Production Transcript for Firearms Episode.mp3

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>> [Background music] The stigma affects our clinical judgement.

[00:00:04]
>> Racism is a system.

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>> That they might have inadequate social support, no place to stay, not a great way to get their medications.

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>> The best way to approach this really is not to say I know the answer but to say I have a question and go to the people who you intend to benefit and ask them what they think the answers are. And believe it or not, they're right most of the time.

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>> A society, at least in America, doesn't emphasize these issues. It doesn't emphasize the social aspect of healthcare.

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>> Welcome to Announce, a podcast on social emergency medicine, where we know that the patient's medical history can be very different from the patient's story. My name is Aisha Kahn. I'm your host, an emergency physician. And this is my cohost.

[00:00:46]
>> Quincy Moore, an emergency physician.

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>> In today's episode, we talk to two emergency medicine physicians who have focused their work around gun violence as a public health issue. Dr Megan Ranney is an associate professor of both emergency medicine and health services policy and practice at Brown University. She has an extensive research background and is the chief research officer for a firm, The American Foundation for Firearm Injury Reduction in Medicine. Dr Marian Emmy Betz is an association professor of emergency medicine and in the School of Public health at the University of Colorado. You may have seen her TedX talk on how to talk about guns and suicide which highlights her interests in both suicide prevention and injury prevention. She also has an extensive research background.

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[ Music ]

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>> 2018 has seen a remarkable wave of youth activism against gun violence in the wake of the Parkland, Florida shooting. On the southside of Chicago, a young man named Delmonte Johnson and some friends formed an organization called Good Kids Mad City, to advocate for gun control and more mental health and drama-informed schools in their community. On September 5, 2018, Delmonte, who was 19 at the time, was dropping his younger brother off at basketball practice when he was shot and killed in a driveby shooting. D'Virgo, the younger sibling, said he saw his brother sustain multiple gunshot wounds to the chest and abdomen and laid next to his dying brother and held him in his arms. "I knew he was leaving me, but he's still with me," D'Virgo said.

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>> He makes over 30 loved ones and people that I've worked with to be murdered by gun violence in the city of Chicago.

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>> You get a young activist, and it's sad for a person that's trying to stop the violence to be gunned down.

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>> Delmonte's story, the 12,000 other gun-related deaths that occurred in 2018, and the more than 22,000 completed suicides from guns are all too familiar to us as emergency physicians. So, thanks so much for joining us. Megan, we wanted to start with you. Can you tell us a little bit about how you came to focus your work on gun violence and why this is an issue that's so important to you?

[00:03:14]
>> Sure. That is a really kind of multi-part answer. The first part of it is that I worked on violence prevention in general for a very, very long time, since long before I went to medical school. And I actually, after finishing residency did a specific fellowship in injury prevention with a focus on violence prevention. I had thought I was going to work on gun violence and was told very specifically that I couldn't because there was no funding and because it was a political hot topic and would ruin my career if I took this on as an issue. I still tried to think about how to bring an evidence-based focus to gun-violence prevention, even despite those warnings. But then kind of the second part of the multi-part answer is I had a number of clinical cases and I think Emmy and I can both talk about kind of those personal stories that impacted my appreciation and empathy and determination for talking about firearm injury as different from other types of violence against self or others.
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And then the third part was of course the changes in the national conversation. You know,

Sandy Hook was for me, as for many of us, a turning point and that was really when I started to not just try to squeeze in little bits of research on firearm injury in my larger work on gun violence prevention and mental health, but to really speak on a national level about the importance of addressing firearm injury the same way that we address every other public health problem.

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>> Fascinating. You mentioned that there was some particular cases that drew you to persist in your quest to focus on this in the emergency department particularly. Can you share one of those with us?

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>> Yeah. I think like all of us in emergency medicine, I have dozens if not hundreds of cases, right? But there were a few that sat particularly deeply with me and one of them was a case that I had very early on in my career as an attending. It was a, you know, summer weekend evening and we got a call over the EMS radio that there was a GSW code blue on its way in. And we prepped the room the way that we always do in an urban level 1 trauma center. And, you know, I had all my new second-year PGY2s who are looking forward to getting to do some procedures. Then the patient rolled in. And it was not what any of us thought was going to come through the door. It was a young man who had shot himself in the head with a family member's firearm.

