

Firearm Injury Prevention in Undergraduate Medical Education in the United States: Current Landscape, Barriers, and Future Directions

CHRISTOPHER CHANG, ScB; ANWEN LIN, BA; MICHAEL BRENNAN, BS; MAGUIRE ANUSZEWSKI, BA;
MICHAEL MELLO, MD, MPH; ANITA KNOPOV, MD, MEHP

ABSTRACT

BACKGROUND: Firearm injuries remain a leading cause of preventable death in the United States (US), with physicians uniquely positioned to contribute to firearm injury prevention (FIP). Despite this, there is a lack of recent national assessment of FIP inclusion in US undergraduate medical education (UME). Thus, we looked to assess how medical schools currently incorporate FIP into curricula and what challenges affect its implementation.

METHODS: We distributed a REDCap-based survey to medical education leadership at all LCME- and COCA-accredited medical schools in the US between April and December 2024, assessing FIP curricular content, timing, modes and settings of instruction, assessment strategies, extracurricular opportunities, and perceived barriers to implementation.

RESULTS: Fifty-five institutions (27%) responded, with 64% reporting the inclusion of FIP content in their curricula. Most schools (62%) introduced FIP during clinical years, particularly in pediatrics, emergency medicine, and surgery, and some schools (51%) integrated content preclinically. Common curricular topics included firearm safety counseling, access screening, and identifying risk factors. Only 27% of schools reported formally assessing FIP knowledge. The most frequently cited barriers to implementation were limited curricular time and political/ideological concerns.

CONCLUSIONS: Our findings suggest encouraging progress in the incorporation of FIP education within UME compared to the most recent previous data, but they also highlight significant variability and persistent gaps. Broader adoption of standardized FIP curricula, earlier integration during training, and development of robust assessment strategies may enhance awareness and preparedness among future physicians to address firearm injury as a vital public health issue.

KEYWORDS: undergraduate medical education; firearm injury prevention; curriculum reform; national survey

INTRODUCTION

In 2023, approximately 46,000 people died from firearm-related injuries in the US.¹ Over 96% were due to suicides or homicides, representing the leading cause of preventable death in the US.¹ Physicians have an essential role in firearm injury prevention (FIP), as they frequently encounter the physical and psychological consequences of firearm-related trauma in clinical practice.² At various institutions, students are taught to ask about firearm safety and counsel patients on FIP. However, training on FIP has been inconsistently addressed in medical school, resulting in a lack of preparedness among physicians to discuss these topics with their future patients.³ A 2016 systematic review that included articles from the 1960s to 2014 from PubMed, Scopus, Google Scholar, PsycInfo, EMBASE, and MedEdPortal databases found that FIP training is rarely incorporated in graduate and undergraduate medical education (UME).⁴ Resident physicians also report having inconsistent and insufficient discussions about firearm storage and injury prevention.⁵

Integrating FIP training into UME is a critical upstream intervention to address this gap. Early and structured training can equip future physicians with the knowledge and confidence to incorporate FIP into clinical care. While several institution-specific FIP curricula have been developed,^{6,7} evidence is limited on the broader implementation of FIP education in medical schools. Additionally, while national consensus-driven priorities for firearm injury prevention (FIP) education exist—including training in the identification of firearm-related risk in clinical encounters, development of counseling strategies for high-risk patient populations, appropriate documentation practices, and follow-up or referral pathways—there is no formal Liaison Committee on Medical Education (LCME) requirement specific to firearm injury prevention. As a result, no standardized curricular framework exists defining the required content, structure, or instructional methods for FIP training in undergraduate medical education, and current implementations vary widely in their balance of didactic instruction, case-based learning, and skills-based or simulation training. Nevertheless, understanding the depth and nature of FIP incorporation in UME is essential for identifying gaps, optimizing educational models, and promoting widespread adoption of FIP training.

