

Post-Discharge Needs of Victims of Gun Violence in Chicago: A Qualitative Study

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Abstract

The purpose of this study was to understand the post-discharge needs of violently injured patients and their families to improve health outcomes and reduce the impact of gun violence. We recruited 10 patients from the trauma registry of a Midwestern university hospital with a Level I Trauma Center (LITC). After obtaining the informed consent, semi-structured, face-to-face, in-depth interviews were conducted. Discussions focused on post-discharge needs and resources to facilitate the recovery and rehabilitation process, and aid in community reintegration. Interviews were audiotaped and transcribed verbatim. Transcripts were analyzed thematically in stages of open, axial, and selective coding methods. Seven main themes were identified at the hospital and community level. These included the following: (a) feeling stigmatized by hospital personnel, (b) patient–provider communication, (c) feeling discharged too soon, (d) issues in obtaining medicines, (e) challenges with

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Chicago Police Department, (f) transportation to trauma center for follow-up care, and (g) concerns with returning back to the community. Patients reported the need for mental health counseling for themselves and their family, more follow-up, and help with financial paperwork among others. For the victims of gun violence, there exists a chasm between injury and care, and an even wider one between care and rehabilitation. The findings can inform health care, social workers, and rehabilitation professionals in their efforts to better address the myriad of unmet needs pre- and post-discharge. For trauma centers, the identified needs provide a template for developing an individualized- and community-centered resource pathway to improve outcomes and reduce suffering for this particularly vulnerable subset of patients.

Keywords

racial disparities, gun violence, trauma, qualitative research

Introduction

Although there has been a recent substantial decline and stability in gun violence-related deaths in the United States from 7.0 per 100,000 in 1999 to 3.6 per 100,000 in 2010, 2016), it is still 25 times higher than in other high-income countries (Grinshteyn & Hemenway, 2015). The burden of this violence falls disproportionately on young men as it is the leading cause of death for African American males aged 15 to 25 years and the third leading cause of death overall (CDC, 2016). Furthermore, the geographical distribution of gun violence in America is not widespread or random, but rather heavily concentrated in impoverished neighborhoods of a few cities. Over the last decade, while most cities including New York and Los Angeles have become safer, Chicago has not seen a similar precipitous decline in crime rates (Gorner & Sweeney, 2015). Extreme poverty (Illinois Commission, 2015), a high rate of unemployment (U.S. Department of Labor & Bureau of Labor Statistics, 2016), failing school districts (Gowins, 2014), easy access to illegal guns (Hinkel, 2012), and with at least 59 active gangs and 625 factions (Isackson, 2012), violence has become an endemic, intractable problem. In 2015 alone, Chicago recorded 2,988 shooting victims and 488 homicides (Crime in Chicago, n.d.).

This exacting death toll draws frequent comparisons between the city's segregated neighborhoods and war zones by news media and local rappers. However, for the medical community in Chicago, these grim statistics pose a

major public health concern. The socioeconomically distressed neighborhoods are not only plagued by gun violence; these neighborhoods as well as the seven trauma centers in and around the city are not evenly distributed, thereby creating “trauma deserts.” Our previous work has shown that this decreased access to immediate care, that is, suffering a gunshot wound (GSW) more than five miles away from a trauma center, adversely affected mortality rates (Crandall et al., 2013). The ones who do survive are swiftly discharged after receiving treatment and the hospital loses contact with them as they often live in medically underserved neighborhoods and lack medical insurance to seek further treatment (Lee, 2013).

The post-discharge period is challenging for any patient as continuity of care is interrupted, which can expose them to high rates of adverse events such as medication errors (Forster et al., 2004), or lack of follow-up on tests results (Roy et al., 2005). However, the post-discharge period is an especially vulnerable time for these victims as they return physically and psychologically wounded to the same marginalized communities where they were originally harmed. Researchers studying the 5-year mortality rates for the survivors of gun violence found it to be higher (5.1%) than in other trauma cohorts. The majority of deaths occurred early, usually in the first year, suggesting that the post-discharge may be a critical period to alter the trajectories of these patients (Fahimi et al., 2015). The violent trauma recidivists tend to be African American males with a median age of 31 years, unemployed, uninsured, have a history of substance abuse, drug trafficking, and an annual income less than US\$10,000 (Cooper, Eslinger, Nash, al-Zawahri, & Stolley, 2000).