[00:06:03]
>> Wow.

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>> And the room just went silent. And the case took my breath away, partly because it was still to this day the only time I've taken care of someone who committed suicide with a gun. And it made me wonder, why, right? We take care of suicide victims, or people who have attempted suicide every day. And I know Emmy will talk more about this, but that was part o the reason. Another part was how much it highlighted how much we accept gun violence as just part of our daily bread and butter, and how we have built up these walls between us and empathy, right? Any of us that work in a level 1 trauma center see victims of community violence. And the fact that we were able to approach it, you know, without the respect and consideration that we make for any other type of injury or disease also really sat with me and made me think long and hard about how we take care of victims of violence and the role of trauma-informed care and all of the social determinant that go into any form of violence but certainly gun violence being kind of the ultimate, or the most serious form.
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And that was, again, that was one of many cases. I have others, but that was one of the ones that really crystallized for me the ways in which firearms are different and firearm injury is different from other types of injury and violence.

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>> It's a interesting point. I think, I think you're right, Megan, that a lot of times, you know, when people think about the problem of gun violence, suicide is not necessarily the first thing that comes into mind. Emmy, you know, this has really been a focus of your work. Can you, can you tell us a little bit about sort of what experience in your life led you to the work that you're doing right now?

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>> Yeah. I feel like it was also kind of complex path, but not necessarily one I had predicted. I think I, you know, am similar to Megan because of events like Sandy Hook and sort of national conversations was interested generally in the topic of firearm injuries and particularly the role of physicians. Around the same time, I had started doing work related to suicide prevention and care of suicidal patients in emergency departments, which is certainly something I think anyone who works in an ED is aware that it's a big issue. You know, we, there are lots of gaps in care and questions about how we can improve care for patients who are in really tough times. And I think then those two things really came together for me. Especially, I would say, after hearing about the work of Kathy Barber and colleagues in New Hampshire and sort of partnering with gun shops and really realizing how much common ground we have in the idea that nobody wants to lose a family member from suicide.
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And people who own firearms are no different in that way. That of course they don't want their family members dying. You know, I had also had personal losses, friends and family, from suicide and so there was a sort of connection there for me. And it's just kind of all continued to coalesce. I think the really interesting scientific question, so as a researcher it's been a fascinating area to work in. And I think then it also has felt very fulfilling as someone who cares deeply about public health and thinking about how do I as a physician and physician researcher, how can I have a larger voice. It's been an area where I've been really grateful to work. And how do I improve care for the next patient I see on shift but also how do I help inform kind of the, you know, the national conversation that we're having.

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>> Thanks, Emmy. So, you mentioned the national conversation. It occurs to me that the national conversation isn't actually about suicide. The national conversation tends to be about mass shootings, homicides. But I believe, and you can correct me if I'm wrong, that the largest number of firearm-related deaths are suicides. Is that correct?

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>> Right. You know, here in Colorado for example, it's even magnified different. 75% of our gun deaths in Colorado, where I live, are from, by suicide. So, I mean, three-quarters. That's, that's not what people think of, right? And nationally I think last year it was about 60% of all gun deaths in the US were due to suicide. It's something like 1% were mass shooting. Less than half a percent I want to say were accidental shootings. And then the, you know, the remainder of that chunk of like a third to 40% were homicides or police-involved shootings. So, that's not

