# Rounding@IOWA: Better Ways to Talk About Rural Firearm Safety

## Transcript

[Upbeat theme music plays]

**Dr. Clancy**

Welcome to Rounding@IOWA, a continuing medical education podcast developed by and for healthcare teams. I'm your host, Dr. Gerry Clancy, Senior Associate Dean of External Affairs for the Carver College of Medicine at the University of Iowa. Today, we'll delve into discussing firearm safety with patients and family members with a focus on rural settings. For our objectives today, our participants will be able to first Evaluate the specific risk factors, exposure patterns, and cultural perspectives regarding firearm ownership in rural households to be able to conduct home safety risk assessment. Second, utilize evidence-based, non-judgmental communication strategies to counsel patients and families on secure storage options during clinical encounters and high-risk scenarios. And third, integrate standardized firearm safety screening workflows into clinical practice while identifying local community partners and voluntary temporary storage resources for patients experiencing acute mental health crisis or cognitive decline. Our expert guests today are Dr. Marc Doobay and Dr. Charles Jennissen. Dr. Marc Doobay is a clinical associate professor in the Department of Physician Associate Studies and Services and the Department of Family Medicine and Community Medicine at the University of Iowa Carver College of Medicine. He holds a Bachelor of Science from the University of Iowa, a Master's of Physician Assistant Studies from the University of Iowa Carver College of Medicine, and a Doctor of Medical Science from Southern Illinois University College of Medicine. Dr. Charles Jennissen is a clinical professor emeritus in the departments of emergency medicine and pediatrics at the University of Iowa Carver College of Medicine. He holds a Bachelor of Science in Chemistry from St. John's University and earned his Doctor of Medicine from the University of Minnesota Medical School. He completed his pediatric internship and residency at the University of Iowa Hospitals and Clinics and was board certified in pediatrics and pediatric emergency medicine. Marc, welcome to Rounding@IOWA and Chuck, welcome back to Rounding@IOWA.

**Dr. Doobay**

Thank you so much for having us. It's wonderful to be here.

**Dr. Jennissen**

Yeah, Gerry, it's a pleasure to be back on the podcast.

**Dr. Clancy**

Yeah, the first one we did together was great. And I think this one's going to be really important as well. So Marc and Chuck, I just provided our listeners with your official backgrounds. Could you tell me what a typical work week might look like for each of you now? And let's start with Marc.

**Dr. Doobay**

Sure. My work is probably best described as wearing three or four different hats. and occasionally realizing I have all of them on at the same time. My primary academic role in our college is in PA education. I direct our didactic phase of our PA program. So a large part of my week involves teaching and curriculum development, working with our students and faculty, and thinking about how we can better prepare our future PA colleagues for the parts of medicine that are sometimes harder to teach from a textbook, things like communication. We really emphasize professionalism, knowing how to deal with uncertainty and being more preventative in our care, and really kind of trying to hone our clinical judgment skills. I also practice in outpatient family medicine, which is very important to me because it keeps all that educational work tethered to what actually happens in the exam room. There's also a scholarship piece, including work around our rural firearm safety work that we're talking about today, injury prevention work and how clinicians can better communicate about these really sensitive topics.

**Dr. Clancy**

Great, great. Well, that's what some of the best of academic medicine is is being able to do all these different things at once. So you've done a great job. Chuck, I mentioned that you're emeritus, but it doesn't really seem like it. What's a work week look like for you?

**Dr. Jennissen**

Yeah, I officially retired in July of this year, but I am still serving as the Stead Family Children's Hospital's principal investigator for the Injury Free Coalition for Kids, our site here. And so I'm very involved with our injury prevention and outreach program. And I still am doing a lot of mentorship for undergraduates and also medical students who have a bunch of research projects are still going on. I'm still involved with a lot of research. So I'm still spending a lot of time in my office.

**Dr. Clancy**

Yeah, well, we're glad you do. We're glad you do. So firearm safety in rural settings is our topic today. Could you tell us what drew you to this work? How did you come about this as an area that you've been writing about and researching?

**Dr. Jennissen**

Well, I think the biggest thing is that a few years ago now, firearm injuries became the number one killer of young people less than 20 years of age. That was something that kind of woke me up related to this problem. Certainly working in the emergency department, I've seen a number of children who have had unintentional injuries related to people leaving firearms out that were younger, but also how it has impacted now adolescents and their use of them, firearms, and committing suicide. And so that's something, particularly when I had this 11-year-old boy who came home from school, no history of mental health disease, grabbed the family's handgun that was loaded and unlocked, and shot himself within minutes of coming home. He died in the emergency room and it really made a huge impact on me that this is something that could be prevented. It didn't have to happen and I needed to be more involved in doing something about this issue.

**Dr. Clancy**

Sure. Marc, how about you? How did you come about working in this area?

