CSTS podcast series
Let's Talk About Your Guns
Episode 4: Doctors and Patients

1.	NOTES	AUDIO
2.		**DR MARY CAMPAGNOLO:** I was new to practice two years out of residency and joined a group in southern New Jersey in a small town there. I took the practice of a doctor who had retired after practicing for at least 30 years in the town.
3.		**DR MARY CAMPAGNOLO:** It's an area that had a little bit more of a farming culture. And also it's a location that's close to the military base. So many people do seem to have guns.
4.	transition to new beat	
5.		**DR MARY CAMPAGNOLO:** One day, a man arrived in the office for the afternoon session. He seemed like a very calm, somewhat quiet gentleman. He was about 76 years old. And he lived by himself in the town.
6.		**DR MARY CAMPAGNOLO:** He came in because he had injured himself that day while he was opening a box with a box cutter and unfortunately sliced his leg.

7.		**DR MARY CAMPAGNOLO:** I met him briefly, went over his records from the prior physician.
8.		**DR MARY CAMPAGNOLO:** I sutured his wound and had some pleasantries and then I advised him for a follow up.
9.		**DR MARY CAMPAGNOLO:** The following week he came back for suture check and removal and the wound was doing well.
10.		**DR MARY CAMPAGNOLO:** I expected that if I treated him properly and with good compassion that he would continue to be my patient and I would continue to see him in the future.
11.	Transition to new beat	
12.		**DR MARY CAMPAGNOLO:** Two weeks later, my nurse came and said, oh, you know that man you saw last week? Do you know what I just heard? He had shot himself in his driveway.
13.		**DR MARY CAMPAGNOLO:** I was totally floored. It just really struck me that I felt like I had had these opportunities to talk with this individual who must have had some deep-seated trouble at that time. So I felt a kind of a lost opportunity. Could I have done something different?
14.	Transition to new beat	

15.		**DR WEST:** Dr Mary Campagnolo's experience isn't unique. Nearly a third of the people who die by suicide visit a primary care provider in the month before their death[1]… leaving many physicians to wonder if they could have done something more.
16.		**DR MARY CAMPAGNOLO:** In retrospect, I wondered why did he even have that injury in the first place? Maybe it had some other meaning other than just accident. As a new doctor it made me think more about the fact that people have guns and they could be having troubling circumstances. And that if they do start to have some emotional upset that we need to kind of talk about that and what to do with their gun.
17.	Transition to new beat	
18.		**DR WEST:** I'm Curt West: Associate Professor of Psychiatry and Scientist at the Center for the Study of Traumatic Stress at the Uniformed Services University. Today, in *Let's Talk about Your Guns* we'll learn how this encounter inspired Dr. Mary Campagnolo to incorporate conversations about guns and safe storage with her patients.
19.		**DR WEST:** We'll also talk to Dr Joseph Simonetti, a clinical psychologist who studies the relationship between firearms, safety, and suicide.

[1] https://afsp.org/story/more-than-referrals-the-role-of-primary-care-in-suicide-prevention

20.		**DR WEST:** He'll share what he believes are best practices for physicians who want to broach the topic of firearm safety with their patients.
21.		**DR WEST:** Firearm safety in the home is built around five principles. Weapons should be stored unloaded. They should be taken apart or stored with a disabling device engaged. They should be stored in locked containers, and ammunition should be stored in a separate locked container. Finally, firearm safety in the home involves having a plan for storing guns in an alternate location during times of crisis.
22.		**DR WEST:** In the last part of today's podcast, we'll discuss some strategies for how physicians can talk with patients who may be at risk of using their guns for self-harm.
23.		**DR WEST:** Because this podcast isn't about whether you are for or against firearms. It's about how to have open and honest conversations about safe storage. Conversations that may save a life. So now… *Let's Talk about Your Guns.*
24.	Transition to new beat	
25.		**DR WEST:** Dr. Campagnolo, at that point in your life did you know anything about guns?
26.		**DR MARY CAMPAGNOLO:** No, I knew nothing at the time. There was not any in my medical school training that I

