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Law, Ethics, and Conversations between Physicians and Patients about Firearms in the Home

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Abstract
Firearms in the home pose a risk to household members, including homicide, suicide, and unintentional deaths. Medical societies urge clinicians to counsel patients about those risks as part of sound medical practice. Depending on the circumstances, clinicians might recommend safe firearm storage, temporary removal of the firearm from the home, or other measures. Certain state firearm laws, however, might present legal and ethical challenges for physicians who counsel patients about guns in the home. Specifically, we discuss state background check laws for gun transfers, safe gun storage laws, and laws forbidding physicians from engaging in certain firearm-related conversations with their patients. Medical professionals should be aware of these and other state gun laws but should offer anticipatory guidance when clinically appropriate.

Introduction

In the United States, firearms are present in approximately one-third of all households [1]. Research has demonstrated that, compared to homes without guns, households with firearms are at increased risk of experiencing a homicide, suicide, or accidental firearm death of a household member [2].

Because guns are so prevalent in the United States and are associated with these serious health risks, physicians should be prepared to offer appropriate guidance to their patients. This type of anticipatory guidance involves providing information about ways to reduce risks associated with firearms in the home [3]. Several state and federal firearm laws, however, might complicate a physician's ability to provide the most effective counseling regarding firearms, raising both legal and ethical issues. We present three examples of such laws—temporary transfer restrictions, safe firearm storage laws, and laws forbidding asking patients about firearms—and discuss the difficult issues they could raise for practitioners and how they can be resolved.

Laws Restricting Temporary Firearm Transfer

Because access to firearms increases the risk of death by suicide [2, 4], reducing access to lethal means, including firearms, is an effective, evidence-based method for suicide prevention [5-7]. Upon encountering a firearm owner at risk of self-harm, clinicians might recommend that the owner temporarily store the firearm away from his or her home, perhaps with a friend or family member. This anticipatory guidance is provided on an individual basis and is therefore distinct from reporting requirements like those included in New York's SAFE Act, which requires physicians or other health professionals to report to authorities if they conclude, using "reasonable professional judgment, that such person is likely to engage in conduct that would result in serious harm to self or others" [8]. Under this act, the person's firearms can then be seized [8]. Some physicians, however, might be hesitant to discuss firearms or advise removal due to concerns about legality or about offending firearm-owning patients. Concerns about offending patients could be alleviated by cultural competency training designed to help clinicians understand firearm owners [9, 10]. The legality of temporary firearm transfers, however, is a more complicated issue.

Federal and state laws require background checks prior to many firearm transfers [11, 12]. But federal law only requires background checks for firearm purchases from licensed dealers [12]. Most states allow private transfers to occur without a background check, but 19 states and Washington, DC, have so-called universal background check (UBC) laws mandating a background check whenever a firearm is transferred, although some of these laws apply to handguns only [11]. The definition of a transfer in state laws is typically quite broad, including even gifts or other nonsale transfers [13]. While these laws make it harder for high-risk persons to acquire firearms and are therefore associated with reductions in rates of firearm suicide and other harms [14-17], they could make it more difficult for patients to temporarily transfer a firearm to reduce access to lethal means.

For patients at risk of death by suicide, time is of the essence. For gun-owning patients at risk of suicide, the time required to perform a background check prior to a temporary transfer might enhance the risk for suicidal acts, which are often impulsive. Some UBC states have mechanisms that facilitate temporary transfers without a background check to certain persons (e.g., family members) or for certain time periods (e.g., 72 hours), but others do not [13].

In states with UBC laws, physicians might face a dilemma. While it could be beneficial for a patient to immediately remove a firearm from his or her home, physicians might worry that they are advising the patient to transfer a firearm in an illegal manner. Physicians, therefore, need to know the specifics of state gun laws. In states with rigid UBC laws, physicians should understand the background check requirements and exceptions, if any,

so they can offer tailored advice to lower the risks facing their patients. These objectives could be accomplished through professional education or personal initiative. In addition, in states where the legality of temporary transfer to lower suicide risk is murky, physicians are uniquely positioned to advocate for changes in the law that would provide clarity and to facilitate suicide prevention counseling.

Safe Firearm Storage Laws

Eighteen US states have so-called child access prevention (CAP) laws [18]. These laws mandate that a firearm be stored so that a child or teen (the applicable age varies by state) is not able to gain easy access to the gun. CAP laws do not typically mandate a specific storage method, although unloading the firearm and locking it up separately from the ammunition is recommended by some researchers [19]. In several evaluation studies, state CAP laws have been associated with lower rates of both accidental deaths of children and suicides among teens [18, 20].

Despite the effectiveness of CAP laws, the safest alternative for households with children or teens is to not bring a firearm into the home at all. In this way, CAP laws are a form of "harm-reduction" approach—analogous, at least in part, to other harm-reduction strategies such as needle exchange programs. Yet, as noted previously, a patient who stores his or firearm safely will be complying with applicable law in 18 states. In addition, among firearm owners, the primary reported reason for owning the firearm is personal or home protection [21]. Some patients are therefore likely to believe that, on balance, their home is actually safer with a firearm.