**Dr. Doobay**

Well, I think I, in my kind of early career here as an educator, I really have tried to meet my students where they are in their developmental learning stage. And I try to think of my patient care very similarly. I think what I love about the work that I do and how it's multifaceted is that I think the different pieces really kind of inform each other. The research changes how I talk to patients. Patients change how I teach my students. Students ask questions that make me rethink the research. And I love that cycle of learning and teaching and counseling and care. This work, I think, really piqued my interest when I learned about that real strong mismatch between how familiar firearms are in many rural households and how very unfamiliar many healthcare professionals are with talking about them. In our rural and agricultural communities, a firearm may be a hunting firearm, something used for livestock or predator control, a recreational object. Sometimes it's something that's passed down from a family member, or something that's used for personal protection. But sometimes it's several of those things all at once. And if a clinician enters that conversation without really understanding those meanings, I think we can really quickly lose credibility with our patients.

**Dr. Clancy**

Sure. So finally, before we really delve into the details of the subject, how did you both begin to work together on this topic?

**Dr. Jennissen**

Marc, I'll let you answer that question.

[laughter]

**Dr. Doobay**

Well, I was very fortunate here in our college to be invited to serve on a firearm safety panel for our medical and PA students here in the Carver College of Medicine. They asked me to kind of represent the primary care clinician on the panel. So learning how to kind of discuss with our patients and how to counsel our patients on firearm safe storage in rural homes, but also just across our state of Iowa. And also how to provide anticipatory guidance for families, particularly those with young families and who may be new to firearms in the household or how to navigate firearms in their neighbors or family members' households. That panel really kind of piqued my interest. I started delving deeper into firearm storage practices and the research. And through that work, I learned about our firearm safety task force here at University of Iowa Health Care and Dr. Jennison's robust work in this area. And he seemed like the type of guy I like to work with, somebody who's a little bit quirky, somebody who's very skilled and adept, who's connected, and very passionate about his work. And those are the virtues that I really find myself gravitating towards. So working with him as a mentor and now as a colleague was really a boon for me.

**Dr. Clancy**

It's a good thing you're working together, I can say that. So what does the public health data look like for firearm incidents, morbidity and mortality in rural areas? And how does that compare to urban and suburban areas? What do we know about kind of the public health landscape here?

**Dr. Jennissen**

That's a topic we could talk a long time about, right? I think the US has more civilian firearms than the rest of the world together, I believe. And we certainly have more firearms than we have people, adults and children, civilian firearms. And so this is something that's very prevalent in our society. And as I said earlier, it's become the number one killer in young people less than 20. So this kind of made us kind of look into this. We have done a few now studies related to firearm use and firearms in the home, especially in rural areas.

And so one of the things that we did at the University of Iowa Stead Family Children's Hospital on injury prevention and outreach program is we wanted to do something more about preventing these injuries and deaths. So to start out, we kind of really wanted to look at what the problem is in Iowa as far as storage practices and use of them by rural youth. So we've done a lot of surveys at the state FFA Leadership Conference. FFA used to stand for Future Farmers of America, but now they kind of go just from the acronym FFA. But it's an organization for young people in high school and middle school who are interested in agriculture and leadership. And we have over 270 chapters in Iowa. There's chapters, of course, throughout the country. And so this was a good place for us to reach rural adolescents and find out a little bit more about adolescent storage and use of firearms with this population. And so we surveyed almost 1,400 adolescents at the Iowa FFA conference in 2019. And I wasn't surprised. I grew up on a dairy farm in central Minnesota. I wasn't really surprised that there was a lot of rifles and shotguns and firearms in the home. There was 84% of the adolescents that stated that they had at least one rifle or shotgun in the home. But growing up a number of years ago now in central Minnesota, I didn't really know really many people who had a handgun. And almost three-fifths, 58% of the adolescents said they had a handgun in the home. And when I thought, that's a lot. And I wonder how we compare to this nationally. So at the national FFA conference, we did that a couple of years after that in 2021 and surveyed them across the country. And we found that actually we're a little bit less than nationally. There was 87% of the adolescents in FFA at the FFA national conference said they had firearms in the home, rifle shotguns in the home, and 71% said they had a handgun in the home. So that was, strikingly, we found that those that lived on farms had higher proportions that had firearms in the home, of course, than those that lived in town. And the big thing is that for here in Iowa, around four-fifths of the adolescents said they had at least one firearm stored unlocked or unloaded. So what we would consider not really secure firearm storage. And so that's something that's kind of motivated us to do a little bit more about this issue. And you know, a lot of young people are using firearms. We found that, you know, the majority of them had fired rifles and shotgun, rifle shotguns and also handguns. Like around three-fifths of them had fired handguns as well. And they did so early. 41% of them had fired a rifle shotgun before 9 years of age. And I think for handguns, it was like 44% before age 11. So they're using these frequently and very at young ages. And so we felt that this is something that we really need to work on, especially given the fact that in rural areas, we know that suicides and unintentional injuries occur at a higher rate than for those that live in urban areas. And certainly urban areas, often they talk about homicides because homicides are a huge problem in urban areas related to adolescents and firearms. But in rural areas like here in Iowa, it's really suicides and unintentional injuries that are more of a problem.

**Dr. Clancy**

Marc, a few questions backou commented on the traditional uses of firearms in rural areas such as hunting and pest and predator control and home protection. How does that relate to how firearms are stored, particularly in rural areas? Because these weapons are needed, but at the same time, we would hope they're stored safely, but is there a disconnect there?