This multiplicity of risk factors and their interactions create an environment in which reinjury thrives. Studies from different urban trauma centers indicate that the rates of violent reinjury vary widely from 15% to 44% (Brooke, Efron, Chang, Haut, & Cornwell, 2006; Mccoy, Como, Greene, Laskey, & Claridge, 2013; Sims & Bivians, 1988). Brooke et al. (2006) analyzed 15,973 trauma visits and further found that the likelihood of reinjury increased with the number of repeated admissions for trauma, and with each subsequent penetrating trauma visit, the likelihood of mortality increased over twofold. Exposure to gun violence during adolescence doubles the probability of committing an act of violence within 2 years (Bingenheimer, Brennan, & Earls, 2005), and the retaliatory injury risk among young victims of violence was 88 times higher than among those who were never exposed to it (Dowd, 1998). A host of studies have documented that children and adolescents who have been witnesses or victims of violence display a wide array of psychological symptoms ranging from posttraumatic stress disorder (PTSD) and depression to substance abuse and suicidal ideation (Lieschutz et al., 2010; Mazza & Reynolds, 1999; Mrug & Windle, 2009; Vermeiren,

Schwab-Stone, Deboutte, Leckman, & Ruchkin, 2003; Zinzow et al., 2009). Altogether, these findings illustrate that trauma resulting from gun violence is not an acute, single, one-off episode but a chronic recurrent disease, which turns the streets as well as the trauma centers into a “revolving door.”

Despite this vicious cycle of violence and suffering, there is a paucity of data about this subset of patient population. Other than basic demographics, little is known about their immediate post-discharge needs as well as the long-term challenges that lie ahead in terms of rehabilitation and reintegration into society.

Method

Patient Recruitment

To explore the question of self-identified post-discharge needs of patients injured by violence, we utilized qualitative methods and in-depth, individual interviews. After approval by our university institutional review board, we sought out to recruit 10 participants from our Level 1 Trauma Center (LITC) trauma registry. Our inclusion criteria included English-speaking trauma registry patients between the ages of 18 and 40 who had been injured by firearm violence. We excluded trauma registry patients who did not experience firearm violence and were not within our specific age range. We attempted to contact 39 patients during July and August of 2014. We found that 27 did not have valid contact information, one had died, and one was not interested in participating. Our sample was therefore comprised of nine Black male participants and one Black female. They were healthy, reported no previous hospitalizations, and were victims of gun violence for the first time. They had suffered significant penetrating trauma and the nature of their injuries ranged from multiple GSWs to abdomen, arms, and legs ($n = 7$) to single GSW to pelvis, leg, and back ($n = 3$). Eight participants had been formally discharged from the university hospital and two were inpatient at the time of the interview. All participants provided informed consent for interviews conducted in August and September of 2014. For the purposes of this article, the authors have used the terms *patients*, *participants*, and *victims* interchangeably. Furthermore, to protect the identity and confidentiality of our participants, we have used pseudonyms for their names (IN1, IN2, etc.) and altered medical details as needed.

Interviews

The interviewers have more than 10 years of qualitative training in urban settings. The interviews lasted from 30 to 90 min and took place in a university hospital for inpatient participants and in public places that the participants

suggested were convenient and safe. We developed an interview protocol composed of open-ended questions focusing on the self-described needs of injured patients and their families regarding post-discharge resources to support community reintegration such as housing, job information services, school interventions, health care, parenting classes, family violence resources, and other services. Sample questions were generated by the research group and used to begin conversations. Examples included “What happened that brought you to the hospital?” and “What are some things that would have helped you after discharge?” We were cognizant that discussing the firearm-related injury may trigger additional stress for the participants. As such, all participants were offered psychosocial support from the interviewers who are all trained mental health clinicians and from a community partner, Claretian Associates. A US\$20 Visa gift card was given to all participants as a token of appreciation for their time.