what we hear about. It's the mass shootings that understandably get us all scared and upset and sort of lead to these arguments about how to prevent them, and there is no easy answer, I don't think, to that. Megan mentioned her case of caring for someone who was a victim of firearm suicide.
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And in the ER, we also don't see that, as she pointed out. It's like the only time she's ever taken care of someone. Because usually they die at the scene, and so they don't make it to our ER. And so I think those of us on the front lines also don't really realize that that's where the bulk is. Because the victims that we're seeing coming in are typically either in sort of interpersonal shootings, whether it's, you know, youth interpersonal violence or domestic violence or sadly, you know, when you're the closest hospital to a mass shooting like my hospital was in the Aurora shooting case. So, there's this big, there's a big mismatch and I think some of it is that people just maybe don't know the numbers. And I think some well-intentioned firearm control groups over the years have not necessarily called out the epidemiology the way they maybe could. I also think it's what gets people's passions going, though, right? That there's still so much stigma around suicide and blame and wrong ideas about how it wasn't preventable or it was the person's fault.
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Like all of this, this baggage that we still need to work through that makes suicide much harder to talk about. But that's where the bulk of these deaths are and certainly those deaths should count just as much as any of the other deaths. So, it's been a really interesting area to work in for that reason as well, because it's, it's like two taboo subjects sort of put together. And so figuring out how to talk about that in a way that is meaningful and spurs action is, has been really interesting.

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>> I would love to echo off of what Emmy just said around the national conversation. I think one of the things that you'll hear from my work and Emmy's and that of so many other emergency physicians and other healthcare professionals who are active in this space right now is the effort to shift the national conversation. And to really shift it from a discussion of mass shootings. Or a discussion of firearm injury as a criminal justice problem. To a discussion of firearm injury and death as a public health problem, as a medical epidemic just like any other, right? We don't talk about car crashes or cancer or HIV as a criminal justice problem. And we don't refuse to talk about car crashes because some are intentional and some are unintentional, and some have people who are drunk, and some have people that are driving without a license, right?
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We talk about them all together. And one of the things that we're trying to do is to change that conversation in the same way here so that this doesn't have to be a partisan or a political issue but rather can be an issue that is about the health of our patients and our communities. Both in preventing shootings before they happen, but also in stopping that downstream ripple effect of shootings after they have happened.

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>> Megan, how do you sort of approach people who say that this is a political issue and this is not really something that emergency physicians or physicians in general should be touching on?

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>> Oh my gosh. Well, we could do a whole hour podcast on that one, but-

[00:14:26]
>> Sequel!

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>> But I-- , yeah, right! Exactly. I think at the base of it, it is talking about really kind of reframing around the conversation again on the patterns of injury and death. And on the ways in which this is a health problem. And talking about the ways that we have used the public health approach to solve epidemics like this over and over again across history. PS, we have decreased car crash deaths by over 50% from their peak without taking away peoples' cars. And I think that when we get caught in this rhetoric of gun, you know, ban all guns, arm everybody, we lose sight of first of all the people at the center of this who are getting hurt. And we also lose sight of the fact that we know as physicians or other healthcare professionals that there is a value to evidence and that things that may emotionally resonate with us as solutions may not actually work. And so when I can come to this, I think about it, you know, the same way that you engage in a conversation with, say, your spouse when you are at two opposite sides of an argument.
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When you can come at it with an open mind and with an understanding that neither your side nor the other side position is wrong, but rather that you both have the same underlying goal which is to keep your patients and your community safe, then you can start to create solutions together. And, you know, Emmy and I have done a lot of work around that together, with others across the country, and certainly with a firm research, which both of us are a part of and strong supporters of. But Emmy actually has some great stories around that depoliticization of the discussion. She's done some amazing work I'll let her talk about.

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>> Yeah, thanks. I would also say, you know, your question was, you know, sort of the role of physicians and this is isn't their topic or their sort of issue to discuss. And I think we need to be clear in what we're advocating for. So Megan and I and all the others working in this space I think unanimously would agree that there are contexts and situations when of course physicians should be talking about firearm safety with patients. So when someone is a risk of suicide or has other risk factors for violence, when there are young kids in the home and so forth. Of course it is within our realm and I would argue it is our responsibility as healthcare providers to be asking and counseling in a way that is culturally competent and respectful and appropriate. In the same way that we talk about risk of sexually transmitted infections or we talk about alcohol use or other things that could potentially, you know, damage someone's health, that we want to talk about.