**Dr. Doobay**

Yeah, I think this is where context becomes really, really important. If someone owns a firearm primarily for long-term collecting, for example, their storage priorities may be quite different from someone who believes they need rapid access for livestock protection, predators, or personal defense. So from that person's perspective, accessible defense may be precisely why they have the firearm. So our national FFA data to which Chuck alluded illustrates the consequences of that tension. Among adolescents surveyed, nearly four-fifths had a handgun or rifle or shotgun stored unlocked and or loaded at least some of the time, which is very, very impressive. Youth living on farms had greater odds of reporting firearms stored loaded and unlocked than youth living in towns. And I think that distinction about the geographic distribution is really important. So the clinician's job is not to pretend that those competing priorities don't exist. In my opinion, it's to ask who needs access, how quickly, under what circumstances, and who absolutely should not have access. The important distinction is that available to the responsible adult and available to everyone in the household don't have the same meaning. Really modern storage options give us much more room between those two extremes than people sometimes assume.

**Dr. Clancy**

With rural households frequently using firearms for hunting, pest and predator control or home protection, how do these intended uses of firearms dictate storage habits and impact pediatric injuries?

**Dr. Jennissen**

Yeah, I think that one of the things about this issue is that a lot of rural households because of the way they like to use them, their feeling is that they need to have quick access. And a lot of them are not believing that they can actually have them locked and still have them available for those uses. And so one of the things I think that's been important for us is it kind of hopefully kind of help change that, move the needle a little bit related to that, there's lots of storage types that are available now that allow for quick access to the firearms in a way that I think would still meet the needs of rural and other households. This kind of quick access for protection and or for protecting their livestock from a rabid animal that comes into the farmyard. They could still have that firearm locked and secured and

protected from children, yet still have that quick access that allows them to use it the way they want to.

**Dr. Clancy**

Just a little more careful thought into what works. Absolutely.

**Dr. Jennissen**

Marc, would you like to go ahead and say something different? Yeah.

**Dr. Doobay**

No, I guess, you know, just to kind of, you know, from a clinical perspective, I think when we talk about firearms, we use the term, storage, safe firearm storage. And, this nomenclature and verbiage is very, very important. Some people don't want to store their firearms and the idea of like using the verbiage of safe storage sometimes may be off-putting to some families. So sometimes, you know, some verbiage that's now falling into vogue is more about safe firearm staging. So thinking about staging your firearms and again, trying to meet our patients and community members where they are. With staging, that might be very, very similar, but it kind of takes into the context the purposeful and timely use of the firearm for the families in those rural settings and thinking about how to stage their firearm in a way that's safe. The American Academy of Pediatrics recommends storing firearms locked, unloaded, and with the ammunition stored separately from the firearm. Sometimes again, for a family who may be using a firearm for self-defense, that may be a non-starter conversation. So approaching it instead, thinking in terms of firearm staging and what elements of that can we try to implement in that household to ensure that those who are not authorized to have access to that firearm do not get access to that firearm.

**Dr. Jennissen**

And I think that's important, that, and that's true for rural, but also urban. A lot of the urban folks have firearms for protection, and they have that same kind of feeling about staging it and having it available for protection at a moment's notice.

**Dr. Clancy**

Yeah, great. Well, let's get more into the details of some of the phrases and terminology that actually does work and some of the things that don't work. We know that some of your work and others work shows that firearm safety messaging can fail when perceived as politically motivated. What specific non-judgmental language allows physicians and other clinicians to frame lethal means counseling strictly as a routine preventive health

measure? And how might clinicians account for this familiarity when assessing home safety without appearing dismissive of these traditions that are very common in rural areas.

**Dr. Doobay**

I think you're absolutely right. Evidence suggests that firearm safety messaging may be less credible or less well received when it's perceived as politically motivated. Personally speaking, and perhaps I can speak on behalf of Chuck, you know, our work really is not politically motivated. What we're really, really motivated to do here is to reduce unintentional injuries in Iowa.

**Dr. Jennissen**

And suicides.

**Dr. Doobay**

And suicides. I'd start by explaining why I'm asking before I ask, what we tell our students to signpost, right? Something like the go-to verbiage I use is I ask families about a few things in the home that can cause serious injury, things like medications, vehicles, water exposure, and firearms. If there are firearms in the home or places where your child spends time, how are they stored? And that's usually my go-to kind of phrasing and signpost for that question. For me that does several things all at once. It normalizes the conversation, it connects it to injury prevention, and it doesn't begin by demanding that someone declare themselves as a firearm owner. Sometimes another phrase I like conceptually is that I'm not here to tell you whether you should or should not own a firearm. My concern is whether someone who shouldn't have access, particularly a child, or a visitor or someone going through a crisis could get to it. And I want to minimize that risk in your home. That distinction matters for me. In our focus groups, rural Iowa parents specifically expressed skepticism toward politically motivated messages. And health professionals themselves were not automatically perceived as credible firearm safety messengers. So that cultural humility really, really is paramount here. Don't bluff firearm expertise that you may not have. Don't assume the reason for the ownership. And absolutely don't turn a preventative health conversation into some sort of ideological pop quiz for the patient.