		recall. I did do public health service in the National Health Service Corps in somewhat of a rural area in Maryland. And it was a little more of a gun culture that I was exposed to there, but that was pretty much the limit.
27.		**DR WEST:** So what has changed between the way you approach that patient and how you would approach him now?
28.		**DR MARY CAMPAGNOLO:** Family physicians in general, I think now feel that it is our responsibility to help to protect our patients and their families. And so it has become more routine that we have on our intake forms to screen for guns in the home. So I think we're doing a lot more to try to screen and counsel than we were doing back in the time when this incident happened.
29.		**DR WEST:** So it sounds like the medical culture has begun to make conversations like this a bit more common. But what makes it hard for physicians to talk to patients about guns in the first place?
30.		**DR MARY CAMPAGNOLO:** I think there's a sense that we might be treading on areas that patients feel might not be our business. And I think perhaps physicians feel they don't want to have to deal within a potential degradation of the relationship with their patient. And also dealing with the circumstance where a patient might be angry. You don't want to make somebody feel like you are judging them or attacking their behavior or their family's values.

31.	Transition to new beat	
32.		**DR WEST:** Dr. Joseph Simonetti studies how primary care providers can discuss firearm safety with their patients. He's heard these concerns before.
33.		**DR. JOSEPH SIMONETTI:** We're talking about guns in America. And this is a very passionate and a somewhat sensitive topic. And if you've never had these discussions with patients, you're not sure how they're going to react. None of us want to upset our patients. We don't want to damage our relationships. We need those relationships to help patients navigate health related issues. So initiating sensitive conversations feels like a little bit of a threat. If they don't feel at ease with us, or even worse, they feel threatened by us or the conversation we're having, then we're simply less effective.
34.		**DR WEST:** Are physicians trained on how to have these conversations about firearm safety when they're in medical school?
35.		**DR. JOSEPH SIMONETTI:** Most of us have never been trained to ask about firearms or to initiate firearm discussions with our patients. It has not been a component of traditional medical training across a lot of different clinical spectrums and certainly not in primary care. That is obviously changing in contemporary medical training. But that's still not commonplace. And so most of

		us just don't know to do it. Most of us just don't know to do it or haven't known to do it.
36.		**DR WEST:** Are there cultural or social impediments out in society against medical personnel talking to patients about their firearms?
37.		**DR. JOSEPH SIMONETTI:** I think there are a lot of cultural and social impediments to having these discussions. Having these conversations means that we have to address our personal biases about firearms and in some cases, completely set them aside so that we can deliver high quality evidence-based care. And that's an uncomfortable task for some people to do, especially, I think, those who don't have a good understanding of why people value guns in the first place.
38.		**DR WEST:** Can you elaborate on that?
39.		**DR. JOSEPH SIMONETTI:** When we ask someone to temporarily stop using their firearms or keep firearms out of their home while they're at risk of suicide, it just can't be understated what a huge ask this is that we're making of our patients. If you didn't grow up around guns or experience guns, you probably don't understand what this means. That's okay. But I often ask clinicians when we're when we're doing trainings, what's your thing? You know, what is it that you care very much about? And maybe it's biking or riding motorcycles or book club, yoga, snowboarding, brewing your own beer.

		Imagine if I asked you to stop doing that even temporarily for a clinical reason. I think most of us would say, wow, if I had to give up the thing I cared very much about this thing that my identity is tied to, even for a short time period, I would really struggle to do that. And so if if you don't understand what guns mean to people, you can certainly relate to what something means to you. And that's the challenge we're asking people to navigate here.
40.		**DR WEST:** What would you suggest for a provider to do to better understand what firearms mean to their patients who own firearms?
41.		**DR. JOSEPH SIMONETTI:** That is a great question. There are a number of different trainings available right now on firearm cultural competency, trying to understand how people and why people attach value to both having firearms, using firearms and also their constitutional right to do so. I think that's an important thing that you can do. Some would encourage clinicians to go to firearm ranges. I don't think that's necessary, but that is one particular option. I think the best way is to start asking patients and try and understand what it is people have their firearms for what they do with them and why it means something to them. We can learn a lot from our patients. We know this and we can do the same when it comes to guns.
42.		**DR WEST:** Is there any specific language that can be helpful in these conversations about firearms and safety?