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We are not advocating for having conversations about firearm safety when let's say we see someone with an ankle sprain or strep throat or sort of cases that aren't as relevant. So I think it's important to say, like, we're not, when we talk about this public health approach and the role of physicians, we are not advocating for like universal screening or for physicians telling patients not to own guns. That is not what we're talking about here. Separately then, I think there is an important role for physician organizations, public health groups to play in informing the conversation around firearm legislation, firearm policy, using data. So, as physicians we build our practice on evidence. We need to be advocating for science, for understanding the, the risks or potential benefits from having firearms. For having conversations that are informed and educated. But I think, you know, my take on this and I think Megan agrees and not everyone may, but the whole, this is our lane phenomenon for example.

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>> Yeah, a super interesting conversation that occurred.

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>> Yeah.

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>> This is Our Lane is a movement that arose after the NRA criticized physicians for publishing a series of research papers about firearm injuries and deaths in the Annals of Internal Medicine, including their new recommendations to reduce gun violence. The NRA tweeted, "Someone should tell self-important anti-gun doctors to stay in their lane. Half of the articles in the Annals of Internal Medicine are pushing for gun control. More upsetting, however, the medical community seems to have consulted no one but themselves." The tweet was posted hours before a gunman opened fire in the Borderline Bar and Grill in Thousand Oaks, California, killing 12 people before turning the gun on himself. The tweet garnered more than 3000 likes and 22,000 comments. A few in support of the gun rights group but most of them pushing back. Several tweets from doctors, including trauma surgeons and emergency room physicians included graphic images of what operating tables or hospital scrubs can look like in the bloody aftermath of a gunshot wound case.
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They included the hashtags #stayinmylane #thisismylane.

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>> I mean, I think that is, to me that whole conversation was about saying to the NRA when I am with a patient, as a physician, if it is relevant and important for me to be talking about this, I'm going to talk about. I'm regulated by my own code of ethics as a society, as a profession. But if it's pertinent to the patient's care, I'm going to, I'm going to talk about it and you can't tell me not to. I don't think that that movement was, or should have been about sort of physicians for gun control. Does that make sense? To me, there's a big distinction there. And outside of the clinic, outside of the ER, physicians can get involved in all kinds of ways that feel meaningful

to them. But when we're with our patients, it really shouldn't be about politics. And that's the sort of approach I think that we're advocating for in having these respectful and informed conversations with patients when it's appropriate.

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>> So, who do you screen for either the possession of firearms or consideration of depression or suicide related to firearms?

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>> Yeah, absolutely. And there's some great resources out there that I'm hoping maybe you guys can link to from the podcast. So, there's a new free training that we helped develop with the American Medical Association that goes through this. There's also some great resources from UC Davis, the What You Can Do program. But it basically boils down to when there are risk factors violence, including self-inflicted violence. So somebody who's at risk for suicide. So certainly if they're saying they're suicidal, but I would argue also people with significant depression or other mental illness. People who have other risk factors for violence such as having been engaged in, say, youth violence in the past. If it's a teenager you're seeing who's already, you know, been involved in some assaults, that's someone you might worry about. Domestic violence. Alcohol abuse and substance abuse, since those can raise the risk of violence. Cognitive impairment is another one we're starting to think more about. So when someone in the home has dementia or another form of cognitive impairment. And then pediatrics.
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You know, if there are very young children in the home, and that's an area where I think even responsible gun owners would agree. Like, of course guns should be locked up. And so that may be more kind of outpatient pediatrics issue than what we're seeing in the ER. But the basics is that when someone has a risk factor for violence, then we should be thinking about talking about firearm safety. Typically I ask questions like do you have access to firearms where you live.

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>> And I'll add there, sorry, that I think of it kind of the same way. You know, one of the things that Emmy and I advocate for is that we should approach this again the same way as any other public health problem. So, you think about heart disease or domestic violence or any other condition that we're involved in caring for in the emergency department, right? And so we know that for our patients who come in, again, with like an ankle sprain to use Emmy's analogy. We're not going to go on a deep dive in the ED as to risk factors for heart disease, right? Unless they're complaining of chest pain. So unless they have some sort of a pre-existing indication that this is something that we should be paying a lot of attention to. Now, if we were a cardiologist and a patient was walking into our door, we might approach it differently, right? And so similarly for a psychiatrist who's taking care of a patient, they might have a slightly different approach than we do in the Emergency Department. For domestic violence, we have great evidence saying that we should be screening all patients, all women of reproductive age, for

domestic violence.
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We don't have evidence like that right now for firearm injury. And so those categories that Emmy provided really are, really broad brush strokes and are kind of a starting point. And that's where we're hoping that the research progresses over the next year, two years, five years, 10 years, to help us as emergency physicians do a better job taking care of our patients.