**Dr. Jennissen**

I think that it's really important for healthcare providers to kind of just assume that families have a firearm in the home. Start out with that. And if they say that they don't have a firearm, if you're talking about that, I think you say, well, that's great. That's probably the safest way to protect your child from firearms is not having a firearm in the home. But when they say, yeah, we do, you can talk about more secure storage and how they use it and

being able to then just change your advice based on how they use it a little bit. And so if they're using it for protection and they need to have quick access, you can talk about means that you can secure the firearms from children, yet meet those needs that they use the firearm for. I think one of the things is that make certain that it's kind of part of your routine, like Marc said, that this is just one of the safety things that we talk about, like drowning prevention, like wearing bike helmets, like wearing seatbelts. It's just we're not doing it selectively. We do this for everybody. And I think that parents are going to be more likely to accept it if it's understood it's about the safety of their children and adolescents and their family. And that's very important.

**Dr. Clancy**

Keeping the family safe, absolutely. In rural settings, who might be the most trusted voices on promoting firearm safety and who can clinicians work with to kind of broaden the message and say that there's a lot of people that care about this rather than just physician or physician assistant.

**Dr. Doobay**

So I would say our findings were pretty humbling for healthcare providers. Rural Iowa parents and our focus groups identified local law enforcement, firearm dealers and safety instructors, the Department of Natural Resources personnel, and people with lived experience of firearm injury as particularly credible messengers. Familiarity with the local community mattered. Health professionals and university affiliated voices were viewed more skeptically by some participants. And that's consistent with the broader literature. There was a 2026 systematic review that found that peers, veterans, and law enforcement voices often rated highly in firearm harm prevention messaging. And that value aligned and child safety message could improve receptivity, I think the implications is that healthcare doesn't have to own the whole conversation. We may be effective as one member of a larger coalition in that effort. The white coat's good for a lot of things, but apparently it doesn't automatically confer expertise on gun safes. So rather than asking, you know, how do we make people listen to us? I think the more productive question really here should be, who are people already listening to? And then how can we partner with them?

**Dr. Jennissen**

Yeah, I think that's very important. Although families do look at their healthcare provider as somebody they trust, especially their local provider. And so I think that still is an important person to discuss this because they know that as a healthcare provider, we have the best interests of their children in mind. And so I think it becomes really important for us as healthcare providers to be a little more knowledgeable than maybe we have been about

firearms in the past and just being, they don't have to be experts, but getting a little more information by becoming educated, seeking out information like at websites like the American Academy of Pediatrics website. They have a nice section on firearm safety and talking about delivering, discussing secure firearms information with families and even nice videos on this that are on the website. So I definitely would encourage people to look into that.

**Dr. Clancy**

So I want to get a little bit more into the detail of some of the conversations that you might be having with family members. Marc, you previously said that the recommendations are storing firearms unloaded, locked, and separate from ammunition. Are there alternatives? Is there some type of middle ground sometimes when maybe a family member says, but I really have to have access, ready access? Is there other alternatives or suggestions you can work with someone on this?

**Dr. Doobay**

Absolutely. I think the key is to stop treating safety as black and white. I think there are situations, particularly in acute suicide crisis, for example, where temporary storage outside the home may be the safest option. But other than those circumstances, there's a continuum of ways to reduce access, locking the firearm, storing it unloaded, locking ammunition separately. Also limiting who has access to the keys or combinations using rapid access secure storage when it's appropriate, or sometimes even multiple barriers. Clinical guidance really supports open, non-judgmental counseling that includes removal of firearms when appropriate and using personalized, safer storage strategies for families who keep firearms in the home. So I might say there are several ways we can make this safer. What would actually work in your home? I think that shared decision making is really, really important for patients. Theoretically, perfect safety recommendation that someone rejects has zero real world effectiveness. So harm reduction means being very clear about the safest option while still being willing to make it work with the patient on the safest achievable next step. That's not lowering the standard. That's understanding how behavior changes the work we do.

**Dr. Jennissen**

I think that it's really important to be able to discuss compromises. So we might not be able to move a family to the best practices, but we might be able to make them move into a better practice. So maybe because of how they want to use it, they just can't have the, they want to have the firearm loaded and ready to be used. But maybe we can get them moved into some sort of storage that has biometric access or a quick combination access that

they can literally get to the firearm in seconds. And if it's loaded in the firearm, they can still use it in the way that they want to use it for. But it's at least locked and hopefully that will be enough to prevent their children from getting access.

**Dr. Clancy**

Great, great. Well, I know in my field of psychiatry, it is a very common part of our workflow to talk about firearm safety, particularly in the emergency room. But for more generalists, are there workflow strategies to build this into screening during well-child visits and adolescent sport physicals. How do you, Marc, you're in a family medicine clinic. How do you work it into the clinic in the first place?