In this study, we surveyed curricular leadership at US medical schools to characterize the national landscape of FIP education. We limited our survey to institutions with formal UME accreditation—Liaison Committee on Medical Education accreditation for MD programs and Commission on Osteopathic College Accreditation (COCA) accreditation for DO programs—because these bodies establish standardized curricular expectations and competencies. Accordingly, accredited programs represent the settings where systematic integration of firearm injury prevention education would most likely occur first. Specifically, we examine the prevalence and characteristics of FIP content in undergraduate medical curricula, providing insights into current practices and identifying opportunities for future development.

METHODS

The Lifespan Institutional Review Board determined that this study met the criteria for exempt status. Between April 2024 and December 2024, we distributed an email linking to an online REDCap survey to faculty responsible for medical education at 160 LCME-accredited allopathic and 41 COCA-accredited osteopathic medical schools in the US. Because the institution was the unit of analysis, we sought one response per medical school from an individual in a role expected to have broad knowledge of the undergraduate medical curriculum. Primary contacts were identified from publicly available institutional websites and selected based on the leadership position most closely aligned with medical education or curriculum oversight, such as Dean or Associate Dean of Medical Education, curriculum dean, curriculum chair, or an equivalent role. Faculty names and email addresses were obtained from institutional websites when available.

The survey invitation described the study purpose, identified the survey as a national assessment of firearm injury prevention education in undergraduate medical education in undergraduate medical curricula, and included a link to the REDCap survey [Supplemental Digital Appendix 1]. We initially sent up to three email invitations or reminders to the primary institutional contact. For institutions that did not respond after these initial attempts, subsequent survey waves included a secondary contact, when available, who also held a medical education or curriculum leadership role. In total, three initial rounds of emails were sent to primary contacts, followed by five additional survey waves that incorporated secondary contacts. The timing and number of responses by survey wave are summarized in Supplemental Table 1. [Editor's note: Email corresponding author for all supplemental material and appendices.]

Our survey gathered data on the FIP curriculum, including implementation timing, assessment strategies, whether the curriculum was required or elective, curriculum components, instructional methods, and coverage of topics such as

general injury prevention, gun violence, firearm access, and risk modification strategies. It also collected demographics of the schools (osteopathic vs. allopathic, public vs. private, geographical location), key components of firearm injury prevention (FIP) curricula, the timing of FIP topic introduction in the curriculum, future FIP initiatives at each institution, and perceived challenges in expanding or implementing FIP curricula. The survey assessed curricular timing and instructional modality but did not quantify the instructional “dose” of FIP education. Respondents were asked whether FIP content was included in the preclinical curriculum, clinical curriculum, or both, and to identify broad instructional formats such as lecture, small group, self-directed learning modules, OSCEs, or other approaches. We did not ask respondents to report the number of contact hours, number of sessions, frequency of exposure, longitudinal reinforcement, or amount of supervised skills practice devoted to FIP education. This decision was made to limit respondent burden and preserve feasibility for an initial national survey of curriculum leaders. Additionally, opportunities for student engagement outside the formal curriculum were assessed.

No formal screening questions were used. Eligibility was determined a priori based on the respondent's publicly listed leadership role in undergraduate medical education or curriculum administration. No institution submitted more than one response; therefore, no duplicate institutional responses required reconciliation or adjudication. Because the institution was the analytic unit, the primary response rate was calculated at the institutional level as the number of responding schools divided by the total number of eligible LCME- and COCA-accredited medical schools.

The survey was developed to characterize institutional-level FIP curricular practices and was not intended as a formally validated psychometric instrument. The survey was critically reviewed by educational leadership at The Warren Alpert Medical School of Brown University and was piloted among the medical student authors (CC, AL, MB, MA). No formal reliability testing was performed. Because the study sought one institutional response per medical school, interrater reliability between multiple respondents from the same institutions could not be assessed.

Survey data were collected and managed using REDCap electronic data capture tools hosted at Brown University.^{8,9} Written responses were collected regarding additional institutional initiatives for injury prevention and perceived barriers to implementing FIP curricula. Descriptive statistics were conducted using RStudio.

RESULTS

Education leadership of 55 of 201 (27%) US medical schools completed the survey. Forty-nine (89%; [49/55]) were allopathic institutions and 6 (11%; [6/55]) were osteopathic; 28 (51%; [28/55]) were public and 27 (49%; [27/55]) private.