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>> Absolutely. So, one thing that occurs to me is, you know, in the emergency department, where I practice I have a certain population I take care of. Megan, I'm sure you have a certain population that you take care of. But our practice and our population really informs I think the culture that we come to accept with guns. For example, I would venture to say there's parts of the country where everybody has a gun. It's not really considered a safety issue. Everyone knows how to use a gun. It's just the way that they've been brought up, whether it's for hunting or what-have-you. And then there are other parts of the country where just having a gun indicates that there is a concern or a risk for violence. I struggle with and think about a lot how our own preconceptions influence the screening questions that we do ask.
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And whether race plays into it, whether the sort of culture, the assumptions that we make about our patient play into it. So, if you're saying that we need to ask about gun safety in terms of mental health, I mean, even that concerns me because it's well known that patients that suffer from mental health have more violence perpetrated against them than they actually commit violence. So, who is it, or should we just have a broad, like for domestic violence, should we have a broad questionnaire that's done at triage, do you have firearms in your household? Do you keep them locked up? Is that something we should just add into our general screening?

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>> Yeah, so I'll jump on that one.

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>> Sure. I would say absolutely not. I think we have no evidence that that kind of broad screening is effective in preventing injuries or deaths later and I think it has the potential to do a lot of harm, especially because of the sensitivities about how these questions are asked. And we all know, right, like the screening questions that get asked up front, when the person has like just met whoever it is who's doing the screening questions, you know, I think we're all maybe skeptical of how valid those answers can be. It's very different than if you've established rapport and you're talking about it. I also just wanted to clarify something. When I was talking about risk factors for violence, when I talk about violence I include suicide in that. Because suicide is violence. It is self-directed violence. So when I'm talking with people who have depression or anxiety, when I'm talking about firearm access, it is not because I'm worried that they're going to hurt someone else. It is in the context of suicide risk, and it is the, you know what, while you're going through this tough time, let's think about how we can maybe make your home safer. Do you have firearms or medications where you're living?

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Those kinds of questions. Because I think you're right, we need to be very careful that we're not further stigmatizing mental illness. But I also think when we talk about gun violence, we need to be including self-inflicted violence in that. And we know that while many people who die by suicide don't have a documented history of mental illness, having a history of mental illness is probably the biggest risk factor for suicide. And so that's sort of where that connection comes in. But I don't think we have evidence right now for the kind of broad screening. And so yes, it makes it harder, but it sort of, the same way that questions like, that we learned in medical school. I remember being really giggly when we had to sort of first learn how to say do you have sex with men, women, or both.

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>> Right.

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>> And that felt really awkward and now I don't even think about it. I don't ask everybody that question, but I've learned when I think a sexual history is relevant to their case and I will ask the question in way that is respectful and nonjudgemental, and I think that's what we're advocating for here as well.

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>> And if you look at the difference, Emmy, I'm not going to date us, but you and I did residency around the same time. And you look at the difference between the way that we approach discussing sexual orientation, sexual behaviors with patients now versus 10, 15, 20 years ago, right? We've had a huge shift and I anticipate that we'll see the same thing here. I think part of the challenge in answering these questions is that we simply, like Emmy said, just don't have the evidence right now. And so I think the questions like yours around, you know, being conscious about the role that implicit bias or stigma could play in our decision making around how to interact with patients is really important. And I'll say that there's also a concern around implicit bias and stigma for folks who are firearm owners. Something that I hear a lot in my work and that I know Emmy does too is a fear of disclosing that you're a firearm owner because you're fearful that you're going to be judged and thought of as not thoughtful or not protecting your kids or whatever. And so I think we also have to be aware of our own implicit biases and stigmas there and to really approach all of our patients with an open mind and just awareness.
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You know, we can't fix every bias that we have but the first step is knowing that it's there and being conscious of it and checking it. And hopefully someday soon the state of the research will catch up and give us better guidance here.