43.		**DR. JOSEPH SIMONETTI:** Being mindful of language is probably one of the most important things that clinicians have to learn how to do, not just in firearms, but everywhere across all of clinical medicine. Language is critical. Having a shared language is a fundamental. It's necessary to have a shared dialog. And I think few things probably demonstrate the cultural divide we're navigating on this topic more so than the lack of that shared language that we just haven't developed yet.
44.		**DR WEST:** What do you mean by shared language?
45.		**DR. JOSEPH SIMONETTI:** First of all, the term safety, which we all use in some way, even the term lethal means safety can be problematic as a clinician. And many of us would say, well, firearm safety within the context of suicide prevention is keeping your gun unloaded or locked or out of your house. And while it's not unreasonable to think that those are safety behaviors for suicide prevention, that might be very different from what the person sitting in the exam room with us thinks about in terms of gun safety. Gun safety has been taught for generations in this country far longer than I or we have been thinking about it as doctors and safety means a lot of things don't shoot at something if you don't know what's behind it carry your gun down. Don't climb a tree stand with a loaded rifle. It might mean to some people keeping your gun loaded and ready for use in case somebody invades your home. So we really need to think hard about whether safety is the term we

		should be using it in what scenarios we should actually be using it. There are other things that firearm specific terms which can be problematic to assault weapon gun violence using the term clip instead of a magazine. Now, I think a lot of clinicians will hear this and say, this feels a little bit silly to me. Why should I have to learn new language to have a conversation about keeping my patients safe? And while I think that's a valid point in some ways, we unfortunately don't get to pick the things that go in to whether our patients deem us as credible or not. I had to learn a lot of new words to discuss heart conditions and drug use before my patients, before I could effectively engage them in treating their heart conditions and their drug use disorders. This really is no different.
		DR WEST: So let's focus perhaps on patients that keep their guns for self-protection. Does that present any unique challenges in the conversation with them about safety and safe storage?
46.		**DR. JOSEPH SIMONETTI:** Yeah… When we talk to clinicians in the field, one of the biggest challenges that they're trying to navigate is when they're having a firearm related discussion with a patient who keeps their firearms for protection and feels strongly about doing so. If you talk to an individual who owns a gun and keeps the gun for protection and is concerned that somebody's going to break into their home in the middle of the night, and you

		say, what is it you're doing to protect yourself? Well, their answer is very commonly, well, I have a gun and I need to keep it very close to me in case somebody were to attack me or I would have need that gun in the middle of the night. But what we know in firearm suicide prevention is that time matters. For individuals in crisis the ability to very quickly access a means of harming oneself, such as a firearm that has a lethality of greater than 90% that is what leads to elevated suicide risk. And so it's really a challenging conversation to talk to somebody who thinks they need to reduce their time in accessing a gun and motivate them to increase their time in accessing that gun.
47.		**DR WEST:** What would you suggest?
48.		**DR. JOSEPH SIMONETTI:** Often times I said to patients in the inpatient setting, I know why you keep that gun. I know that you feel safer with that gun next to you at night. But you were just in my emergency department because you had a gun to your head the night before. You know, what's most likely to happen over the next couple of weeks is that somebody for the first time ever is going to break into your house or is that your suicide risk - the reason you're here with me in the hospital - is going to be the bigger problem. Can we think about making some changes, at least until you're feeling better? Removing, reducing access to firearms, at least during that short time period is what we focus on.