Interviews were audiotaped for transcription purposes. All digital recordings were kept on a secure server at the University of Michigan until they were professionally transcribed; after transcription, they were deleted. Interview transcripts remained on secure, password protected servers. These transcripts were titled, dated, and given coded ID numbers for compilation. These transcripts comprised the metadata or log.

Data Analysis

We used a grounded theory approach to analyze the data. Interviews were coded using “open, axial and selective coding” (Glaser & Strauss, 1967). The analysis used dedoose (www.dedoose.com, 2014) qualitative data software to code the data. In the first phase of data analysis, we developed a codebook based on initial readings of two interview transcripts from a three-person analysis team. Meetings were held after the open coding to generate and refine codes. After exploring various meaning and patterns found in the data, we established a final codebook. During this stage of analysis, we developed codes such as hospital visit, follow-up, neighborhood, violence exposure, procedural difficulties, and so on. The second phase of analysis involved axial coding, comparing interactions embedded within the initial codes while comparing interactions with any larger concepts that emerged. For example, we looked for variation in how participants experienced the hospital during their inpatient stay. We noticed that participants’ experiences of the hospital were in part influenced by the type of contact they received from physicians, nurses, and social workers. The type of contact received in the hospital therefore affected their ability to re-enter their community after their firearm-related injury. During the final phase of coding or selective coding, we integrated existing categories and themes in an effort to describe specific

conditions in the hospital and in their respective neighborhoods that influence how they experience life after a gun injury. Consensus was reached in team meetings when interpretations of interview data were not aligned. The final codebook was checked for validity and reliability through member checks (presenting interpretations to other team members) and interrater reliability, which demonstrated >90% concordance.

Results

We examined the post-discharge needs of a university hospital trauma patients injured as a result of gun violence. Across our participants, we identified community-level factors and institutional factors that characterize the self-described needs of trauma patients. We also described specific patient recommendations for better supporting trauma patients inflicted by gun-related violence.

Institutional Factors

Feeling stigmatized by hospital personnel. Patients in our study talked candidly about their time spent in hospital. Their accounts revealed a general dissatisfaction with how they were treated by doctors and nurses. For example, one patient who suffered multiple GSWs remembered feeling as if doctors and nurses looked at him differently when they discovered that he was a gunshot victim:

Interviewer: How did you feel about sort of . . . 'cause I'm just trying to think about other people I've talked to, too. Once nurses and doctors understood where your injuries came from, do you feel like that changed the way they perceived you or changed the way they provided care in any way versus . . .

Interviewee (IN4): Yeah. In a definite big way because of . . .

Interviewer: Like a young man who's been shot

Interviewee (IN4): Yeah. They got the tubes out and everything like that, so they was like, "You're done. You have the tubes out. There's nothing really we could do for you really. You could take the medicine all you want. It might not work, might will work." And I'm taking it still, but it doesn't really work. And because I guess I come from the south side of Chicago, it does kinda seem like you are basically out on your own to fend . . .

Another respondent had suffered multiple GSWs to the leg and felt that doctors and nurses lacked compassion when he was admitted. He attributed this to negative stereotypes about gunshot victims:

Interviewee (IN6): So they lose actually compassion like, “Man, this person just went through something he never went through, and not all people did something to get shot.” Sometimes people are at the wrong place at the wrong time and get shot in the middle of somebody shooting.

Others felt neglected during their stay. For instance, a patient who had suffered a GSW to the leg recalled feeling that nurses were unresponsive to his needs while recovering in hospital. He was frustrated at the slow response time of some nurses:

Interviewee (IN8): It’s a nice hospital, but me personally, I don’t think the nurses do their job how they should be. Like . . . Like I be buzzing and anything could be going wrong. I could slide outta my bed. I’m buzzing ’em and they take a long time to answer to see what I want. I coulda been fell outta my bed, anything. So personally, I think it’s a good hospital based on the doctors right after they helped me get myself back together, but the nurses, I don’t think . . . I think they just here for a paycheck.

