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PEER-REVIEWED CME ARTICLE: MEDICAL EDUCATION

What If a Resident or Medical Student Is Raped? Hospitals' and Academic Medical Centers' Title IX Obligations

Melinda Manning, JD, MSW

Editor's Note: To claim one AMA PRA Category 1 Credit™ for the CME activity associated with this article, you must do the following: (1) read this article in its entirety, (2) answer at least 80 percent of the quiz questions correctly, and (3) complete an evaluation. The quiz, evaluation, and form for claiming AMA PRA Category 1 Credit™ are available through the [AMA Education Center](#).

Abstract

Title IX of the Education Amendments of 1972 protects medical students and residents from all forms of sexual discrimination, including sexual harassment and assault. Hospitals that train residents as well as medical students must follow Title IX mandates, including investigating and addressing all reports of sexual discrimination, harassment, or violence. While these processes can help eliminate potential barriers to women in medical training, the pressure to participate in an internal investigation can discourage some medical students and residents from seeking help. Hospitals should work closely with university Title IX officials to design and implement effective policies and procedures to both prevent and address all types of sexual discrimination as well as to support trainees who have been victimized.

Introduction

Numerous studies show that sexual harassment is still a persistent issue in medicine. One study published last year reports that 30 percent of female clinical researchers and 4 percent of male researchers in academic health centers have experienced sexual harassment at some point in their training or career [1]. Residents and students can be more vulnerable to harassment and assault due to the inherent power differentials embedded within medical education [2, 3]. A 14-school study published in 2002 found that 83 percent of female students had experienced sexual harassment and/or gender discrimination during medical school [4]. On the other hand, less than 15 percent of students reported experiencing some type of sexual harassment or discrimination on the 2017 Association of American Medical Colleges (AAMC) [Graduation Questionnaire](#) [5]. Over a longer period, a 2014 meta-analysis of studies conducted between 1987 and 2011 showed that 33 percent of trainees (all genders) had experienced some form of sexual harassment during their training [6]. Sexual harassment can influence students'

decisions regarding residency placements [7], distract trainees from their studies, and negatively affect patient care [8].

Sexual assault is a criminal offense, but it is also classified as a severe form of sexual harassment, as it can interfere with one's educational opportunities [9]. Roughly 45 percent of women have experienced some form of sexual violence victimization other than rape in their lifetime [10]. And roughly 1 in 5 women and 1 in 71 men have been raped in their lifetime [10]. Although roughly a third of women who are raped are physically injured as a result, only 36 percent of those injured receive any immediate medical treatment [11]. There is little research on how many medical trainees are assaulted by coworkers. One older study of 916 female family practice residents found that 2.2 percent had been sexually assaulted by coworkers during their residency [12]. Research has shown that roughly 86 percent of all victims are assaulted by people they know [10], so a reasonable assumption can be made that some trainees are raped by acquaintances from their workplaces.

The Legal Landscape of Title IX and Sexual Harassment

In 1972, Congress passed the landmark Title IX Amendment. This legislation mandated that "no person" can be denied any educational benefits or be discriminated against on the basis of sex. The law's impacts were immediate, as it applied to any public or private educational institution that received federal funding. Many more colleges and universities (including medical schools) were forced to open their doors to women, allow women on sports teams, and permit pregnant students to attend school [13].

Alexander v Yale (1977) helped establish the idea that sexual harassment is a form of sexual discrimination, holding that "academic advancement conditioned upon submission to sexual demands constitutes sex discrimination in education" [14]. When a student reports sexual harassment, an educational institution has a responsibility under Title IX to investigate and respond to the harassment in order to eliminate potential gender discrimination [14]. In order to convince policymakers to increase federal intervention in combating sexual discrimination in education, a landmark 1980 Department of Education report established a classification system for sexual harassment based on five categories of behaviors that formed a continuum of severity. The most severe category was titled "sexual crimes and misdemeanors" and included behaviors such as groping and rape [9].