Geographically, 18 (33%; [18/55]) were located in the South, 15 (27%; [15/55]) in the Midwest, 12 (22%; [12/55]) in the Northeast, and 10 (18%; [10/55]) in the West [Table 1]. Thirty-five institutions (64%; [35/55]) reported inclusion of FIP content in their curriculum, 12 (22%; [12/55]) did not, and 8 (15%; [8/55]) were unsure [Table 2]. One institution responded “no” to the survey item—“Does your curriculum cover firearm injury prevention, gun violence, firearm access/risk modification?”—but provided details on FIP-related curriculum components and how the curriculum was taught and was therefore included in subsequent analyses.

Overall, 34 schools (62%; [35/55]) indicated the presence of FIP content during their clinical years, while 28 (51%; [28/55]) reported delivering FIP instruction during their pre-clinical years. Of those with FIP curricula, 29 (83%; [29/35])

described it as part of required didactics, and 2 (6%; [2/35]) as elective coursework [Table 2]. The most frequently reported curriculum component was counseling on firearm safety and storage (53%; [29/55]), followed by firearm access screening of patients (47%; [26/55]), identification of

Table 2. Overview of Firearm Injury Prevention Educational Offerings Among Respondents

Does your curriculum cover firearm injury prevention, gun violence, firearm access, or risk modification?	n (%) ^a
Yes	35 (64)
No	12 (22)
Unsure	8 (15)
Year curriculum is taught?^b	
Only preclinical	13 (24)
Only clinical	19 (35)
Both preclinical and clinical years	15 (27)
N/A	8 (15)
Is the curriculum a required didactic or an elective?	
Required didactic	29 (53)
Elective	2 (4)
Unknown	24 (44)
Are there ways to assess students on the content?	
Yes	15 (27)
No	25 (45)
N/A	15 (27)

Abbreviations: N/A, not applicable; FIP, firearm injury prevention.

^a Percentages are based on total respondents (n = 55) and rounded to the nearest whole number.

^b When respondents selected both a stage (“preclinical” or “clinical”) and “N/A,” they were categorized by their stage selection. The “N/A” group included only those who selected “N/A” exclusively or made no selection.

Table 1. Demographics of Responding U.S. Medical Institutions

Type of Medical School (N=55)	n (%) ^a
Osteopathic	6 (11)
Allopathic	49 (89)
Public versus Private	
Public	28 (51)
Private	27 (49)
Geographical Region^b	
Northeast	12 (22)
Midwest	15 (27)
South	18 (33)
West	10 (18)

^a Percentages are based on total respondents (n = 55) and rounded to the nearest whole number.

^b Geographical regions were determined using definitions from the U.S. Census Bureau.

Table 3. Specific Educational and Assessment Strategies and Clinical Rotation Details for Firearm Injury Prevention Curriculum Among Respondents

Question	Respondents, N	Response, n (%)
How is the curriculum taught? ^a	55	Lecture, 27 (49); Small group, 20 (36); Self-directed learning module, 6 (11); OSCE, 2 (4); Other, 18 (33); Unsure, 5 (9); None, 11 (20)
What components related to firearm injury prevention are included in your curriculum? ^b	55	Epidemiology, 23 (42); Identifying at-risk individuals and risk factors, 24 (44); Firearm access screening questions, 26 (47); Firearm safety and storage counseling, 29 (53); Acute treatment and hospital course for firearm injuries, 19 (35); Pre-hospital treatment for firearm injuries, 11 (20); Firearm policy, gun laws, public safety, 14 (25); Unsure, 7 (13); None, 11 (20)
How are students assessed? ^c	15	MCQ/quiz/exam, 10 (42); OSCE, 4 (17); Discussions or reflection, 5 (21); Faculty evaluation, 5 (21)
Which rotation(s) is the material covered in? ^d	34	Pediatrics, 20 (59); Family medicine, 7 (21); Emergency medicine, 8 (24); Surgery, 10 (29); OB/GYN, 1 (3); Other, 10 (29)

Abbreviations: OSCE, Objective Structured Clinical Examination; N/A, not applicable; MCQ, multiple choice questions; OB/GYN, obstetrics/gynecology.