49.		**DR WEST:** Are there specific steps that you counsel your patients on to increase the safety of firearms in their home?
50.		**DR. JOSEPH SIMONETTI:** There are specific recommendations we do make. First and foremost, we know across a number of studies now that the safest thing is likely to have a gun outside of the home. That's the thing that puts the most time between a person and their access to a firearm when they're in crisis. And so it's a personal policy of mine as a clinician that with each patient, I will at least mention what I think is the safest thing. And I will do so cautiously. And I will do so with the understanding that most patients aren't ready to remove their firearms from their household, even temporarily. And many may never go about doing that. But I think it's important to be honest about what I think the evidence says, and I think it's important to make that recommendation because some patients go and do that. And for those patients, I have achieved what I think is the greatest suicide risk reduction. So that's important. But again, many people aren't going to do that, and that's perfectly okay. As I said before, this whole conversation, we're just navigating a couple of things and it's trying to find the intersection between what the evidence tells us so far and what is acceptable to patients and what's achievable to patients. If we don't find something that works for our patients, then we're wasting our time.
51.		**DR WEST:** What about patients who are not willing to remove guns from their household?

52.		**DR. JOSEPH SIMONETTI:** For those that aren't ready to remove their firearms from the household, even temporarily, we talk about other things. And those typically are related to locking behaviors and secure locking behaviors within the household. There's dozens of ways to do this, you know, using external locking devices like a cable lock or a clamshell, using a gun safe or a gun cabinet, removing the ammunition, storing the ammunition elsewhere. There are other things that I think are really important when they're going to keep their gun in the home and lock it up. And those can include things like, Hey, can your spouse or your neighbor come over and hold on to the keys while that gun's in the safe? Will your brother come over and just change the number combination and do it for seven days while you're going through this time period? Those are important steps that will increase the time necessary for somebody to access their firearm if they go into their crisis. Again, it's a conversation. It's navigating those different options to figure out what works for them, because if it doesn't work for them, they're simply just not going to do it.
53.		**DR WEST:** You've been involved with the Lethal Means Safety program with the Veterans Health Administration. Can you tell me about that?
54.		**DR. JOSEPH SIMONETTI:** The VA has been clear about its priorities for quite a long time now, and suicide prevention basically leads them. I think there's a realization

		that if you're not talking about firearm suicide prevention, you're not doing everything you can to prevent suicides. So what we started was an educational program that is aimed at encouraging our clinical workforce to engage at risk veterans in adopting different firearm behaviors to reduce their own suicide risk. It's based on education, training, real time to support to clinicians and consultation to both VA clinicians and community non-VA providers who might be caring for veterans. One of the things that we have traditionally lacked is what do we do when somebody is reluctant or ambivalent or not ready to make behavior change? Are there ways that we can have conversations with them which help them explore some of their ambivalence maybe, or some of the conflict in the things that they value to help encourage, motivate or motivate changes in their firearm storage behaviors. We're now in the VA developing a competency-based training program, which is just in the early days of doing this right now. But it's largely going to be centered on motivational interviewing work. And my colleague Francis Hannon, who's at VA Connecticut and the Yale School of Medicine, is developing at least the first I've seen a firearm specific motivational interviewing manual that will help empower clinicians to have patient centered discussions about their firearms.
55.		**DR WEST:** What do you know about whether or not this training works?

56.		**DR. JOSEPH SIMONETTI:** That's a hard one to answer. We have first survey data which shows that clinicians are learning. They're learning the basic content and the evidence and the skills that are necessary to have these conversations. We can look into the clinical record and see that these conversations are happening so that that's incredibly important. Ultimately, we'd love to see changes in suicide rates. That's what everybody wants. But from a measurement perspective, isolating the impact of any single intervention, like firearm related conversations on something as broad as population level suicide rates is just an extraordinary challenge. I think the evidence in the encouragement is just more subtle than that. In my opinion, the conversation around firearms change in the past five years. It's slowly changing, I think, nationally, within the context of firearm suicide prevention. And I think in health care systems, the conversation is changing as well. Five years ago we were answering questions to clinicians about, well, what's the evidence and what's the percentage of suicides that are related to guns? Today we're answering much higher-level questions, which is, well, my patient has this really specific firearm scenario and I'm just having trouble navigating through the conversation to identify something that would specifically work for her. Can you help me think through this a little bit? And that's evidence to me. We just know that they're engaging on this topic, and obviously that's not entirely because of the VA's work.

