm violence. Every day, 46 children and teenagers are shot and 7 of them die. The overwhelming majority of those shootings and deaths are the result of interpersonal violence, though some are from an accidental discharge of an unsecured firearm and some are suicides and are attributed to underlying mental illness.<sup>1</sup> Sometimes the shooting is described in a bylined article in the local newspaper, but most of the time it is not reported at all. What does get reported skews toward senseless acts of terror, with the blame placed squarely on the shoulders of a mentally ill monster. But gun violence in the United States is not primarily a mental health problem.

Nearly a month after the deadliest mass shooting in modern American history, which killed 58 people, we predictably find ourselves witness to another mass shooting, this time in a small town near San Antonio, Texas. In this attack, 25 Americans, including a pregnant woman and up to 14 children (the most children affected since the shooting in Newtown, CT, in 2012), were murdered by a single perpetrator dur-

ing Sunday prayer services. On the evening news, only hours after the tragedy, we are told once again that it is time for "a national conversation about guns."

From the vantage point of a trauma surgeon, conversation seems a terribly feeble response. Gun violence, whether on the streets of Chicago or in the churches of Charleston and Sutherland Springs, is a national health emergency. It is an epidemic as deadly as the global Ebola crisis or the opioid epidemic in this country. But in those emergencies, a call for action has been followed by at least some action, not simply by the ritual and empty call for thoughts and prayers and, at most, a mere discussion. Congress appropriated \$5.4 billion for the Ebola response as part of its final fiscal year 2015 spending package. The Centers for Disease Control and Prevention is awarding more than \$40 million to support state efforts to address the opioid-overdose epidemic. After the introduction of the Dickey Amendment in 1996, government funding for research into firearm injuries and deaths has been restricted.

President Donald Trump has said that gun violence in America is a mental health problem, but the issue is far more complicated. Only if funding for research on firearm-violence prevention and public health surveillance is reinstated can we determine the best approach to addressing the public health crisis of firearm violence. Furthermore, expanding the National Violent Death Reporting System from 40 states to all 50 states plus Washington,

D.C., would provide more information about where we should be focusing our attention.

In addition, the American Academy of Pediatrics has laid out three key priorities for confronting the crisis<sup>2</sup>: access to appropriate mental health services, particularly to address the effects of exposure to violence; enactment of firearm legislation that includes stronger background checks, banning assault weapons, addressing firearm trafficking, and encouraging safe firearm storage; and protecting the crucial role of physicians in providing anticipatory guidance to patients about the health hazards of firearms.

It is time for more than a discussion. Surely there is, in our collective power, some more concrete way to address the public health crisis that is gun access. We can no longer allow one mother after another to know the pain of losing a child to senseless gun violence. We remain haunted by their screams.

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1. Swanson JW, McGinty EE, Fazel S, Mays VM. Mental illness and reduction of gun violence and suicide: bringing epidemiologic research to policy. *Ann Epidemiol* 2015;25:366-76.

2. American Academy of Pediatrics. Gun violence prevention: federal priorities to keep children safe (<https://www.aap.org/en-us/advocacy-and-policy/federal-advocacy/Pages/AAPFederalGunViolencePreventionRecommendationstoWhiteHouse.aspx>).

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