

POLICY FORUM

What Should Be the Scope of Physicians' Roles in Responding to Gun Violence?

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Abstract

What role, if any, physicians should have in the response to gun violence is a question not only of professionalism but also of law, culture, and ethics. We argue that physicians do have important roles to play in the larger landscape of advocacy, public opinion, and reduction of gun violence, but that it is not ethically or legally appropriate for them to serve as gatekeepers of gun privileges by assessing competency.

Introduction

Physicians and other health care professionals have numerous interests in participating in gun violence discussions, with their most obvious interest in treating victims. However, as Frattaroli et al. note, "although treatment of the wounds is an essential role for health care providers, it should be our last line of defense" [1]. What these other defenses should or should not include is our central question. Potential answers range from policy-level advocacy to community-level outreach, and from bedside education to serving as gatekeepers to obtaining concealed weapon permits [2-5]. Overall, physicians are being asked to redefine their professional responsibilities to engage larger legal, cultural, and ethical questions about gun ownership.

The National Medical Association [2], the American Medical Association [3], the American Public Health Association [6], and a host of other professional organizations [7] have all issued policy statements reflecting the position that gun violence is a public health crisis necessitating health professionals' involvement. However, we argue that physicians should not act as gatekeepers of gun privileges by, for example, assessing a patient applying for a concealed weapon permit at the request of a law enforcement officer [4]. By not serving as gatekeepers, physicians can more effectively advocate for policies and other interventions that could help make gun ownership safer. A model of such advocacy is physicians' contributions over the last 50 years to making automobiles safer by counseling on the use of seatbelts and on the importance of not driving under the influence [8]. But even proven evidence-based public health interventions like seat belts and motorcycle helmets are subject to cultural criticism and objection on the basis of a right to be free from state power. Ethically, if we understand that the right to bear arms and the right to life, liberty, and the pursuit of happiness (by not being shot or

killed) are both rights, then, like any good ethical dilemma, the question of physician involvement in gun violence is a question of values and the relationships among specific rights. In this article, we argue that rights to health and safety are paramount, and we describe ways physicians can uphold these rights without infringing on the Constitutional right to bear arms.

Key Roles for Physicians in Mitigating Gun Violence

There are five potential loci of physician involvement in responding to gun violence: advocacy, [research](#), education, expert advice, and gatekeeping. The first four we agree with wholeheartedly. As advocates, physicians can use the credibility and power of the profession to promote policies and legislation regarding violence prevention, violence-free popular media, mental health surveillance, and a tax on ammunition, among other policy changes [9, 10]. As researchers, physicians can work to gain a fuller understanding of gun violence. Because gun violence has not been comprehensively studied, data is lacking on the effectiveness of advising patients on gun safety. In a 2017 11th Circuit Court of Appeals decision upholding a physician's right to discuss firearms with patients, the court wrote: "A number of leading medical organizations, and some of their members, *believe* that unsecured firearms 'in the home increase risks of injury'" (emphasis added) [11]. This sentence highlights, perhaps unintentionally, the lack of evidence-based approaches to firearm violence prevention available to physicians. Finally, as educators, physicians can [advise patients on gun safety](#). Physicians play this role in other areas, such as advising on the potential hazards of biking without helmets, having swimming pools without fences, riding in a car without seatbelts, and so on. More evidence about the effects of patient education on gun safety will serve to bolster physicians' bedside educational role in this area. Advocacy, research, and education are all common and ethical roles for physicians that we support.

Health care professionals are also called upon, as a part of their professional responsibilities, to reduce and prevent death by suicide whether by a gun (61 percent of gun deaths are caused by suicide [1]) or by any other means. Psychiatrists and psychologists are [legally mandated to report](#) to authorities if a patient seems to be a danger to him- or herself; physicians and nurses are called upon to spot early warning signs of self-harm and to counsel patients or report to others; and physicians are empowered to recommend involuntary commitment of patients who threaten their own or others' lives. However, in each of these instances, it is not a health care professional who ultimately decides the *legal* question of whether a person's liberty should be restricted; a judge must make that determination.

Similarly, in the realm of interpersonal gun violence, we argue that physicians cannot and should not be the ultimate arbiters of "fitness" for owning or possessing firearms, which is a legal determination, just as competency is a legal determination that might result in deprivation of liberty and possibly involuntary commitment. Thus, the fifth proposed

locus for physician involvement, gatekeeping, is fundamentally different from the other four, and we believe legally wrong and culturally and ethically problematic. We make no distinction in our ethical argument that follows between gatekeeping with regard to gun ownership or possession; therefore, we will use “gun ownership” as a blanket term to refer to both.