^a Schools were asked to select all applicable methods of formal instruction; one school responded “No” to the survey question - “Does your curriculum cover firearm injury prevention, gun violence, firearm access/risk modification?” - but still provided details for a curriculum and thus were included in this table.

^b Respondents were instructed to select all applicable components; one school responded “No” to the survey question - “Does your curriculum cover firearm injury prevention, gun violence, firearm access/risk modification?” - but still provided details for a curriculum and thus were included in this table.

^c This question was presented as a free-response text box (n = 15) where respondents could provide any applicable information. Responses were categorized and independently evaluated by three team members (CC, AL, MB), with conflicts resolved through discussion. Percentages are calculated based on the total number of respondents.

^d This was a free-response text box (n = 34) that asked “Which rotation(s) is the material covered in?” Responses were categorized and independently evaluated by three team members (CC, AL, MB), with conflicts resolved through discussion. Percentages are calculated based on the total number of respondents.

Table 4. Challenges, Reported Barriers, Extracurricular Opportunities, and Future Plans for Firearm Injury Prevention Education in Medical Curricula

Question	Respondents, N	Responses, n (%)
What are the perceived barriers to implementing this curriculum? ^a	44	Lack of time, 27 (61); Lack of time and lack of expertise, 3 (7); Lack of time and political/ideological challenges, 3 (7); Lack of expertise, 4 (9); Lack of expertise and political/ideological challenges, 1 (2); Political/ideological challenges, 6 (14)
Are there other engagement opportunities outside of the curriculum to practice this topic? ^b	55	Community engagement, 19 (35); Department of Health elective opportunities, 6 (11); Injury prevention centers elective opportunities, 7 (13); Other, 5 (9); N/A, 26 (47)
Are there current efforts to expand the firearm injury prevention curriculum at your medical school?	55	Yes, 23 (42); No, 32 (58)

Abbreviations: N/A, not applicable.

^a This question was presented as a free-response text box (n = 45) where respondents could provide any applicable information. Responses were categorized and independently evaluated by three team members (CC, AL, MB), with conflicts resolved through discussion. Percentages are calculated based on the total number of respondents.

^b Respondents were instructed to select all applicable components.

risk factors and at-risk individuals (44%; [24/55]), epidemiology of firearm-related injury (42%; [23/55]), acute clinical management (35%; [19/55]), firearm policy education (25%; [14/56]), and pre-hospital care (20%; [11/55]). Pediatric rotations were the most common setting for FIP discussions, followed by surgery, emergency medicine, family medicine, and obstetrics/gynecology. Fifteen institutions (27%; [15/55]) reported formally assessing students on FIP-related content. The most commonly employed assessment methods were multiple-choice examinations, followed by in-class discussions, faculty evaluations, and Objective Structured Clinical Examinations (OSCEs) [Table 3].

Of those schools reporting perceived barriers to implementing a FIP curriculum, the most common response was lack of time alone (61%; [27/44]), followed by political/ideological challenges (14% [6/44]), and lack of expertise (9%; [4/44]). Extracurricular opportunities related to FIP were also reported. The most prevalent were community engagement (35%; [19/55]), followed by participation in injury prevention centers (13%; [7/55]), and collaboration with local health departments (11%; [6/55]). Twenty-three schools (42%; [23/55]) reported ongoing efforts in expanding or implementing FIP curricula at their institutions [Table 4].

DISCUSSION

Encouraging Trends in Firearm Injury Prevention Education Implementation

Most responding schools reported incorporating FIP content in our study, demonstrating substantial progress from earlier reports that suggested minimal integration of such prevention topics in medical education.^{10,11} Interestingly, even among the 15% of institutions that were “unsure” about having an FIP curriculum, their qualitative responses showed incorporation of FIP in their preclinical curricula and their clinical rotations, particularly in surgery, emergency medicine, family medicine, and pediatrics. Hence, our study demonstrates that FIP education appears to occur

organically in clinical settings without formalized curricula. Still, schools may benefit from comprehensively reviewing their clinical curricula to identify and formalize FIP content, ensuring consistent messaging and coverage of content throughout relevant clerkships. Encouragingly, almost half of the respondents reported ongoing efforts to expand or implement FIP curricula at their institutions.

