A Balancing Act

The Emergency Physician Role in Firearms Safety

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As the nation watches helplessly each time a mass shooting takes place, emergency physicians jump into action, caring for the wounded. Once it's over, they are among those trying to make sense of gun violence, wondering what physicians could possibly do to help stop the carnage.

The responses from the medical community run a spectrum from promoting research to better understand the problem to joining gun control advocates in seeking restrictions on sales of firearms. That advocacy is particularly fraught for a group such as the American College of Emergency Physicians (ACEP) because an estimated 40% of its members are gun owners, many of whom may be uncomfortable with physicians' taking a political position on an incendiary topic.

Still, ACEP's board was unanimous in approving a resolution at the college's annual meeting in October that supports the state adoption of gun violence restraining orders, which allow families and police to seek a judge's order to temporarily remove firearms from a person who poses a threat. ACEP member Howie Mell, MD, said the measure found support even among individuals who might be most reticent to step into the gun control advocacy arena, ACEP's tactical medicine and military medicine members. Dr. Mell said it would be hard to find someone who didn't think it was a good idea to remove access to lethal weaponry from a person who is a threat.

Aimee Moulin, MD, an emergency physician at UC Davis, promoted the resolution at the meeting and said she was "pleasantly surprised" that it received universal support and was passed as part of the consent agenda. One of Dr. Moulin's colleagues at UC Davis, Garen Wintemute, MD, MPH, believes these specialized restraining orders can save lives, and points to 2 specific instances in California in which they've been used to stop someone likely to have carried out a mass shooting.

Dr. Wintemute, who runs the University of California Firearms Violence Research Center, has been studying the health aspects of gun violence for nearly 40 years. He and colleagues Megan Ranney, MD, MPH, and Marian Betz, MD, MPH, recently unveiled a Web site with resources for physicians on what they can do address gun safety (http://www.ucdmc.ucdavis.edu/vprp/WYCD.html). The site includes advice on how to bring up the topic with patients and what to say.

The site's main message is that it is legal for physicians to raise the subject of firearms; at the same time, it isn't necessary to screen every patient. Dr. Wintemute said there is still misunderstanding on this point among physicians. "It's not only legally permissible [to bring up the topic with at-risk patients] but it's also the standard of practice," he said. These are conversations prompted by specific situations, such as when a patient shows signs of being suicidal or at risk of interpersonal violence.

Rocco Pallin, MPH, a research data analyst who directs the center's What You Can Do initiative, cites 3 kinds of firearms risk that could prompt a conversation:

- patients at acute risk for violence to themselves or others
- patients with individual-level risk factors such as history of violence, abusive partners, substance abuse, serious mental illness, dementia, or impaired cognition
- demographic groups who might need screening in primary care, such as parents of children who live in a home where firearms are kept

The scenarios emergency physicians commonly encounter include patients at risk of suicide and victims of domestic violence. In both cases, Dr. Ranney said, asking about firearm safety can be a natural part of a patient encounter. The conversation works best when it's clear why the physician is asking about access to guns, and when the physician asks without any judgment or political agenda.

Drs. Wintemute, Ranney, and Betz discussed the topic recently on Dr. Mell's "So What?" podcast in June; Dr. Mell presented the following scenario to his guests: a 15-year-old patient who has taken pills in a suicide attempt is being treated in the emergency department (ED) and is accompanied by his father, who appears to have a concealed carry weapon in a holster on his leg. "The resident doesn't know guns and is a little freaked out…and is not sure how to approach him," Dr. Mell said.

Dr. Wintemute suggested the physician first establish some rapport with the patient and father; give the

father a sense the physicians know about firearm safety by noting how risky it is to have a gun accessible to someone who is thinking about suicide. The physician can share facts: most young people who successfully commit suicide do it with a gun, and suicides by firearm are the most lethal method, often leaving medical personnel little chance to save the victim.

Dr. Ranney added that although it's important to sound authoritative, the physician should not lecture or talk about "what the research says," which can be a turnoff, particularly to gun owners who may believe research has been used politically in the gun debate. It helps to keep the focus appropriately on the safety of the teenager.

"You bring it up as about safety, not judgment of someone else's life choices," Dr. Ranney said. "You can say, 'Let's talk about how to make your home safer while your kid is going through a tough time,'" she suggested. The conversation can then address all safety risks, including accessible prescription drugs and firearms.

For physicians who don't have a background in guns, it helps to better understand people who do. Christopher Barsotti, MD, practices in a rural area of Vermont, and he and many of his neighbors own guns for hunting. He routinely brings up gun safety with patients when it's relevant and said he's never had a bad reaction. After all, it's not a new topic; hunters routinely take gun safety courses, he pointed out. Drs. Wintemute, Betz, and Ranney are developing videos to educate physicians on firearms discussions. The American Medical Association is also developing a training video on the topic.