In response to increased public awareness about campus sexual assault, the Department of Education issued a "Dear Colleague" letter in 2011 to help clarify schools' responsibilities for addressing all forms of sexual discrimination, including harassment and assault [15]. As specified in the letter, under Title IX mandates, whenever an institution becomes aware of potential student-on-student harassment, it must take "immediate action to eliminate the harassment, prevent its recurrence, and address its

effects” [16]. Certain employees, designated as “responsible employees” [17] (i.e., mandated reporters) are required to report any possible incidents to the schools’ Title IX officials. Schools are also required to institute grievance procedures to resolve students’ sex discrimination complaints that violate Title IX, as well as provide interim measures such as no-contact orders against the alleged perpetrators while allegations are being investigated [15]. However, in September 2017, the Department of Education formally withdrew this letter, so it is unclear which requirements remain in place [18].

The recent decision in *Doe v Mercy Catholic Medical Center* (2017) establishes that any hospitals that train residents are also subject to Title IX, as residency programs are a type of “education program or activity” [19]. Hospitals can be held civilly liable by the courts for failure to promptly address any form of sexual discrimination, including harassment and assault, as well as retaliation against trainees who report sexual discrimination [20].

When the Medical Trainee Is the Victim

Sexual harassment and assault clearly have no place in a hospital environment. Medical workplace harassment has been shown to negatively affect individual performance and effectiveness as well as individual and group morale [21]. Female clinical researchers who have experienced harassment in their career often report that it hurts career advancement and confidence in their professional abilities [1].

There are multiple barriers that keep victims of sexual harassment, particularly sexual assault, from reporting, including shame, poor treatment by the criminal justice system, and fear of not being believed [22]. Residents and students assaulted by coworkers may face additional barriers, such as fear of retaliation from attending physicians and concerns that their privacy will be breached by their treatment team. They might have the added burden of seeing their assailant around the hospital.

Like other sexual assault victims, medical students and trainees can report to the police, but under Title IX if they are assaulted by a coworker (fellow trainee, attending physician, or other hospital staff), they also have the option of reporting it to their medical school or hospital for formal investigation and adjudication. The Department of Education gives institutions a great deal of leeway in how to conduct these investigations. Some institutions hold formal hearings in which both sides present evidence and call witnesses while others use a single decision maker who collects and reviews the evidence. When the accused are found “responsible” for violating the institution’s policies, sanctions can range from a formal reprimand to dismissal [17]. These processes, while well intended, may place additional stress on the victims due to time burdens as well as embarrassment. Hospital administrators conducting investigations might not be trained in [trauma-informed practices](#) and inadvertently cause emotional harm while interviewing victims.

Hospitals and medical schools' Title IX responsibilities can clash with the needs and desires of students and trainees who experience sexual assault. Research has shown that victims recover best when they are able to make their own informed choices regarding treatment and reporting [23, 24]. Some survivors may want support but no formal investigations or actions taken against their perpetrators [25, 26]. Mandatory reporting policies thus might keep students and trainees from seeking treatment post-assault for fear of triggering a formal investigation by the hospital or medical school. The increased federal and state scrutiny of the handling of sexual harassment and assault cases, however, may cause hospital and medical school administrators to pressure student and trainee victims to participate in internal investigations if the school or hospital learns of the assault [27]. Hospitals and medical schools might find themselves in a quandary, having to balance the autonomy and confidentiality of trainees with Title IX mandates to investigate all incidents, while also protecting other staff and patients from possible perpetrators.

Recommendations

Medical schools and hospitals should have clear policies in place that discourage fraternization between trainees and attending physicians. Such policies help to establish clear boundaries between learners and teachers and eliminate some venues where sexual harassment and assault might take place. In addition, there should be increased training on professional boundaries for students, trainees, and attending physicians [28]. This training could help prevent [boundary violations](#) by attending physicians, students and trainees, and patients. Previous research has shown that poor education on proper boundaries is a common factor in this type of physician sexual misconduct [29].

Medical schools and hospitals should also reaffirm the confidentiality of medical records of students and trainees, as well as those of all staff members. It should be made clear that receiving treatment for sexual assault will not trigger a formal investigation. Title IX policies should make clear which staff members are "responsible employees" (i.e., mandated reporters) versus employees responsible for evaluating requests for confidentiality (i.e., confidential employees) [17]. Programs should consider establishing a confidential advocate on staff to guide victims through the reporting and investigation process and refer victims to other services such as counseling, legal assistance, and support groups. There should be explicit policies in place affirming that victims will not be retaliated against for reporting and that every effort will be made to separate their work assignments from the alleged perpetrators. For hospitals affiliated with colleges and universities, collaboration with existing Title IX offices is essential to create policies and procedures that are consistent with state and federal law and best practices [20].