Organizations like the American College of Physicians have encouraged physicians to counsel patients on the risks of having a firearm at home [3]. This counseling may involve advising a patient that the safest action is to remove firearms from the home. However, unlike when a physician (for example) recommends seat belt or child safety seat use—which is mandated in all 50 states—the physician who counsels removing a firearm from the home entirely is in the position of recommending that the patient take steps in excess of those required by state law. Because a physician advising removal is suggesting a safety action that both exceeds the law and may be complicated in certain states or disapproved of by certain demographic groups, physicians should also advise patients of safe storage practices. Safe storage requires less effort than removal and allows gun owners to maintain control of their guns, which might be preferable to some patients, but these practices do not mitigate risk as effectively as complete removal. How to craft anticipatory guidance that effectively navigates both the safest approach and the approach mandated by law (in the 18 CAP states) can also be affected by other risk factors in the home—for example, a history of depression in a teen child, the age of younger children, or a past episode of intimate partner violence within the home. This conflict between the safest approach (firearm removal) and a legally permissible, easier approach (safe storage) might create both practical and ethical difficulties for physicians.

Laws Forbidding Asking Patients about Guns

Recently, some states have experimented with laws that limit what physicians are permitted to ask their patients about firearms or gun ownership [22]. These laws are proposed under the auspices of patient privacy and respect for patient firearm rights. In some cases, the evidence offered in support of the bills is anecdotal—proponents focus on stories about doctors declining to care for patients who refuse to answer questions about firearms [23].

Two of the first states to propose laws forbidding inquiry into patient firearm possession were Virginia and West Virginia. In 2006, bills were introduced in both state legislatures but did not pass [24]. The proposed laws would have prevented physicians from asking a patient about firearms if the physician was planning to use the answers to either gather data about firearm possession or to offer anticipatory guidance. This would have created a problematic scenario in which a physician could either offer firearm counseling to all patients without asking about firearm ownership first or wait for a patient to broach the subject before offering any counseling [24].

These proposed laws raised at least two different legal and ethical concerns. First, physicians would have faced the choice between legal compliance and malpractice claims. Many national organizations, including the American College of Physicians and the American Academy of Pediatrics, have stated that physicians should inquire about firearm access and offer counseling on safe practices [3, 25]. Courts and administrative bodies often use best practice guidelines to establish the standard of care in malpractice cases [26], and these best practice guidelines might conflict with gag laws. On the one hand, a physician following the guidelines might run afoul of the gag law and put his or her medical license at risk. On the other, a physician following the gag law and eschewing the guidelines would put herself at risk for malpractice claims. The second legal concern triggered by these proposed laws is the potential violation of physicians' freedom of speech. In general, any law allowing the government to prohibit speech based on its content will trigger scrutiny by the courts under the First Amendment [27].

Florida is the only state to have actually enacted a gag law—the Firearm Owners' Privacy Act (FOPA), which took effect in June 2011. The law explicitly prohibited physicians from asking patients about firearm access or possession, discriminating against firearm-owning patients, and "harassing" patients about firearm ownership [28, 29]. Physicians and medical associations filed a federal lawsuit, claiming that FOPA violated physicians' First Amendment rights [28]. The District Court for the Southern District of Florida held that many of FOPA's restrictions violated the First Amendment as applied to the states [27]. Florida officials appealed and a panel of judges on the Eleventh Circuit Court of Appeals reversed the District Court's decision and upheld the law [27]. The full Eleventh Circuit Court of Appeals reheard the case, and in February

2017 it affirmed the District Court's opinion striking down most of the FOPA restrictions [27]. The court held that FOPA's content-based restrictions on speech violated the First Amendment as it applies to the states [27].

Other states have enacted statutes related to firearms and health care practices, but none are as stringent as the Florida law. Minnesota, Missouri, and Montana all have restrictions on how firearm information can be collected and stored, but they do not broadly prohibit physician inquiries [7, 30-33]. Because these laws do not broadly prohibit physician inquiries, they might not affect physician-patient interactions but could still make health care workers wary about discussing guns. For now, physicians should be comforted that no state currently bans firearm counseling outright. In light of the Eleventh Circuit's decision on Florida's gag law, physicians should feel confident that discussions of firearms with patients are lawful.

Conclusion

Medical and professional ethics support counseling patients about firearms in their homes. These discussions are lawful. The particular advice offered, however, might be complicated by state policies like UBC and CAP laws. CAP laws might require less precaution than a physician would advise. When counseled that he or she—or a family member—is facing elevated risk of self-harm, a patient might choose to simply abide by safe storage laws instead of removing a firearm from the home entirely. If a patient does seek to remove the firearm entirely, UBC laws might complicate quick temporary firearm transfers. The longer this process takes, the longer the patient is at risk. There are, however, exceptions to UBC laws in some states that can facilitate transfers intended to save a life [13]. Medical professionals should be aware of state laws pertaining to firearm counseling, temporary transfer, and safe storage, but they should offer anticipatory guidance when clinically appropriate.

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