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>> Yeah, I totally agree and I think one thing for listeners to maybe try out is even just talk to their coworkers. I think you might be surprised at how many people you work with, even, have firearms at home, for whatever reason. That's not to advocate that we all go out and buy them,

of course not. But there is a, in the healthcare or academia communities, stigma against people who own firearms. And you have to really start to embrace that no, of course they don't want their kids to die. They don't want people in their families to die by suicide. Now, many people own firearms specifically to protect their family because they believe it allows them to protect their families. That's a whole separate conversation around whether it does help protect people or not. But that is the reason that many people are buying firearms. So, why would they not want to engage in respectful discussions around safety? And so I think we need to own that in the provider and scientific community, the biases that we may carry with us.

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>> Megan, as an EM doc that doesn't focus her work on firearm safety, what can I do to be part of the solution?

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>> One of my favorite questions in the universe. So, I think there are three big things that you can do every day, no matter who you are across this country. The first is, as Emmy already outlined, you can have thoughtful, honest, empathetic conversations with patients who are potentially at risk for firearm injury, particularly domestic violence, people with suicidal ideation, people with a history of assault injury, people with cognitive decline I would say are kind of the four biggest ones. And if nothing else, just those patients who are suicidal, to have those thoughtful conversations about how to keep them safe and whether or not firearm access plays into that. The second thing that you can do is that you can get involved. Certainly within ACAP as well as within a number of other national organizations. I mentioned AFFIRM. There are many others as well, that are really advocating to change this conversation and to create solutions. And you're welcome to check out our website at www.affirmresearch.org.
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The third thing that you can do, no matter who you are, no matter where you live, is that you can share your story and you can engage in honest conversation with your friends and family, with your neighbors, with your colleagues. One of the things that This is Our Lane really highlighted was the importance of storytelling and the way in which this epidemic is so silent for so many of us across the country. What we do and what we see in the ED stays with us. And it doesn't have to be that way, that when we talk about what we see, it helps to make it real and helps to decrease the stigma for other Americans. And actually, Arlene Chung is organizing an Airway event for next winter to help start to share these stories. And so I would say you could reach out to her if you're interested in doing that on a more national stage, but I think we can do it personally every day in our own communities as well.

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>> Both of you guys have mentioned quite a bit the lack of quality research and data on these topics. I want to ask both of you, because I know you're both researchers. I want to ask you sort of what you think are the most important missing pieces of the body of research and sort of what things you think are going to really move us forward in our dialog. And just sort of give you an opportunity to tell us a little bit more about the work that you're doing in terms of research.

Megan, can we start with you and your work with AFFIRM?

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>> Sure. So, a couple years ago, I led a technical advisory group within ASAP that tried to codify what are the most important research questions for us to answer around firearm injury prevention in emergency medicine. The good Dr Betz was part of that group, as were so many other folks from across the country. And we came up with a list of about 60 research questions. What was staggering to me was not what we know but what we don't know. We need to know what are the best tools for screening and who should we screen. We need to know better who's at risk. How do we intervene in a culturally competent way to help make a difference? How do we decrease risk of PTSD and recurrent injury and self-directed injury after a first exposure to firearm violence, and so on and so forth. And one of the things that most struck us was the degree to which docs across the country in emergency departments, in rural areas, in urban areas, totally lack best practices and protocols.
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And that was part of the rationale for the founding of AFFIRM. My cofounder is a rural ED doc in Vermont and he owns a farm. He owns guns. And he has taken care of a lot of cases in his rural community ED that really shook him, were really high-risk patients, some of whom he identified in time and some of him he wishes he'd had an opportunity to do something different on. And our goal at AFFIRM is to help jumpstart that research, to really use a simple and innovative platform that we have as a nonbureaucratic startup to get that started. And then to spread this message that Emmy and I are talking about, which is that there is a better way, and that it's something that each of us can make a difference in. You know, there are other folks also doing really great research and I'm sure, I'll let Emmy talk about her incredible work. But, you know, I'm doing stuff within the area of youth violence prevention, trying to use digital media.
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There are folks out at UC Davis led by Dr Garen Wintenmute who are doing great stuff around extreme risk protection orders and creating the What You Can Do platform. The Fact Consortium, which is based at University of Michigan and is led by Dr Rebecca Cunningham and Dr Kat Carter are doing great and funded work to restart the field of pediatric firearm injury prevention. But I'll tell you, on part of that Fact Consortium, we just did another scoping review of what research questions we have to answer. And it was kind of, like, déjà vu from our ASAP work a couple years ago, where we basically said well, look at this, there's all these questions. And we just don't have answers because, because there's just this true and profound lack of federal and foundation funding. Which again is one of the holes that AFFIRM is trying to fill.

