VIEWPOINT

Physician Counseling on Firearm Safety
A New Kind of Cultural Competence

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The Centers for Disease Control and Prevention estimates that 33 636 deaths and 84 258 nonfatal injuries from firearms occurred in the United States in 2013.[1] Physician counseling concerning gun safety has been identified as a key component of the prevention of firearm injury and deaths.[2] However, recently proposed or enacted state laws that are perceived as restricting physicians' conversations with patients about firearms have spurred debates about the role of physicians in preventing firearm injury and death. In response, medical, legal, and public health organizations published a statement defending freedom in the physician-patient relationship and the right for physicians to be able to speak openly with patients about firearm safety.[3]

Yet maintaining this right is not enough to protect patients. Physicians and other health professionals also need to consider how to speak with patients. This means identifying what kinds of information, and what approaches to the discussion, are most effective in changing patient behavior concerning firearm storage and misuse. Clinicians need to be able to talk about firearms with their patients, but should not forget the goal of talking with, not at, patients.

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Patient-centered care, now a guiding principle in medicine, requires physician "cultural competence" for patient populations as defined by ethnic heritage, religious beliefs, sexual orientation, or other factors. Cultural competence is a "set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations."[4] Fundamental components of cultural competence include respect for variation among cultures, awareness of a person's own beliefs and practices, interest in learning about other cultures and in developing skills to enhance cross-cultural communication, and acknowledgment that culturally competent practices support delivery of quality health care. In the United States, especially given the current contentious debate over gun control legislation, firearm ownership can be seen as linked to membership in a particular culture. It is time to address cultural competence related to firearm safety counseling. This includes recognizing that there are actually multiple subpopulations of gun owners whose perspectives and preferences may vary based on their reasons for owning firearms.

Some patients who own firearms, especially those who have had interactions with physicians who seem unaware of the issues or intolerant of another's perspective, may not view physicians as trustworthy sources of information about firearms. Some physicians may be uncomfortable talking about firearms because of their own unfamiliarity with guns.[5] However, an estimated 13% to 41% of physicians own firearms,[5,6] and physicians who own guns may be more likely than those who do not to counsel patients about firearm safety.[7] The solution is not for every physician to purchase a firearm or become a gun expert. Rather, physicians who own guns should be asked to provide leadership in developing cultural competence in firearm safety counseling, rather than being marginalized or silenced within the physician culture. Physicians should recognize knowledge gaps or biases and work to reduce them, while simultaneously considering how best to educate and communicate with patients. Physicians already use this approach for counseling about other controversial behaviors that may have health consequences, such as the use of helmets and seat belts, acceptance of childhood immunizations, and reliance on naturopathic remedies.

There is limited evidence on the perceptions of gun owners about communication with physicians. From the few studies available, several suggestions emerge.

First, physicians should adopt respectful counseling behaviors that are simultaneously individualized to the patient[5] and routine for certain high-risk patient populations. High-risk populations include patients with suicidality, given the clear link between firearm access and elevated risk of suicide because of the high lethality of firearm suicide attempts. Other groups potentially at higher risk of firearm injury include children, patients with cognitive impairment, and survivors or perpetrators of domestic violence. Explaining the context for asking about firearms can help physicians preserve an individualized approach when routinely assessing firearm safety when indicated. Approaches might be further tailored to the context for counseling; for example, a clinician may use different educational messages with parents of young children than with family members of patients with cognitive impairment or suicidality.

The physician's attitude is also important. Patients prefer that physicians provide nonjudgmental firearm

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safety information empathetically without explicit orders to do something,[5] suggestions in line with principles of shared decision making. Clinicians should respectfully educate patients about firearm safety, including known statistics about the risks of injury or death; written educational materials with resources may support this less judgmental approach.[5] But to refine these educational approaches, physicians need to collaborate with a range of representatives from within the larger community of gun-owners to identify acceptable and effective strategies for incorporating firearm safety counseling into clinical care. Ideally, gun safety counseling could incorporate a range of safe storage options from which patients could choose the most acceptable and feasible option. For example, those who own only long guns for hunting may choose certain storage options (eg, a combination gun safe in the basement), whereas those who own handguns for personal protection may choose others (eg, a fingerprint-operated lock box in a bedside table).

Policies to encourage these kinds of physician practices—a third aspect of cultural competence—could exist across the spectrum from individual clinical practices to organizational policies and laws. Such policies might also include respectful, inclusive public health interventions to prevent firearm violence, ideally developed through partnerships with a range of stakeholder groups. An example is a collaborative suicide prevention project in New Hampshire led by a statewide coalition of suicide prevention professionals, firearm rights advocates, and firearm dealers.[8] The project, now being replicated in Colorado and other states, uses social marketing approaches to normalize the idea that friends, families, and gun dealers can save lives by recognizing warning signs for suicide and by helping individuals in crisis safely store their guns in, or temporarily outside of, their home.[8]

Physicians, entrusted with the power of the "white coat," can—and should—act as leaders in educating the public and advocating for public health and safety in topics ranging from nutrition to firearm injury prevention. Yet physicians also need to remember that, in individual patient encounters, that same white coat can serve as a barrier to connection and communication. Physicians are entitled to their own perspectives and political opinions, but to serve patients and protect them from disease and injury, it is important to counsel them in ways that are respectful, meaningful, and effective. At times, clinicians may feel uncomfortable or uninformed when discussing certain subjects, and may disagree with a patient's choices or beliefs. However, this discomfort or disagreement cannot justify either offensive condescension or silent inaction.

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