Gatekeeping is Different in Ethically Relevant Ways

Physicians as gatekeepers—interpreters and evaluators of whether a person is fit for gun ownership—is both the most extreme proposal and the most ethically problematic. Calls for physicians to play a role in assessing fitness for firearm ownership are treated as analogous to the ways physicians act as gatekeepers for drivers’ licenses by flagging patients with conditions that would make operating a vehicle unsafe, such as a seizure disorder or Alzheimer’s disease [10]. However, were physicians called upon to evaluate fitness to own a firearm, their determination would necessarily have less to do with applying their biomedical knowledge to assess patients’ physical or mental capacity to operate a firearm safely than with the broader question of keeping guns out of the “wrong hands,” since there is no biomedical test for firearm ownership fitness. Although federal law prohibits gun sales to certain persons, such as those who abuse controlled substances or who are dangerously mentally ill [13], there is no clear clinical indicator for abuse of controlled substances or dangerous mental illness, which is part of the reason why physicians are not well positioned to be arbiters of fitness for gun ownership.

Assessing fitness to carry a concealed weapon now is in the hands of police departments, which generally do some combination of surveying, questioning, and testing of applicants to determine if they meet the basic criteria for fitness to carry a concealed firearm in states where permits are required [14]. Generally speaking, fitness for firearm privileges need not be affirmatively proven—rather, it is defined by the absence of a set of factors. In determining whether someone is, by the legal definition, fit for firearm privileges, the only legally relevant information that physicians and other health care professionals might have is whether that person has been “committed to any mental institution” or “adjudicated as a mental defective,” meaning that a court has made a determination (based on a physician’s recommendation) that a person is a danger to him- or herself or lacks the mental capacity to “contract or manage his or her own affairs” [15]. Some states have strengthened the requirements for fitness for gun ownership to exclude people who have *voluntarily* sought inpatient mental health or substance abuse treatment within a certain time period [16]. But it is important to note all that the federal law requires is for retrospective information to be provided in a background check about a person’s mental health history or developmental disability [15]. There is no legal role for physicians to prospectively determine a patient’s fitness for gun ownership and alert any state or local authority not to allow that patient to obtain a license to purchase or carry a gun.

Physician involvement in assessing firearm competency is being met with resistance within the medical community. One of the few physician attitude surveys conducted found that 65 percent of 222 respondents disagreed or strongly disagreed that it is primary care physicians' role "to assess whether their patients are mentally and physically sound enough to carry a concealed weapon" [17]. While that study didn't ask respondents to elaborate on their responses, physicians writing in other public forums provide one clue as to what might underlie this result and make us comfortable with our equating gatekeeping with respect to gun ownership and concealed-carry permits—specifically, the belief that most killings are with guns purchased illegally, so intervention or gatekeeping would not work [18]. It must be noted that, as with many beliefs about gun violence, there is no research that supports or refutes this belief.

Another common sentiment expressed by physicians is that they are not currently adequately trained to properly take on the gatekeeping role:

Reasonable physicians might disagree about whether patients with Parkinson's disease, prior strokes, atrial fibrillation, seizures, or chronic pain are physically competent to use a weapon safely, as well as about whether people who have a history of depression, substance or alcohol abuse, anxiety, or insomnia or who are taking psychotropic medications are mentally competent to do so. *Guidance is needed regarding the need and protocols for collection of urine toxicology or blood alcohol reports to rule out drug or alcohol use before signing off on permits* (emphasis added) [19].

The desire expressed at the end of this quotation—to have clear-cut guidelines supported by objective tests—is common in medicine. But it is not possible to concretely "measure" a person's fitness to own a gun using any medical standard. Fitness is a legal concept, not a medical one. Human behavior is not reducible to toxicology reports or blood alcohol levels. Physicians themselves disagree over what would be a useful clinical criterion for determining fitness for gun ownership—in one survey, roughly half to two-thirds of physicians believed that those with mild dementia, posttraumatic stress disorder (PTSD), or recent depression were not competent to use a concealed weapon [5]. Moreover, the same survey found that men and gun owners were more likely to believe a patient was competent to use a gun across a range of mental health and other medical conditions [5]. Clearly, then, physicians cannot use objective measures to determine fitness for having a gun, because fitness is not a standard specific enough to be identifiable through the tools of biomedicine. Physicians will never be omnipotent or have technology sophisticated enough to be gatekeepers in this sense, nor should they be.

Conclusion

In 2017, attitudes about guns have become a simulacrum of our identities. Culturally, the question of the Second Amendment and gun violence is a key component of contemporary culture wars and identity politics. Legally, we see no possibility at this time for any change in the constitutionality of the right to bear arms. Ethically, however, in the debate over an individual right to bear arms versus limiting individual freedoms in favor of public health and safety, we are confident that the ethical “winner” must be the option that fosters the latter. Discussion, evidence gathering, and advocacy concerning gun violence can help individual patients be healthy and safe and can highlight the human costs of gun violence. Thus we favor physician advocacy, research, and education pertaining to gun violence in the interests of public health and safety. However, we believe that asking individual physicians to serve as gatekeepers is wrong. Asking physicians to be the arbiters of fitness to own a firearm or carry a concealed weapon absolves policymakers and society from confronting the larger questions that are driving gun violence. Fitness for gun privileges is a legal determination that should not be placed in the hands of physicians. The role of physicians and ethicists, who assert that [gun violence is a contagion](#) and a public health crisis, is in leading public discussion, evidence gathering, and argumentation about gun violence [13, 20, 21].

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