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>> Do you think the needle is moving on that? Do you think, are you starting to see sort of more funding streams? I mean, certainly it seems like there is more media attention these days. Do you think money is following that?

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>> Yeah, I think, it's funny. I actually just put out a Twitter thread a couple of days ago about the degree of hope that I have now as someone who's worked in this area a long time. I am seeing media attention but I'm also seeing again that shift in the conversation, that we helped lead with this This is Our Lane and that we're working on so hard at AFFIRM. To changing this to a conversation about health and public health. And I'm seeing that start to snowball, and that is giving me tremendous hope. And it's also bringing new people in. You know, there's a few private funders, the Arnold Foundation, Kaiser, American Academy of Pediatrics have all stepped up recently. And there's potentially some movement on the federal funds as well. At the time of this podcast, the House just voted to allocate $25 million to the CDC and another $25 million to NIH to study firearm injury prevention. Of course, it has to go through the senate and there's a long way to go between here and there. But other than right after Sandy Hook, you know, this is, this is the most movement that we've seen. So I have a lot of hope.
[00:36:01]
I also believe that the voices and the will of individual docs and individual Americans makes a difference. And I can't overstate the degree to which the outpouring of support and energy after This is Our Lane really made a difference. But we all need to keep it up and need to keep it up together, because there's power in our voices united.

[00:36:22]
>> Thanks, Megan. Emmy, can you just tell us a little bit about your research on the Colorado Firearm Safety Coalition?

[00:36:30]
>> Yeah. So, I am mostly focused on firearm suicide within the realm of firearm injury prevention. We've been doing work with funding from the National Institute of Mental Health, developing a decision aid, a web-based decision aid that is intended for patients to help kind of think through firearm storage options. And it hopefully will allow providers to offer counseling in a way that is maybe a little more informed. I think many providers are like ew, I don't really know what to say. So we were trying to build a tool that would sort of get around some of those issues and be acceptable to patients. So, the research realm has really been how do we improve care of suicidal patients in emergency departments, specifically in this piece of lethal means counseling and discussions around reducing access to firearms. So along the way, in 2015 I think it was, I was fortunate to be able to do a Ted talk here in Denver. And then right around the same time, we had an editorial published in JAMA around this idea of cultural competence and firearm safety counseling.
[00:37:33]
And that led to some amazing connections with in particular a firearm instructor who's a physician here in Denver. And together were able to build this coalition called the Colorado Firearm Safety Coalition. It's a group of firearm range owners, instructors, other people in sort of public health and suicide prevention. And we meet really to talk about how to help educate the firearm owning public around suicide prevention basics. And that has been just awesome, like, speaking at ladies night at the gun club and there's ways to reach populations who really maybe haven't heard some of these messages before. It's also been incredibly helpful for my

research and my thinking about kind of what the research gaps are and what do we need to move forward. And I really feel like there's so much we need to do in terms of understanding the needs and the behaviors and the wants of the firearm owning community and how do we really work together in ways and make this less of a divisive kind of process.
[00:38:37]
Yeah, so we're continuing our work in emergency departments. Also moving a little more into the space of understanding how these coalitions between, say, academia, public health, and gunshops can potentially, are they effective, how do they work, what do they look like, and so forth. I think like Megan, I also feel optimistic about the sort of funding realm. And we need more and I really hope the senate will take action and refund the CDC. But for people who want to get into this field, there is a way. And there are foundations for suicide prevention, Department of Defense and the VA, they get it. They are funding firearm suicide related work because it's what we have to do to tackle this problem.