**Dr. Doobay**

I think the most promising workflows make this routine brief and hopefully easily actionable. One option is universal anticipatory guidance rather than trying to predict who owns a firearm. So for example, you can say we talk with all families about securely storing their medications and firearms because both can become dangerous very quickly if a child or someone in crisis gets access. Then you offer very practical information or a locking device without turning the encounter into an interrogation. The SAFE firearm model is particularly interesting because its core counseling can take less than a minute. That's a SAFE firearm model. In the ASPIRE trial across 30 pediatric clinics and more than 47,000 well visits, adding implementation support to an EHR prompt resulted in counseling plus lock delivery at 49% of visits, compared with 22% with the EHR prompt alone. So those working together over doubled the outcomes there. The workflow matters enormously. So an EHR prompt, a short standardized script, having accessible locking devices and staff who know where they are, and documentation that isn't burdensome are all kind of really, really fundamental here. And the lesson is very familiar to anyone who has worked in primary care. Prevention relies entirely on a clinician remembering the 27th important thing during a 20-minute visit, prevention is going to lose every time.

**Dr. Jennissen**

Now, I would say injuries are the number one killer of young people, under 40. So talking about injuries and the anticipatory guidance at healthcare visits is just so important. And I think a big part of it is that it has to become an important, you have to believe that it's important. And we all went into this to save lives. So if you want to save children's lives, we have to really talk about these injury issues. One of the things I like to talk about related to this is that, secure storage is not a really controversial thing in my mind. I mean, the NRA, the National Rifle Association, one of their tenets related to firearm owners is that if you're a firearm owner, it's your responsibility to make certain that your firearms do not get

accessed by unauthorized individuals. And young people are unauthorized individuals. And so this is really, I don't think, really controversial across the board. We all want to protect children from firearms. And so this is something that we really need to talk about.

**Dr. Clancy**

Great. Let's talk a little bit about adolescents as well. Adolescents today have access to YouTube. They have access to ChatGPT. They can learn all sorts of things that they may know that their parents might not know. And adolescents often know where the firearms are kept at home. How should pediatricians and family medicine docs talk about adolescent firearm safety?

**Dr. Jennissen**

One of the things related to this issue is that what we found in our focus group studies is that a lot of parents, and especially in rural areas, once their children are using firearms, which can be, as we talked about earlier, can be quite young, 7, 8, nine years of age, once they start using them, they basically have free access to them. And I think this is a practice that's a big issue, especially when you're looking at the suicides that are happening and increasing numbers in adolescents and the high proportion that are accomplished through the use of firearms. And so one of the concepts that I would like to discuss is this concept of parents being the gatekeeper of the firearms in the home. This is a concept that a lot of people don't necessarily follow. We found that a lot of people even kind of felt it was kind of a foreign concept. They felt, that they would, they're kind of monitoring this use, but they don't necessarily think of themselves as gate keepers of the firearms. I think it's best if families, parents, if their adolescents, their children are using a firearm, that they actually unlock it, give it to them to use, supervise them as they should, and then once they're done with it, lock it up. And that the adolescents and the children do not have free access, they don't have the keys or the combination. Even if they're, a lot of young people are involved in shooting sports in schools and teams, even then, I think that it's really important really for parents to be the guardians of the firearms, the gatekeeper, if you will, of the firearms in the home that just makes it less likely for a suicide to happen in that family. That's kind of a hard thing to think about that your child might be vulnerable to doing that, but working in the emergency department and I'm sure for you as well, Gerry, how many of these happen with people that had no idea that their child was suffering and was actually thinking about suicide until it actually happens.

**Dr. Clancy**

It is not uncommon. Exactly, Chuck.

**Dr. Doobay**

Can I ask, can I add maybe one thing to that before you move?

**Dr. Jennissen**

Yeah, because I don't think I did answer the question exactly.

**Dr. Doobay**

I mean, I don't know. I mean, I think you did great.

[laughter]

**Dr. Jennissen**

I just made a point that I wanted to make.

**Dr. Doobay**

I do it all the time. All right, well, you know, I think it's very simple. I think, you know, I really think of hidden as a location and I think of locked as a barrier. And those really should not be used interchangeably. You know, there's one classic study out of Harvard School of Public Health, where it showed that among parents who said their child had never handled the household firearm, 22% of children reported that they actually had. Parents often understandably believe that their kids don't know where a firearm is or have never handled it. But those studies really kind of speak to the contrary. And we substantially underestimate our kids' knowledge and access to firearms. Children explore. Adolescents are very, very observant. I have three kids at home. I see this every day. They know where the keys are. They see adults enter combinations. They spend dramatically more time in the home than most of us remember when we're designing our clever hiding places. So I tell parents, you know, don't make your safety plan depend on your kids never finding something. Make it depend on their being unable to access it if they do. That moves the conversation away from whether a child is good or quote unquote responsible and maybe more toward engineering a safer environment for that firearm and for their family.

**Dr. Clancy**

Great answer. Let's talk about some of the specifics of a plan. We've got cable locks and trigger locks. We've got lock boxes and quick access biometric safety or biometric safes. I know some clinics actually provide cable locks. How does clinician knowledge and clinician discussion work around this? How much does a clinician need to know about these things to help a family put together a solid plan?