One patient recalled having some positive interactions with nurses, but remembered negative encounters with others. For instance, one patient spoke fondly of some nurses, but remembered how others seemed as if they did not want to be bothered by him and his requests. This made him feel like a burden:

Interviewee (IN7): Oh, it was good. Some nurses . . . of them were kinda like whatever . . . so I ain’t even gonna say nothing bad. They were good.

Interviewer: We wanna know the story. Okay. So there’s a few kind of like bad apples type of thing?

Interviewee (IN7): Yeah, a couple. Yeah. Jerk.

Interviewer: Do you think it was because of sort of like the nature of your injury?

Interviewer (IN7): I’ll ask ’em for something and they’ll seem like bothered. Like, “Okay.” Now . . . come back in the room for a while.

Patient/provider communication. Timeliness and attentiveness were not the only areas in which victims felt neglected. One patient described communication issues with doctors and nurses. He felt confused and did not know how many times he had been shot, or even where he had been shot. Instead of explaining these critical details, he felt that doctors and nurses could not be bothered to share this information:

Interviewee (IN6): I asked the resident at least 5 times would I be able to speak with the doctor 'cause I didn't know where I was shot. I didn't know how many times I was shot. And I was telling him I wanted basically the doctor to tell me where I was shot, what it hit, what it . . . I never was explained that.

Other patients like IN10 recalled feeling that doctor's bedside manner could have been more tactful. Before surgery, he recalled talking to a surgeon, who quickly explained the risks of his forthcoming surgery. IN10 felt that this surgeon broached the topic of death quickly, leaving him little time to contemplate the gravity of his situation:

Interviewee (IN10): And so the surgeon come up. He tell me he my surgeon. He tell me to rest. He say, "You been shot in your back. You could possibly die, but I want you to stay calm." I say, "How I'm supposed to stay calm after you just told me I could die?" So he said, "Well, that's just procedure, sir. Here's a pamphlet. You gotta sign this. No time to read it, but just know it state if you die after surgery, during surgery, whatever, that you understood the risk of surgery."

Feeling discharged too soon. Most patients identified "early discharge" as the main reason for their discontent and expressed the desire to stay longer in hospital. They needed time to not only recover and heal physically but also to come to terms with their injuries. Patients felt pushed out, and in some cases where the insurance ran out, they felt that the hospital did not try hard enough to accommodate them or offer alternatives. For those requiring multiple surgeries, the quick discharge only added to their problems as they struggled with the logistics of returning to the trauma center. They further expressed confusion regarding the treatment plan and being discharged in the first place when their care was still ongoing.

Interviewee (IN4): Three weeks and getting shot 5 times in the chest, I shoulda been in there a lot longer with just the process mentally . . . And then with the just basically trying to push it, like push you out. That's how I felt like they could do something

Interviewee (IN8): It makes me angry 'cause I feel like they should do all that while I'm in the hospital. Why should I go home now and come right back to the hospital and need another surgery. And why it couldn't get did the first time when I had surgery? Why you gotta go back in my leg or on my feet again, when I already had surgery there?

Nearly all patients reported having a bullet or fragments of bullets present in them causing a great deal of pain and discomfort. They felt their pain or that they were still healing was not taken into account before discharging them. Furthermore, continuity of care and follow-up coordination were not addressed adequately or established at all in some cases at the time of discharge.

Interviewee (IN6): But one of the most uncomfortable feeling was I was in pain. Really, I was scared. They never made me feel comfortable as far as releasing me that I would be okay. They really made me feel like “Your insurance is up. You gotta go. Regardless if you feel comfortable enough to leave, if you in pain, you need to leave.”

Issues in obtaining medicines. After being discharged, patients described having issues getting medicines for their pain management. For some, this was due to lack of medical insurance or financial resources.

Interviewee (IN4): I don’t have no Norco or anything like that left so it’s like I can’t really go back to the doctor to try to get some more, because it costs, especially since I’m 19 now and even outta high school and stuff like that

Interviewee (IN3): Very hard because and the pharmacist, it was like the attitude that I could get was like, “Well, you don’t have cash. We can’t be bothered with you.”