Conclusion

Unfortunately, medical education is not an inoculation from sexual harassment or assault. The medical community needs to make clear that sexual discrimination in any form will not be tolerated. Hospitals and medical schools have clear obligations under Title IX to address known incidents of sexual harassment and assault. Hospitals and medical schools should be proactive in protecting confidentiality, offer clear channels for reporting, and protect victims from retaliation. Special efforts need to be made to encourage vulnerable trainees to report incidences of sexual harassment or assault and receive appropriate medical and psychological care. Comprehensive research is sorely needed to assist in determining the prevalence of sexual assault within the medical community and to help inform future prevention activities.

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PEER-REVIEWED CME ARTICLE: HEALTH LAW

Does *Volk v DeMeerleer* Conflict with the AMA Code of Medical Ethics on Breaching Patient Confidentiality to Protect Third Parties?

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Editor's Note: To claim one AMA PRA Category 1 Credit™ for the CME activity associated with this article, you must do the following: (1) read this article in its entirety, (2) answer at least 80 percent of the quiz questions correctly, and (3) complete an evaluation. The quiz, evaluation, and form for claiming AMA PRA Category 1 Credit™ are available through the [AMA Education Center](#).

Abstract

A recent Washington State case revisits the obligation of mental health clinicians to protect third parties from the violent acts of their patients. Although the case of *Volk v DeMeerleer* raises multiple legal, ethical, and policy issues, this article will focus on a potential ethical conflict between the case law and professional guidelines, namely the American Medical Association's *Code of Medical Ethics*.

Introduction

A recent Washington State case, *Volk v DeMeerleer* [1], revisits the obligation of mental health clinicians to protect third parties from the harmful acts of their patients. Mental health clinicians' obligations to warn or protect third parties from the violent acts of their patients are known generally as *Tarasoff*-type duties after the landmark 1976 California Supreme Court decision in *Tarasoff v Regents of the University of California* [2]. In *Tarasoff*, the California Supreme Court held that when a psychotherapist determines, or should determine, that his patient "presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger" [3]. Following *Tarasoff*, most states responded (either through statute or case law) by detailing when a mental health clinician could (permissive) or must (mandatory) take steps to notify the victim or police or take other protective steps in an effort to mitigate harm. States vary as to the exact requirements [4].

Although the *Volk* case concerned a psychiatrist, its ruling reasonably applies to other types of mental health clinicians in Washington State. Given the vagueness of the *Volk* ruling and the fact that other types of clinicians could, similarly, see patients at risk of harming third persons, future cases could also extend the holding to other clinicians in Washington State, such as primary care clinicians. Thus, it is useful for clinicians to appreciate the legal and ethical tensions involved in [breaching patient confidentiality](#) to

protect third parties.

This article will summarize the recent *Volk* decision and discuss a potential ethical conflict between the case law and the American Medical Association's *Code of Medical Ethics* [5]. Although the *Volk* case raises multiple practical, legal, ethical, and policy issues, the focus of this article will be on describing the case and the potential conflict for mental health clinicians (particularly psychiatrists) between their legal responsibilities outlined in *Volk* and their ethical obligations outlined in the *Code*. Since the *Volk* ruling, mental health clinicians in Washington State face conflicting legal and ethical obligations because the *Volk* decision permits (and, arguably, encourages) clinicians to breach patient confidentiality and issue warnings to protect third parties more broadly than permitted by the *Code*. *Volk* permits disclosure of patient confidences in three important ways that differs from the *Code*: (1) it mandates clinicians to take measures to protect any foreseeable victim (rather than an identifiable victim); (2) the clinician incurs responsibility when his or her patient has dangerous propensities (rather than when the patient presents a threat of serious physical harm); and (3) it calls for clinicians to take action when there is a possibility (rather than a probability) of harm to third persons.

Volk v DeMeerleer

Facts of the case. On July 18, 2010, Jan DeMeerleer entered the home of Rebecca Schiering, his ex-fiancée, and murdered Ms. Schiering and one of her sons. Her other son escaped. Mr. DeMeerleer then shot and killed himself.