Opportunities for Improvement

In our study, FIP was more likely to be integrated into the clinical curriculum rather than the preclinical period, although it was often taught in both. However, clinical rotations represent students’ first extensive patient encounters and carry additional cognitive demands for students.¹² During the clinical years, students have important roles in managing complex patient care and may have limited capacity to absorb new content on FIP. FIP training in preclinical years can build knowledge of epidemiology, risk factors, and evidence-based counseling approaches for FIP, helping students recognize teaching moments during clinical rotations. Medical schools should consider introducing FIP training earlier in the curriculum.

Pediatrics, emergency medicine, and surgery clerkships were the most common clerkships in which FIP was discussed in our study. While these specialties have frequent exposure to firearm injuries and represent important settings for FIP discussions, a lack of FIP discussions and integration in other clerkships poses a missed educational opportunity. For instance, primary care physicians are uniquely positioned to routinely conduct screening and counseling for firearm safety, given the frequency with which they see their patients and the fact that primary care physicians regularly screen for various hazards.¹³ Similarly, geriatricians routinely counsel elderly patients on driving safety, yet very few patients receive counseling on firearm safety, despite the increased risk for firearm-related suicides among patients with cognitive decline.¹⁴⁻¹⁶ Moreover, given well-established linkages between firearm access and suicide risk,

FIP education in psychiatry clerkships presents a valuable opportunity to learn more about identifying high-risk patients and counseling them accordingly.^{13,17}

Most schools did not formally incorporate FIP content or FIP-related assessments into their curricula. Although medical school assessments have well-documented issues, they remain important for student learning.¹⁸ Additionally, lacking assessments may inadvertently communicate to students that FIP knowledge is less important or clinically relevant than other topics that are regularly tested in medical school.

Similar to a 2020 LCME survey, our study finds that examination was also the most common method for assessing FIP knowledge.¹⁰ The reliance on multiple-choice questions for assessing FIP knowledge may inadequately capture the complex communication and counseling skills required for effective patient interactions. FIP discussions often involve sensitive topics that require cultural competencies, empathy, and navigation of patient resistance. These skills may be better evaluated through OSCEs or observed clinical interactions rather than written examinations.

Implementation Barriers

Most medical school leaders reported that time constraints were a major barrier to implementing FIP education, likely reflecting curricular overcrowding in medical education.^{19,20} However, FIP content does not need to displace existing didactics; rather, FIP content could be integrated into existing courses on epidemiology, public health, preclinical courses that teach medical history taking, and clinical clerkships. Additionally, our study shows that many medical schools integrate FIP content through community engagement programs. Extracurricular approaches may help supplement the formal curriculum without competing for valuable classroom time. Community-based FIP education provides an opportunity to explore community perspectives and may help improve clinical practice and community-level health literacy.²¹

Another common barrier was the presence of political/ideological challenges. In many states, physicians are discouraged from asking patients about firearms.³ Medical schools could frame FIP education in terms of objective scientific data and from a patient safety perspective,²² similar to how medical education has historically addressed other sensitive topics.

Limitations and Future Directions

This study had several limitations. Our response rate of 27% is lower than that of previous institution-based surveys in medical education—a source of potential nonresponse bias.²³ Some medical schools (e.g., in states with greater political barriers, with less robust FIP curricula) may have been less likely to respond. Thus, the results of this study may overstate the prevalence of FIP in US medical schools. All data