Although this advice may be helpful to working physicians, it is still only that: expert advice. What those in the field yearn for is scientific evidence that these conversations actually make a difference and what elements would be supported by evidence. Dr. Barsotti also wants evidence-based guidance for physicians on how to assess patients.

"I want to know how to reduce the risk for this patient," he said. "What things about this patient's cognition and behavior with a firearm are predictive of negative health outcomes and which ones can I modify? We can't ignore the fact that doctors are having to make decisions on this without adequate evidence and guidance."

Another challenge is providing physicians with answers to difficult questions that may come up during one of these conversations. They may not be sure what to do next, particularly if they aren't familiar with local gun regulations and safety practices. Some scenarios, such as an elderly dementia patient or someone agitated who has mental health issues, may require contacting specialists or using community resources beyond the ED.

Dr. Wintemute's group recommends that EDs plan for these various scenarios and give emergency physicians ready access to referrals so risky patients don't just walk out the door with no support. That might include working with a local gun shop to come up with vouchers allowing a patient or his or her family to have a place to store a patient's guns for some period.

Some of the tension around firearms safety as a public health campaign stems from America's current political climate and the sense that gun owners live in one cultural reality and many physicians, particularly in urban areas, live in another. Dr. Ranney wants to see more interaction between the 2 sides, which she doesn't believe are really that far apart. Gun owners just don't want to feel judged or as if they've made a poor choice by owning firearms, she said. Dr. Mell favors efforts to study risks and effective physician interventions. He is less comfortable with the idea of physicians becoming advocates for specific gun control measures.

"It's questionable whether there is a role for physicians in the overall realm of gun control," he said. "Should physicians be advocating for restrictions on the sale of weapons?"

As shocking mass shootings continue, there are growing efforts to get physicians more involved. One of these was organized at Stanford University after Dean Winslow, MD, stated during his Senate confirmation hearing that it was "insane" that anyone can buy a semiautomatic weapon in America. Controversy over his comment prompted Dr. Winslow to withdraw his name from contention for assistant secretary of defense for health and later propelled him to start an organization for health care professionals to address the dangers of gun violence.

The group, called Scrubs Addressing the Firearms Epidemic, held its first national event in September to convene locally and hold gun-violence-related education activities. Sarabeth Spitzer, a fourth-year medical student at Stanford, helped organize the group after a community discussion on mass shootings generated "tons of energy and excitement" and the sense that "there was really more physicians should and could be doing about it." Spitzer described the group as "apolitical" and said its first efforts will involve developing a curriculum for medical and nursing schools about firearms as a public health problem.

"One of the main areas we're really lacking is in formal training of providers," she said. "An estimated 75% of practicing physicians have never

been taught anything about broaching the topic and what information they should provide patients once they do."

Advocating that physicians talk to their patients about their guns makes some physicians uneasy. Doctors for Responsible Gun Ownership advises gun-owning patients to decline such requests. The group believes some efforts to raise the gun issue with patients, such as by pediatricians with parents, are really motivated by gun control advocates with a political agenda.

"When doctors' inquiries about their patients' guns are used as a tactic to prejudice patients against gun ownership, or to persuade them to give up their right to own guns, that questioning constitutes unethical physician conduct," the group's Web site says, and urges discipline of physicians who do so. At the same time, Doctors for Responsible Gun Ownership says it sees inquiries as legitimate "when they are motivated by real concern about patient safety." The group's Web site includes a "pro-gun provider referral" service that offers names of physicians who "respect the Second Amendment."

Dr. Wintemute says that although much of the debate about guns takes place at the far edges, there's actually a large area of common ground between gun ownership advocates and the public health community addressing injury prevention. What it really needs now is research that can supply physicians with evidence-based guidelines on how to proceed, Dr. Wintemute and others have said.

Research on gun violence and health has been hampered by funding limitations; a 2017 research letter published in the *Journal of the American Medical Association* compared the amount of research funding for gun violence with that for other leading causes of death (cancer, heart disease, diabetes, etc) and found it had 1.6% of the funding expected according to the associated mortality rate.[1]

Among the efforts to turn that around is a coalition known as the American Foundation for Firearm Injury Reduction in Medicine, which aims to partner with the private sector to fund research. Dr. Barsotti is the group's chief executive officer and Dr. Ranney its chief research officer. The National Academies of Sciences, Engineering, and Medicine held a 2-day workshop in October reviewing the state of research on the topic and specifically about what health systems can do about it. Reducing injury and death from firearms could be like earlier public health campaigns that have addressed drunk driving and intimate partner violence, advocates say.

Kaiser Permanente has taken an active interest in the topic, committing $2 million toward research; the organization is currently evaluating where within its own integrated research network to apply the money to start filling gaps in understanding, said David Grossman, MD, a senior investigator for Kaiser in Seattle.

"We have the means and tools to identify who these high-risk people are, but we don't have loads of best-practice or high-quality scientific evidence on interventions," he said. "We need to make clinicians more comfortable and standard in their approach."

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