**Dr. Doobay**

I think clinicians need enough knowledge to discuss the categories, but honestly, I don't think we need every graduating PA or medical student to be an amateur gunsmith or anything to that extent. Cable locks are inexpensive. They're widely available and they're compatible with many firearms. If they're properly installed, they run through the action and prevent the firearm from being loaded or fired. They're also easy for health systems to distribute. Lock boxes provide actual containment and can work particularly well for one or a small number of firearms. They may use a key, sometimes a combination. Some more sophisticated ones may have an electronic keypad or even biometric access. Larger safes can secure multiple firearms and other equipment and often greater protection from unauthorized access or theft, but they can be more expensive, certainly less portable, and require more space in the home. Trigger locks are another compact option, although like cable locks, they don't provide the containment of a locked box or safe. Electronic or biometric systems may allow faster authorized access, as we mentioned earlier, which may make them more acceptable to someone who owns a firearm for protection. But the device's quality and their user preferences vary quite dramatically. So rather than declaring one device universally best, I would ask, what are we protecting against? Who needs legitimate access? What device will this family reliably use?

**Dr. Jennissen**

Those are all good points Marc made. I think one of the things is that cable locks and trigger locks, they're pretty good protection for preventing young people, you know, younger children from having unintentional injuries. But as far as like suicide prevention with adolescents, I would not rely on those. It's pretty easy, especially in rural areas, a cable cutter. I mean, those are pretty ubiquitous on farms. That wouldn't be hard for them to get into it or hammer to smash the trigger lock and still get into it. So like Marc says, who are we protecting from? So for younger children, those trigger locks, the cable locks, if they're going to use those reliably, they might work. But for adolescents and preventing suicide, certainly other modes of securing the firearm is going to be better. So it depends a lot. I do agree that we don't need to be experts, but we need to be knowledgeable of what these are and being able to talk a little bit about it and what might be best for a family to use based on how they want to, how they use the firearm.

**Dr. Clancy**

Sure. You know, it's clear that you had some success with FFA, both at the state level and national, because they let you participate and build a survey out there. Are there other youth programs in rural areas that you can work with as far as messaging and partnering with? Who do you recommend?

**Dr. Doobay**

One of the clearest messages from our rural parent focus group work was don't build an entirely new communication ecosystem if there's a trusted one that already exists. Participants specifically suggested integrating firearm safety education into these existing structures such as FFA, 4-H, the public school system, local firearm safety programs, our agricultural extension office partners, and other community settings. Those organizations have advantages that health systems simply don't. They have familiarity, repeated contact, local credibility, and in some cases some actual firearm expertise. I can imagine a health system contributing the injury prevention and suicide prevention science while hunter educators, firearm instructors, our law enforcement partners, those extension personnel, and even our youth organizations help ensure that the language and the practical recommendations make sense to our target audience. That relationship should be bi-directional. The medical community should not arrive saying, here is the curriculum we designed for you. And we should be asking, what do you actually teach, what is working, where are the gaps, and what can we contribute? That partnership is more important than, say, public health tourism.

**Dr. Jennissen**

I think trying to convince these organizations that this is an important issue and that they can be part of the solution is incredibly important. A lot of these organizations may not feel like this is necessarily their lane, but I think it's important for us to be able to kind of discuss with them how they're perceived as important potentially partners in this and that they can make a difference by helping to decrease firearm injuries.

**Dr. Clancy**

Great, great. What should rural clinicians and all clinicians know regarding state-specific child access prevention laws and medical confidentiality when you're having that conversation about firearm safety with patients and their parents?

**Dr. Doobay**

Well, first, clinicians need to recognize that these laws vary considerably from state to state. So we should be cautious about giving legal advice from memory. I'm certainly not an attorney, and I don't pretend to be one. But for our Iowa state specifically, the 2026 code makes it unlawful under defined circumstances to leave a loaded firearm unsecured when the person knows or has reason to believe that a child under 14 is likely to gain access. The child gains access without lawful permission and then unlawfully exhibits the firearm publicly or uses it to cause injury or death. That's from the Iowa General Assembly. The statute identifies a trigger lock, locked box or container or another location to be a

reasonable option with regard to secure storage from a child as a means of securing it. That's important because Iowa's statute is not identical to broader safe storage statutes in some other states. With regard to confidentiality, firearm information is not some separate category of clinical information that automatically leaves the medical record. Iowa's physician standards require confidentiality of patient information except where disclosure is authorized by law, authorized by the parent, or if it's required for patient care, again, also from the Iowa General Assembly. Nationally, current clinical reviews note that the clinicians may ask about firearms when it's relevant to patient or household safety. So I think we need to ask clinically relevant questions, protect confidentiality normally, know the exceptions relevant to imminent safety concerns, and don't improvise state firearm transfer law if you don't know it.