Mr. DeMeerleer carried a diagnosis of bipolar disorder and had been in psychiatric care on and off with Dr. Howard Ashby of the Spokane Psychiatric Clinic for nine years. Intermittently over the years, he had thoughts of harm to himself and others, but he had made no suicide attempts during his nine years of treatment with Dr. Ashby. He had his last appointment with Dr. Ashby approximately three months before the event at issue. At that appointment, Mr. DeMeerleer voiced no thoughts of violence and, specifically, reported no thoughts of harm directed at Ms. Schiering, her children, or anyone else. He disavowed intent to harm himself. Subsequently, his relationship with his fiancée ended.

Following the deaths, Ms. Schiering's mother and surviving son sued Dr. Ashby and the Spokane Psychiatric Clinic for failure to follow the standard of care, arguing that Dr. Ashby "might have prevented the attacks by either mitigating DeMeerleer's dangerousness or warning" the victims [6].

Ruling and reasoning. Defendant Dr. Ashby moved to dismiss the case by summary judgment on the basis that he owed no professional duty to third parties in general or the Schierings in particular since Mr. DeMeerleer never disclosed any plan to harm them. Dr. Ashby filed no affidavit or expert material on the standard of care for psychiatrists since any battle of the experts would preclude summary dismissal of the case. Instead,

Dr. Ashby relied on a legal argument and the undisputed fact that Mr. DeMeerleer had not threatened the Schierings in the presence of Dr. Ashby. Citing Washington law, specifically Revised Code of Washington (RCW) 71.05.120 [7], he asserted that a mental health clinician owes a duty to third parties only when the patient has “communicated an actual threat of physical violence against a reasonably identifiable victim or victims,” which had not occurred in this case. The trial court agreed and granted summary judgment to Dr. Ashby [1].

On appeal, the appellate court ruled that the state’s statute (RCW 71.05.120) applied only in the context of involuntary psychiatric treatment and reversed and remanded the trial court’s decision [8]. The Washington Supreme Court affirmed the appellate court. Relying on prior case law in the context of inpatient psychiatric care [9], the Washington Supreme Court ruled that a mental health professional owes a duty of “reasonable care to act consistent with the standards of the mental health profession, in order to protect the foreseeable victims of his or her patient” [10]. Under *Volk*, the outpatient mental health clinician “incurs a duty to take reasonable precautions to protect *anyone* who might foreseeably be endangered by the patient’s condition” (italics in original) [11]. Once there is a “special relationship” between the patient and clinician, the clinician’s duty attaches based on the patient’s dangerous propensities, even if the patient voices no threat of violence and even if no victim is identified (or reasonably identified) [11]. In *Volk*, Dr. Ashby conceded that he had a special relationship with Mr. DeMeerleer [10]. This case was remanded to the trial court to resolve the [liability claims](#).

Conflict between *Volk* and Professional Guidelines

Confidentiality is both a legal and an ethical issue. Generally, health care professionals are prohibited from disclosure of patient confidences unless such disclosure is required or permitted by law. For clinicians, unauthorized breach of a patient’s confidentiality can result in lawsuits and adverse actions by state licensing boards or professional organizations.

The *Volk* standard raises several challenges for practicing mental health clinicians in Washington State. Among them are that clinicians, following *Volk*, could find themselves at odds with state and federal privacy laws, such as the Health Insurance Portability and Accountability Act ([HIPAA](#)) [12]), as well as professional ethical guidelines that aim to protect patient confidences. The *Volk* decision permits clinicians to disclose patient confidences more broadly than privacy laws and some professional guidelines. By way of example, the discussion here focuses on the potential conflict between *Volk* and the *Code*, which provides ethical guidance for all physicians, including psychiatrists.

The importance of the confidentiality of communication between patients and their clinicians is recognized in professional guidelines. The *Code* states:

Patients need to be able to trust that physicians will protect information shared in confidence. They should feel free to fully disclose sensitive personal information to enable their physician to most effectively provide needed services. Physicians in turn have an ethical obligation to preserve the confidentiality of information gathered in association with the care of the patient [13].