However, another patient expressed feeling frustrated as he was referred to different specialists for his prescriptions, which ultimately made him give up. This narrative further highlighted a lack of shared decision making between patient and provider in coordinating care.

Interviewer: Trying to think what else. As far as like medication and stuff like that since you’ve been discharged, has that been sort of available?

Interviewee (IN7): No, that’s kind of been a problem. They give me the runaround sort of. Yeah. Like on my leg and my head [have fragments], everywhere . . . So, I was wishing I could get something to help that out, but they had said that I needed to go . . . first, I was getting it from my primary doctor, and then she said that I had to get referred to a medical specialist or medicine specialist or something.

Interviewer: So you went to a primary doctor and they said you have to go to a specialist

Interviewee (IN7): Yeah. And then the specialist said that they didn't do what I was I wanted some oral pills, like a pill or something, but they were doing steroid injections. That's all they did. So I would like, "No, I don't want that." They sent me some other place, and then they had a 2-year waiting period, so I just stopped bothering with 'em.

Community-Level Factors

Transportation to trauma center for follow-up care. Participants described challenges with getting to and from the trauma center for follow-up appointments that are specifically connected to the distance from their home to the hospital and challenges related to wheelchair mobility during the chilling winter months. Several former patients commented on challenges getting to and from the hospital for follow-up treatment:

Interviewer: And how was the transportation? What was the . . .

Interviewee (IN1): It was rough because I was in a wheelchair and it was the wintertime, and it was a female bringing me back and forth to the hospital.

Interviewer: Is it difficult because of . . . of the hospitals are pretty far from . . . Is that an issue having to go so far in order to get somewhere for that, to go and get checked up, you have to travel

Interviewee (IN2): So far . . . Yeah, that is kinda difficult

Interviewer: Okay. Is there any concern or issue about getting back to the hospital?

Interviewee (IN7): Nah. I mean . . .

Interviewer: As far as like traveling back there?

Interviewee (IN7): Yeah, well, I take the bus, but it's all right. It takes me a real long time, but I'll get there.

In addition to mobilization issues related to weather and general wheelchair mobility, one patient highlighted the specific challenge of geographic challenges with respect to hospital locations and lack of centrality. The quote raised the question why was he receiving treatment at two different hospitals? How did this lack of coordinated care affect his ability to heal from his injuries?

Challenges with Chicago Police Department. Current and former patients described challenges associated with receiving support from the police department after a firearm injury. Participants consistently described a conflict between the police officers assisting them at the time of injury versus

aggressively pursuing the criminal elements of shooting. A patient described his interactions with police following being shot:

Interviewee (IN8): I don't think the Chicago police do their job. I'm laid out on the ground, I'm hurting, and all they doing is asking me questions instead of trying to get the ambulance." I'm in pain. "Like, cause I guess they seen me and they . . . they know they seen me outside. I'm like but I don't give no problems. "Why you giving me problems?" you should be concerned about my health. You should be asking me questions later once I'm all right. I'm trying to save all the breath I can." I'm trying to save all the strength I can. I'm just trying to be calm and you questioning me. I feel like that coulda waited til later.

In a life or death situation, IN8 believed the police officer at the scene of his injury was more interested in pursuing the facts of the impending criminal case as opposed to rushing him off into an ambulance for emergency health care. The patient's reflection on why he was being questioned, particularly given that he was not posing a problem during this critical life threatening moment, reflected a broader concern about police and community interactions, specifically how community members conceptualized appropriate interactions with the police.

Concerns with returning back to the community. Returning back to one's community after a firearm injury ignited a host of socio-economic and emotional concerns for our participants. One patient highlighted new economic challenges that directly related to his firearm injury:

Interviewer: Do you feel like in terms of getting more education or getting into a job, you think you have the resources in order to find those kinda things?

Interviewee (IN3): No. It hasn't gotten more difficult 'cause of the injury.

Interviewer: Can you talk about what are the barriers between getting . . . taking that next step

Interviewee (IN3): Transporting . . .

Interviewee (IN3): And then like just finding the right school or you don't wanna end up in debt. You wanna find some day you know you're gonna wanna do and . . . all payoff. You wanna go do something . . . wasting time.