were self-reported; we could not verify reported curricula or implementation quality due to respondent anonymity. Our study was subject to all other limitations of survey research, including potential bias due to wording or phrasing. Additionally, we sought a single response per institution, we could not compare responses between multiple respondents from the same medical school. Because curricular documents are not uniformly publicly available and responses were anonymous, we could not independently verify reported FIP content, curricular timing, or assessment practices. Therefore, our findings should be interpreted as self-reported institutional practices among responding schools rather than externally audited measures of curriculum implementation or quality. Lastly, we did not assess the quantitative dose or intensity of FIP instruction, including contact hours, number of sessions, frequency of instruction, longitudinal reinforcement, or supervised practice opportunities. As a result, schools reporting the same instructional modality may have delivered substantially different levels of training. For example, “lecture” could range from a brief mention within another session to a dedicated required didactic, and “small group” could reflect either limited discussion or structured skills-based practice. Future surveys should collect more granular information on curricular dose and should examine whether instructional intensity or skills-based modalities are associated with learner outcomes. Broadly, large-scale, comparative studies to evaluate the effectiveness of FIP curricula across medical schools, establish standardized guidelines for content and assessment, and investigate the impact of FIP education on patient outcomes are also needed.

CONCLUSION

In this national survey of 55 medical school leaders, we found encouraging signs of progress in FIP education in US medical schools. As of 2025, most responding medical schools reported incorporating FIP content into their curricula. However, significant opportunities still exist for optimization of curriculum timing, specialty distribution, and assessment strategies. The main barriers to implementation that were routinely cited included time constraints and political/ideological sensitivities. Addressing identified barriers may help promote more consistent and comprehensive implementation of firearm injury prevention education across undergraduate medical curricula.

References

1. Gramlich J. What the data says about gun deaths in the U.S. Pew Research Center. Accessed October 4, 2023. <https://www.pewresearch.org/short-reads/2023/04/26/what-the-data-says-about-gun-deaths-in-the-u-s/>
2. Aubel AJ, Baldwin A, Barnhorst A, Bayer AM. Experiences with and perspectives on firearm injury prevention among emergency medical services clinicians. *BMC Emerg Med.* 2025;25(1):88. doi:10.1186/s12873-025-01241-9