**Dr. Jennissen**

We do know that states that have stronger CAP laws, child access prevention laws, do have lower rates of child and adolescent injuries and deaths related to firearms. But I guess when you're talking with the families, you know, we know that a lot of rural families are not that interested in having CAP laws be. But we do have a CAP law. But the only thing is that it really isn't apply unless the child actually shows the firearm to other people or somebody actually gets hurt or dies from use of that firearm. So it's weaker than some states, but some states have no CAP law at all.

**Dr. Clancy**

I want to turn to two high-risk situations and what clinicians can do in those conversations during those high-risk situations. The first being acute suicidality and what should that conversation look like between clinician and family or patient. And the other would be someone with cognitive decline. And again, now things have changed at home and the risks are up higher and the conversation around firearm safety needs to go to a new level. How do you broach both those areas of higher risk and that we need something more secure than what we've had in the past?

**Dr. Doobay**

This is where the conversation has to become much more direct. If someone has a significant suicide ideation or is in an acute crisis, you have to ask specifically about firearm access, not simply ownership. Are there firearms at the home, in a vehicle, in an outbuilding, at work, or somewhere else where they can get readily easy access? When feasible and lawful, temporary out-of-home storage during that period of elevated risk provides the strongest separation from lethal means. Options might include a lawful trusted person or a firearm retailer or range, law enforcement storage where it's available.

But the legal requirements differ by jurisdiction and have to be checked locally. If out-of-home storage isn't feasible, enhanced in-home security can still add meaningful protection. Firearms locked and unloaded, ammunition secured separately, and critically, the person at risk should not control the key, combination or any other access means. This isn't about punishment. It's about making a temporary crisis harder to convert into an irreversible event. In my clinic, I also work in geriatric medicine. I would frame this similarly to driving in a patient who may have some cognitive decline. You need to start the conversation before the crisis forces the conversation. Early in cognitive decline, we should ask whether firearms are present, how they're stored, who has access, and whether there have been any changes in the patient's judgment or their behavior, their mood, if there's any paranoia or impulsive activity or behaviors. The published geriatric literature recommends reassessing that risk as cognition changes and involving the family or other trusted people in that planning process.

**Dr. Jennissen**

Yeah, I was going to say that a lot of times, as health care providers, we may not know what the options are for firearms to be stored outside of a home. And that could vary where people live. But I think most county sheriff's departments, if you get them involved, they will take care of it and store that firearm. So it's always, if you don't know what the other options are, contact the county sheriff's department in your area.

**Dr. Clancy**

Yeah, I would agree. I've had lots of very helpful conversations with the sheriff’s deputy in the emergency room saying, we're putting together a plan here and can you be helpful? And never have we been turned down. They can be very, very helpful. And on the phone as well. It doesn't have to be face to face as well.

**Dr. Doobay**

I think language matters. I think if we cannot tell grandpa, we're taking your guns away. The conversation has to be more about validating and that you've always cared about handling these responsibly. How do we make sure they continue to be handled responsibly if your health changes? I think that gives them some degree of ownership and empowers them in that moment. And again, I find that when I have those shared conversations with the patient, I just have far better health outcomes.

**Dr. Clancy**

Couldn't agree more. Marc, at the beginning you talked about having a lot of access to the physician assistant students and really working on those deeper skills than just being able

to listen to the heart and take the blood pressure and such. For PA students, nurse practitioner students, medical students, and residents, oftentimes don't get a whole lot of training on what we're talking about here today. What advice do you have for the medical schools and the residency programs as far as this conversation?

**Dr. Doobay**

Well, firearms are absolutely a health topic. I think that sometimes can be a bit of a light bulb for a lot of folks, but I want to make sure that that's crystal clear here. I would focus on training our students as being competent, not necessarily encyclopedic firearm experts here. A clinician should understand epidemiology well enough to recognize who's at risk. They need to know how to ask about access without casting any judgment. They should understand the major categories of secure storage and how to meet our patients where they are and fitting those needs that they need in their home. Being able to use our motivational interviewing skills on which we're trained and harm reduction principles. Know how firearm access changes our suicide risk, and to understand the basics of legal means counseling. Recognizing cognitive decline, interpersonal violence, our pediatric access of our own children, but also children of other parents who may be visiting our home and also knowing some familiarity with the homes in which we're sending our kids. And we need to have some degree of acute crisis training as an important clinical context. We need to know where to find accurate local legal storage resources. I think importantly, though, learners need to practice. We need to give them standardized patient cases. Let them say the words out loud. Let someone respond, why are you asking me that? And then force the learner to answer respectfully. Because clinicians consistently report that a major obstacle isn't the opposition to the idea. It's that they don't know what to say or what to do with the answer once they are in that situation. In one study of residents and fellows, 72% said they would not know what to do with information about firearm access. About half didn’t know how to initiate the conversation or identify risk. And then two-thirds cited a lack of time. We don't need to train our colleagues to be firearm experts. We need to train them not to become silent when a firearm becomes clinically relevant.

**Dr. Clancy**

Yeah, very much so. Chuck?

**Dr. Jennissen**

Yeah, I think that this is not an area that we've talked a lot about in the past in education. I think our students are interested in this. They realize this is a major problem, but they don't have the education, they don't have the knowledge, and they want to have it. So we need to try to incorporate this into our curriculum. And as I said, I think the big thing Marc said

about even practicing, being able to work on that, to be better communicators, and being better at communications and talking about firearms is going to help them be better communicators and talking about everything that we need to talk about as healthcare providers.