New economic challenges arose as he sought to reintegrate himself back into his community. Mobility appeared to be a shared concern across

participants that directly affected their ability to seek care and gain economic resources. Pursuing higher education appeared to be an option for this young man, but he had concerns around affordability and identifying the “right” school.

When asked if there was anything his community could do to ease the transition, he suggested the community focus on the youth, specifically violence prevention: “Something for kids to do to break the cycle of the violence. Like they need some type of after-school program. They need more things to do in the community.” Specifically, he believed the community should organize

community functions or probably through church. That’s how you could reach out to some of them to get their input on things. Like I just seen the other day on the news they had a panel the other day with the mayor and religious leaders, community organizers. That’s a good start right there.

Participants also described needs for emotional support once they have returned back to the community. For example, one victim of a shooting described being more worried about future injury upon returning to his community. He stated,

Interviewee (IN7): I’m kinda more worried. I’m really more worried when I go out now, but that’s only because I can’t really run or do anything, walk fast or nothing. Like if someone gets crazy and tries to fight me, I can’t even fight ’em ’cause my arm’s messed up. It’s ridiculous. I can manage. I got a good support system, so it’s all right.

Even with a good support system, our patient described some emotional challenges that are hard to cope with:

Interviewee (IN1): You be wary of your surroundings. You double-checking. You’re double watch yourself ’cause you don’t want nobody to get close to you ’cause you don’t want nobody to attempt to hurt you or you’re never gonna be the same again ’cause you’re not gonna let nobody get up on your to try to hurt you. You gotta learn how to trust people, again. And you’re gonna be very aware of your surroundings.

For this young man, the injuries associated with being shot are not just physiological. The emotional toll connected to being shot in one’s community impacts general feelings of safety regarding impending threats and the ability to protect oneself and/or flee a potential threat in the community

because of the prior firearm-related injury. In addition, learning how to trust again became an important part of the healing process. Our patient's comments highlighted the complexity of the trusting process after a firearm injury as an individual strives to trust themselves, their community, and others when coping with the realities of their new life post hospital discharge. For some participants, this life-altering experience and the associated challenges served as an impetus to leave their community to escape violence.

Interviewee (IN4): Well, I honestly fear for my life every day in that neighborhood, and that's why I am getting out of Chicago.

Interviewee (IN9): As I speak with them [kids], "oh yeah, we want to move, too." They like, "Yeah, we wanna go somewhere where we ain't gotta go through all this."

Patients' Recommendations

Access to mental health counselors for self. While recalling the events of the shooting and their experiences after returning home to the interviewers, participants reported having flashbacks, and feeling anxious, scared, and depressed.

Interviewee (IN8): I don't even wanna go outside. I'm afraid still. I'm shell-shocked. I still have visions of the first day it happened . . . Like some night I'll be dreaming about it and I'll wake up. I try to get outta my bed. I know I can't go nowhere 'cause my leg . . . I hear the shots still in my head. They was so loud.

Interviewer: What about sort of like . . . I'm trying to think how to ask this. Sort of on like a mental level, was it difficult to go through the incident?

Interviewee (IN9): Yes. The flashbacks and then sometimes just sitting here and just thinking about why is it that it happened now? It just had me thinking about a lotta things, and then it was one point I was thinking this, like "Man, am I really gonna die? What if this bullet moved the wrong way and they couldn't get it?" I was feeling more confused and kinda sad.

They expressed the need for therapy to help them process the residual trauma and address the trauma-related memories and feelings.

Interviewee (IN4): It would benefit a lot I really think 'cause people definitely do need to talk. And I mean feelings and emotion, period. It's a

great form of self-help because you're talking about everything that you're going through and that talking helps period because you never know what will happen. You never know why

Interviewer: And would you have liked to have a counselor during . . . while you were still an inpatient?

Interviewee (IN1): No, because I believe . . . no, because I feel as though you don't need it, because you're actually making human contact with people during the day while you're an inpatient, 'cause the nurse is coming in the doctor's coming in your visitors are coming in. It's when you need the support when you're alone or when that's played into your mind. That's when you need a release. That's when you need someone to talk to.