3. Yanes AF. Gun Violence and Firearm Safety in Medical School Curricula: Missed Opportunities to Improve Patient Health. *JAMA Intern Med.* 2017;177(1):11-12. doi:10.1001/jamainternmed.2016.6734
4. Puttagunta R, Coverdale TR, Coverdale J. What is Taught on Firearm Safety in Undergraduate, Graduate, and Continuing Medical Education? A Review of Educational Programs. *Acad Psychiatry.* 2016;40(5):821-824. doi:10.1007/s40596-016-0490-6
5. Pallin R, Teasdale S, Agnoli A, et al. Talking about firearm injury prevention with patients: a survey of medical residents. *BMC Med Educ.* 2022;22(1):14. doi:10.1186/s12909-021-03024-9
6. Kwong JZ, Gray JM, Rein L, Liu Y, Melzer-Lange MD. An educational intervention for medical students to improve self-efficacy in firearm injury prevention counseling. *Inj Epidemiol.* 2019;6(1):27. doi:10.1186/s40621-019-0201-3
7. Okum SE. A Student Call for Gun Violence Education in Medical Schools. *JAMA Intern Med.* 2024;184(12):1401-1402. doi:10.1001/jamainternmed.2024.3316
8. Harris PA, Taylor R, Minor BL, et al. The REDCap consortium: Building an international community of software platform partners. *J Biomed Inform.* 2019;95:103208. doi:10.1016/j.jbi.2019.103208
9. Harris PA, Taylor R, Thielke R, Payne J, Gonzalez N, Conde JG. Research electronic data capture (REDCap)—A metadata-driven methodology and workflow process for providing translational research informatics support. *J Biomed Inform.* 2009;42(2):377-381. doi:10.1016/j.jbi.2008.08.010
10. Blood AD, Farnan JM, Fitz-William W. Curriculum Changes and Trends 2010–2020: A Focused National Review Using the AAMC Curriculum Inventory and the LCME Annual Medical School Questionnaire Part II. *Acad Med.* 2020;95(9S):S5. doi:10.1097/ACM.00000000000003484
11. Medical Schools Including Topics Related to Guns and Firearms in the Curriculum. AAMC. Accessed October 28, 2024. <https://www.aamc.org/data-reports/curriculum-reports/data/medical-schools-including-topics-related-guns-and-firearms-curriculum>
12. Nteveros A, Kyprianou M, Artemiadis A, et al. Burnout among medical students in Cyprus: A cross-sectional study. *PLOS ONE.* 2020;15(11):e0241335. doi:10.1371/journal.pone.0241335
13. Carter PM, Cunningham RM. Clinical Approaches to the Prevention of Firearm-Related Injury. *N Engl J Med.* 2024;391(10):926-940. doi:10.1056/NEJMr2306867
14. Betz ME, Azrael D, Johnson RL, et al. Views on Firearm Safety Among Caregivers of People With Alzheimer's Disease and Related Dementias. *JAMA Netw Open.* 2020;3(7):e207756. doi:10.1001/jamanetworkopen.2020.7756
15. Morgan ER, Rowhani-Rahbar A. Firearm Safety in an Aging United States. *JAMA Netw Open.* 2020;3(7):e2011182. doi:10.1001/jamanetworkopen.2020.11182
16. Betz ME, McCourt AD, Vernick JS, Ranney ML, Maust DT, Wintemute GJ. Firearms and Dementia: Clinical Considerations. *Ann Intern Med.* 2018;169(1):47-49. doi:10.7326/M18-0140
17. Betz ME, Thomas AC, Simonetti JA. Firearms, Suicide, and Approaches for Prevention. *JAMA.* 2022;328(12):1179-1180. doi:10.1001/jama.2022.16663
18. Kusurkar RA, Orsini C, Somra S, et al. The Effect of Assessments on Student Motivation for Learning and Its Outcomes in Health Professions Education: A Review and Realist Synthesis. *Acad Med.* 2023;98(9):1083. doi:10.1097/ACM.00000000000005263
19. Abdul Kadir N, Schütze H. Medical educators' perspectives on the barriers and enablers of teaching public health in the undergraduate medical schools: a systematic review. *Glob Health Action.* 2022;15(1):2106052. doi:10.1080/16549716.2022.2106052
20. Slavin S, D'Eon MF. Overcrowded curriculum is an impediment to change (Part A). *Can Med Educ J.* 2021;12(4):1-6. doi:10.36834/cmej.73532
21. Ramesh A, Brown KY, Juarez PD, Tabatabai M, Matthews-Juarez P. Curricular Interventions in Medical Schools: Maximizing Community Engagement Through Communities of Practice. *Ann Fam Med.* 2023;21(Suppl 2):S61-S67. doi:10.1370/afm.2925
22. Patel J, Leach-Kemon K, Curry G, Naghavi M, Sridhar D. Firearm injury—a preventable public health issue. *Lancet Public Health.* 2022;7(11):e976-e982. doi:10.1016/S2468-2667(22)00233-X
23. Phillips AW, Friedman BT, Utrankar A, Ta AQ, Reddy ST, Durning SJ. Surveys of Health Professions Trainees: Prevalence, Response Rates, and Predictive Factors to Guide Researchers. *Acad Med.* 2017;92(2):222. doi:10.1097/ACM.0000000000001334

Authors

Christopher Chang, ScB, The Warren Alpert Medical School of Brown University, Providence, RI.
 Anwen Lin, BA, The Warren Alpert Medical School of Brown University, Providence, RI.
 Michael Brennan, BS, The Warren Alpert Medical School of Brown University, Providence, RI.
 Maguire Anuszewski, BA, The Warren Alpert Medical School of Brown University, Providence, RI.
 Michael Mello, MD, MPH, The Warren Alpert Medical School of Brown University; The Injury Prevention Center, Rhode Island Hospital; Department of Emergency Medicine, Providence, RI.
 Anita Knopov, MD, MEHP, The Warren Alpert Medical School of Brown University; The Injury Prevention Center, Rhode Island Hospital; Department of Emergency Medicine, Providence, RI.

Disclosures

Acknowledgments: The authors want to acknowledge John C. Lin for his statistical input and critical feedback. Mr. Lin was not compensated for his work. The authors have nothing to disclose.

Funding: No funding was received for the preparation of this manuscript.

Correspondence

Anita Knopov, MD, MEHP
 55 Claverick St.
 Providence, RI 02903
 781-929-7331
anita_knopov@brown.edu