**Dr. Clancy**

Marc, that's one of the things I do often with particularly third and fourth year students when we're up on the floors doing consults. Before we go into the room, I make the resident or the students say out loud what they're going to discuss. Have it come out of your mouth in front of me first. And it always goes better the second time. It really does. Circling back to the cognitive decline presentation as well. I'm seeing much more often now of an acute presentation where family members have brought a parent in and said, they can't be alone anymore. And it's in the emergency room that the dementia is being diagnosed, unfortunately. But that's your time to have that conversation as well. And so you have to have the conversation around not driving. You have to have the conversation about safe storage as well, because things have changed enough that you can't ease yourself into this conversation. You've got to have it right now.

**Dr. Jennissen**

Yeah, I think that it's important for people to realize that firearms in this patient as the things to talk about. They might not think of that as being an issue, but it obviously is.

**Dr. Clancy**

Yeah. And I pair those two together, driving and firearms together. As you both had said, in general, we're talking about child safety. Well, in general, we're talking about older patient safety in all these areas. You know, I want to circle back again to just a little bit more on clinicians and what you were talking about, Marc. As you said, some clinicians avoid asking about firearms due to fear of patient pushback or their own lack of knowledge. What advice do you have then for clinicians to kind of overcome this barrier in themselves as far as having that conversation?

**Dr. Doobay**

Well, first, I think we should really take a moment and stop just to distinguish between what may be actual patient resistance and the resistance we're imagining on the patient's behalf. National surveys suggest firearm owners are often more receptive to clinically relevant conversations than clinicians assume. In one survey, about 80% of firearm owners believed clinicians should sometimes or always discuss firearm safety when a patient or family member was at risk for suicide. Again, 80% of firearm owners believed clinicians

should sometimes or always discuss firearm safety in those situations. Receptivity is substantially higher when there's an obvious clinical reason for the discussion. So I think that's really paramount here. Second, you don't need to pretend to know everything about firearms. I think in fact, humility can help. I will oftentimes say, you probably know considerably more about firearms itself than I do. I just admit that up front because I want them to kind of know where I'm coming from and the basis of the conversation. I don't want to fake it. And then I say, my expertise is what happens medically when someone who shouldn't have access gets access. Can we talk about how yours are stored? That's an honest division of expertise. And finally, I like to have a script and a plan in place. Clinician anxiety rises when we think, what happens if they say yes or no. In your next two or three questions, you don't really know how to kind of navigate when they respond in a way you don't anticipate. You need to know the basic storage options. You need to know where the locks are. You need to know how the local crisis and temporary storage resources are utilized in your community. This is just like knowing your consult services in the hospital system. Confidence usually doesn't precede practice in my experience. Unfortunately, medical education has never discovered a way to become comfortable having a conversation without actually having the difficult conversation.

**Dr. Clancy**

I would agree. I used to teach that part of the curriculum how to have a difficult conversation. So yeah, absolutely. And as you said before, it's all about actually forming the words and forming the thoughts and actually delivering the message ahead of time to yourself so you know you're organized. Yeah. Well, you've both been great. I've learned a lot. As we finish up, what are some of the take home points you'd like to leave with our listeners? And Marc, let's start with you.

**Dr. Doobay**

Okay, again, thanks for having us. Key take home points here, I mean, there are so many and hopefully our listeners will get a lot out of this conversation. First, rural firearm injury isn't simply an urban firearm problem occurring somewhere else. The epidemiology is different, particularly because firearm suicide carries such a large burden in our rural communities. And Iowa has a lot of rural communities. Prevention has to reflect that reality. Second, I would say familiarity with firearms is not the same as protection from firearm injury. Rural youth may begin using firearms very young and may have substantial experience, but access and storage still matters even in those situations. A hidden firearm is not a locked firearm, and training does not eliminate the need for secure storage. And third, I would say how we communicate matters almost as much as what we communicate. Our own work with rural Iowa parents makes that very clear. People who

deliver the message, whether that person understands their community, whether the recommendation fits real life, whether the conversation feels like safety, counseling, or political judgment, these are all things we need to be asking ourselves.

**Dr. Clancy**

Yeah, great. Chuck, how about you?

**Dr. Jennissen**

I would say that firearm safety and injury prevention is in our lane. And it is something that is a, I said the number one cause of deaths in young people. And so we should all want to be part of the solution. And I think even if you don't feel comfortable talking about this, get yourself educated enough that you feel comfortable and to do it. I think make this a priority in your regular healthcare anticipatory guidance and be part of the change here to help protect our young people from firearm injuries and deaths.

**Dr. Clancy**

Well, that was a great session. Thank you both so much for joining us today and for your great work in preventing injuries.

To our listeners, thank you for joining us for this session of Rounding@IOWA. You can access show notes and instructions for CEUs and CME credits in the show notes, and we look forward to you joining us again on Rounding@IOWA.