		There are a lot of great groups across health care systems, community partners and academic settings that are working on firearm suicide prevention are helping us move the needle.
57.		**DR WEST:** So it sounds like as a result of this training, these conversations are happening more often.
58.		**DR. JOSEPH SIMONETTI:** That's correct. These conversations are happening more often. I think we're more and more finding that not only is it acceptable, it's almost an expected part of clinical care, at least within the context of suicide prevention. We just completed a study, a study which was among a nationally representative sample of adults who live in households with firearms. And 80% of gun owners nationally said that asking about firearms should be part of routine clinical care when somebody is at risk of suicide. And 90% of those who lived in households with guns but didn't identify as the gun owners themselves, they said the same thing. That's a really tremendously high level of acceptability for these interventions. So I think we know more and more that this this is an acceptable thing to do in clinical settings.
59.		**DR WEST:** What do you suggest for physicians who are looking to explore this issue more?
60.		**DR. JOSEPH SIMONETTI:** There are a lot of different basic trainings that are available on lethal mean safety and having these conversations. The VA is just one of them.

		And I would encourage everybody who wants to think about adopting firearm related discussions as part of their clinical practice to start there. I think other guidance which I typically give people is leave your bias at the door. And maybe that's someone who has strong feelings about having more gun policies in America. Maybe that's clinicians who feel very strongly about their Second Amendment rights in their personal gun ownership. It doesn't matter which side of the bias you're on regardless to provide, I think effective clinical care, that bias has to be left at the door in. And really what I would say is to rely on your expertise and just know your limits. You don't have to know what a Mossberg is. You don't have to know what a Glock handgun is to have these conversations, take these conversations as an opportunity to learn from your patients. And if your patient's gun owner probably has more expertise than you, you can engage their expertise in figuring out what to do about that, if anything. And I think most importantly, and I just can't say this enough, is understand what a good outcome is from these discussions. What we're talking about is behavior change. Behavior change is hard. It doesn't matter whether it's asking somebody to change their gun behaviors, promoting weight loss or medication adherence. These are all really hard things to do. And as human beings were imperfect and adopting some of these things. And so what I tell clinicians over and over and over again is do not go in to 100 firearm related conversations expecting 100 of your patients to make the changes that you suggest right off the bat or even

		ever, that that's not the outcome that we should be expecting with these discussions. A positive outcome is simply to engage on the conversation and ideally, maybe you plant some ambivalence in someone's head when they're at risk of suicide. Maybe they make a gun related change. And sometimes we see people make big gun related changes. But I think the win is simply having the conversation in a way that is that is respectable and patient centered.
61.	Transition to new beat	
62.		**DR WEST:** Dr. Mary Campagnolo agrees. She's been having conversations about firearms and safety with her patients for years.
63.		**DR MARY CAMPAGNOLO:** I always couch it as this is something I ask everybody. This is a normal question. It's not like I'm targeting your family or your specific situation. I'm asking everybody when they have their health maintenance visit or as a new patient. And so I do tend to find I've not had any problem responses to those questions.
64.		**DR MARY CAMPAGNOLO:** I just feel we do need to ask these questions as a routine and document answers so that when there might be some circumstance that arises, we can take the proper action to, again, help our patients that might be depressed or feeling suicidal intent. And, I think it's so important that we all do that.
65.	Transition to new	

	beat	
66.		**DR WEST:** Conversations between health care providers and their patients about firearms and safety are an important part of suicide prevention. These conversations start with meeting patients where they are and understanding their reasons for gun ownership and their safety practices. Encouraging safe storage practices is one way of putting time and distance between an impulsive decision and a fatal act.
67.		**DR WEST:** Thank you to Dr. Mary Campagnolo and Dr. Joseph Simonetti for participating in this discussion.
68.		**DR WEST:** You've been listening to Let's Talk about Your Guns. This podcast is made possible by The Henry M. Jackson Foundation for the Advancement of Military Medicine. It's produced by Podville Media for the Center for the Study of Traumatic Stress at the Uniformed Services University.
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