EDITORIAL AND COMMENT

Leveraging patient-centered approaches to discuss firearm storage safety

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While two thirds of Veteran suicides result from firearm injury and half are seen in primary care settings in the month prior to death, the majority (58%) of physicians do not ask patients about firearm ownership.¹ Furthermore, even fewer (23%) physicians report discussing ways to reduce the risk for firearm-related injury or death.¹ This critical gap in communication may result from overburdened primary care teams, knowledge deficits, or the highly politicized—and perhaps even taboo—topic of firearm ownership. Incorporating discussions about firearm storage safety (FSS) into routine healthcare for Veterans has potential to address the current rate of Veteran suicide, yet communication strategies to ensure well-informed and acceptable conversations between patients and providers are lacking. In this issue of *JGIM*, Dobscha and colleagues explored Veterans' perspectives on discussing FSS during primary care visits, with the goal of identifying ways to foster primary care–based discussion of FSS with Veterans at risk for suicide.²

Patient-centered care encompasses five dimensions: *patient-as-person*, *doctor-as-person*, *sharing power and responsibility*, *therapeutic alliance*, and the *biopsychosocial perspective*.³ Below, we describe how this framing contextualizes Dobscha's findings and facilitates our understanding of Veterans' perspectives.

Beginning with “*patient-as-person*,” the authors place a high value on this dimension in their methodologic approach, which used qualitative focus groups and interviews with 68 Veteran stakeholders to understand patient perspectives on FSS conversations. Given that much research on firearm safety has focused on healthcare providers,^{1, 4} highlighting Veterans' perspectives is novel, important, and highly patient-centric. Several important themes were identified. Notably, and understandably, Veterans do not want to be judged by their providers. This begins by not assuming all Veterans own firearms and extends to refraining from making judgements

about those who do. In a potentially contradictory theme, many Veterans also stated they prefer to not be directly asked about firearm ownership. Yet, if Veterans are not directly asked about firearms, launching directly into FSS discussions may imply that the clinician assumes firearm ownership and thus is not respecting the patient as an individual person. The hesitancy to broach firearm ownership on the individual level was present even in the study procedures; the authors neither asked nor collected data about firearm ownership from the participants, underscoring the fraught nature of this topic.

The second dimension of patient-centered care is “*doctor-as-person*,” recognizing that clinicians have an equally important role and responsibility in patient-centered care as the patient. *Doctor-as-person* acknowledges their dual nature, bringing both clinical expertise and personal experiences to the healthcare encounter, and in turn, influencing care delivery. Such care might require addressing potentially taboo topics (e.g., sexual function, intimate partner violence, firearm ownership), and the ability of clinicians to comfortably do so relies on adequate knowledge of the topic and skilled communication. Only 21% of clinicians report having a firearm in their household (which is disproportionately overrepresented by White male physicians in the South),¹ making the acquisition of factual knowledge about firearms from education even more important. In lieu of life experiences, knowledge and skills can be developed via education and training, such that even without personal lived experiences, clinicians are prepared to address potentially sensitive issues with their patients.

Use of scripts, sometimes embedded as clinical reminders, can help overcome knowledge deficits by providing standardized, concise questions or phrases for use by clinicians. Indeed, many Veteran participants in Dobscha's study supported this approach to increasing FSS discussions in primary care. At the same time, they voiced apprehension that this could feel formulaic or forced, perhaps analogous to clinicians' concerns about rigid guidelines or algorithmic medicine. Patient-centered care is inherently not formulaic, and implementing communication-based interventions in an inflexible manner risks losing the spirit of patient-centered care.⁵ Instead, clinicians should strive to find the crucial, yet difficult, balance between authentic, fact-based, but flexible communication that is attentive to the idiosyncratic nature of the patient-provider relationship.

The third dimension of patient-centered care is “*shared power and responsibility*.” Clinical care continues to shift from a traditional and paternalistic model to a patient-centered model of care. The *shared power and responsibility* between the clinician and patient in the latter model may be especially appropriate for FSS discussions, where Veterans likely have greater life experience and knowledge than their clinicians, with military, if not civilian, training in the use of firearms. Moreover, the transition from the traditional model of care may expand *power and responsibility* beyond the primary care provider, such that they are no longer inherently the most appropriate member of the care team to engage Veterans in FSS discussions. Identification of the best individual within the primary care setting, or perhaps within each team, with whom the patient feels most comfortable discussing sensitive topics could facilitate an adoption of initiatives intended to reduce adverse outcomes from firearms. Within the Veterans Health Administration (VHA), an organization with a substantial Veteran population in the workforce, and the increasing adoption of the VHA’s Whole Health System of Care,⁶ peer counselors who are Veterans themselves provide an explicitly Veteran-centered option for addressing FSS. Veteran participants in Dobscha’s study made this same connection, noting how FSS conversations fit into VHA’s Whole Health approach to well-being. This approach extends the traditional patient-provider dyad, to re-considering the best person to discuss FSS and shifts the focus from “*doctor-as-person*” to thinking more broadly about how to implement patient-centered care within the organizational context.

The fourth patient-centered care dimension is the “*therapeutic alliance*,” which moves beyond a patient-clinician relationship defined solely on diagnosis and treatment to one where the *quality* of the relationship has intrinsic value. Patient-provider communication that is high in shared decision-making and empathy is related to important health outcomes, such as improved chronic condition management and measures of utilization.⁷ Recognizing that a key motivation to integrate FSS discussions into healthcare is to reduce the risk of suicide, we must maintain focus on the humanity and life experiences of those at increased suicide risk. By doing so, we can hope to increase the likelihood that the integration of FSS discussions that are empathetic, builds, rather than undermines, the therapeutic alliance.

The fifth dimension of patient-centered care is the “*biopsychosocial perspective*,” which broadens understanding of healthcare problems to more than just the biomedical components. A traditional biomedical model of disease lends itself to ignoring the larger social or political context within which healthcare problems occur. Some individuals and organizations advocate for clinicians to refrain from discussing political topics,⁸ yet FSS discussions do not happen in an apolitical vacuum. The sociopolitical context and the political beliefs that individuals bring to a healthcare encounter have a direct influence on the provision of medical care.⁴ Specific to the topic at hand, there is an unresolved tension regarding the role

clinicians should have in FSS discussions.⁹ However, if framed as a public health and preventive medicine issue, analogous to the use of seatbelts or bike helmets, and delivered with the five dimensions of patient-centered care at the forefront, it is reasonable to envision inclusion of FSS discussions as part of an evidence-based, data-driven provision of care to improve well-being.

Within this framing of the five dimensions of patient-centered care, Dobscha et al.’s findings support the potential for FSS discussions to be accepted as a practice within primary care settings. Explicit steps for achieving patient-centered FSS discussions are still needed, but using established implementation science approaches could facilitate adoption, such as the identification of essential and adaptable components.¹⁰ For example, while proscribed phrases within a clinical reminder may feel stilted and inauthentic, select phrases that can be incorporated into personalized communication may increase adoption by primary care team members. Another potentially adaptable element is which member of the healthcare team is responsible for FSS discussions, recognizing the variability in knowledge and experience of team members and identifying someone best suited for the task. Furthermore, implementation science is explicitly attuned to the context within which evidence-based practices are occurring. Recognition of and addressing the broader social context within which FSS discussions are supposed to occur can thus improve implementation efforts. While there remain many barriers to the routine inclusion of FSS discussions within primary care settings, a patient-centered, non-judgmental, fact-based approach has the potential to reduce the devastating results of a highly lethal means for suicide by putting the patient and her or his needs at the center of the conversation.

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