[00:39:20]
>> Excellent. Any closing thoughts either of you? Or both of you?

[00:39:25]
>> I have just, I guess just one. I think this comes back to thinking about our biases or our perspectives. I had a really interesting day, this was like a few weeks ago now in April here. I live in Denver. I woke up for an early shift. I was in ER doctor mode and that was the day my kids' schools got cancelled because of the woman who was threatening to maybe shoot up a school in Denver. So then I had sort of a parent perspective of like oh my gosh, this is crazy that I have to worry about my kids' safety at school. And I got to work and we heard that the woman might be near our hospital somewhere, so we were sort of preparing for either shooting victims or mental health evaluation for her. And then at the same time, I was communicating with some of my firearm range partners, because I was really interested in what was happening on their end and how they were communicating with the FBI and things. And it just struck me as such, we're in such a weird place in history [laughter]. So I would say, and I sure hope it's going to get better, but I was also really grateful I think to have these different perspectives.
[00:40:27]
And I think we as physicians really can do so much by sharing the views we have and the things we've seen and the patients we care for. And hopefully also can really listen and learn from other people. And I think can really play a leading role in this work.

[00:40:43]
>> I love that, Emmy, and I, so, for my last thing, which I hope you guys will edit so it's not actually the last thing, but Emmy's thing is last because that was just so beautiful. But from my perspective, one additional part to kind of add on is when Emmy and I and others talk about firearm injury prevention, one thing that we kind of get asked from both sides is, you know, are you saying that it's all about the gun? And in injury prevention, we know that decreasing the transfer of energy, to quote Steve Hargarten, decreases the degree of injury and the chance of lethality. But it's also important to recognize that in injury prevention, we also talk about the

sequence of events that lead up to an injury happening. And within the area of firearm injury prevention, both community violence and domestic violence, suicide, mass shootings, even unintentional or accidental injuries, there's always a host of factors that lead up to that moment of a gun going off.
[00:41:45]
And it is so critical for us to talk about those and to talk about all of the structural and social determinates of health that lead to that moment where an injury happens. And one of the things that I would hope that listeners would take away from this podcast is the importance of attention to those social factors in addition to, you know, when we talk about firearm injury prevention, that that social part is just so critical in our attempts to create better prevention and treatment algorithm.

[00:42:21]
>> Amazing. Thank you, both of you.

[00:42:23]
>> It's great.

[00:42:23]
>> We really, really appreciate you joining us and Quincy, any other thoughts? I think that's basically all the questions that I have and I think that was a really great, great talk.

[00:42:35]
>> Yeah, this was fantastic. Thank you guys both so much for joining us.

[00:42:40]
>> Wonderful. Well, thanks for having us.

[00:42:41]
>> So, what did we learn today, Quincy?

[00:42:44]
>> We learned that as emergency physicians, we're directly exposed to the toll of firearm violence but we're also uniquely positioned to address it.

[00:42:52]
>> I learned that although mass shootings are a serious problem and attract a lot of media attention, the majority of firearm deaths in the USA are actually suicides.

[00:43:02]
>> Firearm violence is a public health problem, like drunk driving. And it needs to be addressed on multiple levels of prevention. We've used a public health approach to solve problems like this in the past, and this is not necessarily about gun control. This is about gun safety and

preventing death from firearms.  As Megan said, we've decreased death and injury from automobiles without taking away people's automobiles.  We can do the same for guns.

[00:43:28]
>> Research has been limited by political constraints on funding and more data is needed to find the most effective solutions.  We have many research questions that are unanswered, but we have very little information on best practices in terms of who to screen and how best to prevent injury from firearms.

[00:43:46]
>> Have thoughtful, honest conversations with your patients about their risk for firearm injury. Share your stories with your colleagues and whoever else will listen.  And join the national dialog by getting involved with ACEP and AFFIRM.

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>> And as always, check out our show notes for more information.

[00:44:05]
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