Access to mental health counselors for family. After-effects of violence are not just limited to the patient but also affected his or her family, who are often seen as "secondary survivors." Patients acknowledged the impact the incident had on their family and recognized the need for therapy to help them cope.

Interviewer: Can you talk at all about sort of how your being shot and being in the hospital affected like your lady and your kids and stuff, like how they were able to handle that?

Interviewee (IN9): Oh, yeah. It affected my lady a lot because she didn't understand and she didn't know was I gonna die or not.

Interviewer: Okay

Interviewee (IN9): And the kids, it was shocking to them because it's like they may see the . . . as someone on TV, but to actually . . .

Interviewer: Do you think it would be helpful for family and friends to have access to mental health support?

Interviewee (IN1): Yes. Yeah, especially children because they don't understand what's going on 'cause it's a life changing experience. Like my little daughter, she was dealing with it like a champ, but my oldest was always crying like every time she seen me . . . So, yeah, I think it would help for children of victims to have someone to talk to as well.

Need for more follow-up. Almost all patients in our study experienced a lapse in communication once they left the hospital. During this challenging period, patients desired more contact with hospital staff and social workers to answer questions that they might have and to still feel cared for.

Interviewee (IN9): More follow up. Like I say, at least give a call or ask maybe, "Do you feel you need to come in? How's your health?" So I

feel as though that they should at least allow a certain . . . maybe a nurse or a medical physician to at least contact us, check on our health, at least for at least 3 to 6 months after we left the hospital, to make sure everything is going okay

Interviewee (IN3): I guess the social worker could be more in tuned with you, communicate with you more like that.

Need for transport to LITC. Given the challenges of long commute to LITC from South Side and limited wheelchair mobility, patients desired LITC providing transportation to and from the patients' residence for follow-up appointments.

Interviewee (IN1): It would be a little beneficial if LITC had like their own transportation systems to pick patients up and take them back and forth to the doctor. Yeah, that'd have been very beneficial.

Need for trauma centers

Interviewee (IN3): No hospital close enough really that is gonna treat a gun shooting victim. They transfer 'em all to the LITC. They directly just . . . I don't care what area it is, they just take 'em there

Need for rehab center/outpatient clinic closer

Interviewee (IN3): Outpatient clinic that was closer. Oh yeah, that'd be a whole lot better, especially everything that would go with a discharged person if the facility had another facility closer, oh, yeah, that would help a whole lot.

Interviewee (IN4): A rehabilitation center or something like that, or something like where you'll be able to if you feel like you're not healed all the way, they could tell you like what you can do and what you can't do

Need for information. Patients requested more information on how to take care of their injuries or precautions to follow as they transitioned from hospital to home.

Interviewee (IN4): They could give stuff or instructions or something like that for when you do go back home to-do and stuff or keep you on bed rest for a certain amount of time before you go back out

Help with financial/insurance paperwork. Post-discharge, patients felt overwhelmed with financial hardships due to medical bills and lost income from being hospitalized.

Interviewee (IN9): I miss these days of work. I was off work for like three and half, almost 4 months, so I'm like, "Man, bills way back now."

Interviewee (IN1): Yep, it was all out of pocket. And once, again, it's like pulling teeth when you're trying to . . . when the government has something and you're trying to get it from them. They won't give it to you. Like, for instance I believe the Lisa Madigan Crime Victim Assistance, you have to have everything documented and it's just hard. Who would lie about getting shot or what the done spent back and forth on . . . it's hard especially from the financial aspect of it. If you don't have insurance and a good support system, you'll be doomed mentally and emotionally. Yeah, because instead of you focusing healing, you worried about how this bill gonna get paid, and how you're gonna get back and forth to the doctor. How you gonna get your medication.

As patients struggled to pay their hospital bills, they reported needing help to figure out the insurance paperwork and information regarding resources that could help them.

Interviewee (IN9): And I just wanna say I hope the people in the hospital maybe take that into hand and to thought to check up on the victims once they gone from the hospital. If they could, maybe they could help them get the material to . . . the need so they could probably get some type of insurance or medical card.

Interviewer: That's a good point. Do you feel like there isn't enough sort of assistance or sort of people being like, "This is how you can go get your care paid for. These are resources for you," just being kind of told and explained?

Interviewee (IN9): Right. It is. It's a difficult process, and there's a lot of stuff to do, and there's all these people's paperwork.

Discussion

In general, patients complained that their time in hospital felt frustrating, cold, impersonal, and, at times, dehumanizing. Some of these experiences were likely influenced by what Rich (2009) describes as the hyper-routinization of trauma care. In his study of the inpatient experiences of wounded

young Black men, Rich describes how trauma care has become highly standardized and routinized. This model has led to more efficient ways of processing and caring for trauma patients.

But, this same model of care also neglects the lived experiences of victims, who arrive in hospitals wounded, scared, and deeply uncertain about their future. Their stress is then amplified by processes that leave them feeling marginalized within the clinical setting. Quick and impersonal interactions with health care providers make patients feel as if doctors and nurses do not care about their recovery.

Likewise, our data also raise questions about implicit bias in trauma care. Doctors and nurses working in trauma come into frequent contact with young Black men who suffer GSWs from disadvantaged neighborhoods across the greater Chicago area. The stream of wounded young people may perpetuate stereotypes about gunshot victims as gang-members, drug dealers, or individuals whose lifestyle choices caused their injuries. Although it is very difficult to unearth, our study raises questions about the origins of implicit biases and the many ways that these biases might impact care (Chapman, Kaatz, & Carnes, 2013). Future analyses might look at how implicit bias impacts everything from attentiveness, communication, and other kinds of inpatient outcomes.

In total, our data invite a critical reflection on how to improve the inpatient experiences of gunshot victims. More than anything, our data show how patients often felt that doctors and nurses did not empathize with their situation. This is consistent with other medical research, which examines how patients often feel that doctors do not listen to them or take seriously their “illness narratives” (Kleinman, 1988). Beneath their accounts, victims revealed deep vulnerabilities and expressed a desire to be heard by others and treated with respect (Liebschutz et al., 2010). The act of listening and of being available to a patient is a powerful tool that can improve the inpatient experiences of gunshot victims.

Recommendations from our participants highlighted the need for increased trauma and psychosocial care for patients and their families during their hospital stay and once they return to their respective communities. The American College of Surgeon advocated for language in the Affordable Care Act (ACA) of 2010 that specified patient access to day-to-day trauma care and trauma research. Despite authorization in the ACA, Sangji and McDonald (2014) suggest it has been challenging to secure appropriation for trauma programs as legislators that are interested in repealing ACA are unwilling to provide funding for programs that were established before ACA was enacted. Our findings highlight the necessity for increased advocacy for trauma systems.

Limitations

Identifying the self-described needs of gun-injured patients is an important step in reducing violence and providing necessary trauma care for all. We employed qualitative methods to gain an in-depth and holistic picture of what gun-injured trauma patients need in and outside of the hospital. However, our small sample and lack of heterogeneity of it does not allow us to draw broader conclusions about trauma care and gun-injured patients. Given the institutional mistrust present, the fear of retaliation and repercussion possibly resulted in a self-selection bias in our sample. Future research might consider a larger participant sample across multiple trauma units to disentangle any mechanisms and processes that might be limited to our hospital setting. Finally, social media sites like Facebook, Twitter, and Snapchat have not only changed the way people communicate and engage with each other, but they have become a gateway for starting and fueling violence in marginalized communities. To implement effective interventions, it is imperative that future research aims to better understand the nature of these interactions.

Conclusion

Firearm-related injuries have long-lasting psychosocial impacts on individuals injured by gun violence and their families. Not only is it necessary for hospitals to provide direct trauma care that incorporates psychosocial assessments, therapy, and supportive resources, the same supports are also needed once individuals return to their communities. Understanding the self-described needs of trauma patients injured by gun violence can better inform violence intervention and prevention strategies at the micro (e.g., therapy) and macro levels (e.g., more Level I Trauma Centers) to ensure individuals affected by gun violence have appropriate trauma care in and outside of hospital settings.

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