This guidance is supported by the American Psychiatric Association (APA). The APA's "Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry" [14], adopted from the AMA, includes the following statement: "A physician shall respect the rights of patients ... and shall safeguard patient confidences and privacy within the constraints of the law" [15]. The AMA's and APA's guidance recognizes that confidentiality encourages candid communication, which is vital to psychotherapy and for providing appropriate treatment to patients with mental health conditions.

Although confidentiality is not absolute, patients generally expect their comments to mental health professionals to be confidential absent some clearly defined exceptions. For example, the APA's annotations permit (not mandate) psychiatrists to reveal certain patient confidences when, according to clinical judgment, "the risk of danger is deemed to be significant" [16].

Physicians' ethical obligations to protect confidentiality, however, can conflict with their legal responsibilities outlined in *Volk*. As noted earlier, many *Tarasoff*-type laws, including the 1976 case itself and RCW 71.05.120, balance the interests of the patient and third parties by enjoining a psychotherapist's duty to third persons only when there is a specifically identifiable (or reasonably identifiable) victim and, in the clinician's judgment, the patient presents with sufficient risk of harm. The APA's model statute on the duty of physicians to take precautions against patient violence prohibits clinician liability for breaching a duty to prevent harm unless the clinician fails to take reasonable measures when a patient has communicated an explicit threat to "*kill or seriously injure a clearly identified or reasonably identifiable victim or victims*" (italics added) [17]. Similarly, the *Code* permits disclosure of confidential information to mitigate the threat when there is a reasonable *probability* that "the patient will inflict *serious physical harm on an identifiable individual or individuals*" (italics added) [13].

Comparing *Volk* to the *Code*

The language of the *Volk* ruling conflicts with the *Code* in several important ways. Among these, under *Volk*, the duty of outpatient mental health clinicians in Washington has been expanded to all *foreseeable* victims of a patient's violent acts, even those who have *not* been identified by the patient. Under the *Volk* ruling, then, can (or must, if there is not another appropriate protective measure to take) the clinician contact family if the patient has some risk factors for violence? What about employers? Neighbors? Bus drivers? How

far does the sphere of foreseeability extend if the patient does not reasonably identify anyone? Although the court in *Volk* stated that the standard requires clinicians' actions to be "informed by the standards and ethical considerations of the mental health profession" [18], the holding could, in fact, put clinicians at odds with their professional ethics code by extending the duty to foreseeable victims rather than identifiable victims. Although sanctioned by the *Volk* ruling, every communication by a clinician to a foreseeable (but not an identifiable) victim would put the clinician at odds with the *Code*, as well as expose him or her to possible legal claims for breach of confidentiality. With *Volk* as precedent, the scope of foreseeability will be decided on a case-by-case basis by the trier of fact (judge or jury) as future cases move through the courts. There is no defined professional standard for what constitutes sufficiently foreseeable victims or harm.

In addition, the *Volk* duty is triggered by a patient's "dangerous propensities," whereas the *Code* permits breach of patient confidences only to mitigate a threat of "serious physical harm" [5]. "Dangerous propensities" is not defined in medicine, or under Washington State law, leaving clinicians without clear guidelines as to what triggers their duty under *Volk*, except that an actual threat is not required. Could the clinician's duty be triggered by a patient's expression of hostile emotions? Angry words? History of violence? History of substance use? Arguably, yes, under *Volk*, even when the patient is not manifesting a current actual threat of physical harm. The vague definition of dangerous propensities begs clinicians to consider protective measures—including disclosing patient confidences—without more than a general concern that a patient might present a risk of danger to another. As a consequence of *Volk*, patients with dangerous propensities, but who are actually nonviolent, risk loss of privacy and liberty as a means of protecting other members of society.

What is more, pursuant to the *Code*, for a clinician to breach confidentiality to protect a third person there must be a "reasonable probability," based on clinical judgment, that the patient is at risk for inflicting harm on another [13]. In law, the term probability generally means more likely than not, or reasonable likelihood. Clinicians performing risk assessments can consider whether the level of risk is more probable in comparison to the base rate of occurrence of the type of violence (e.g., homicide) at issue. In contrast, *Volk* creates a duty for clinicians to take an affirmative measure to protect another when there is a mere *possibility* of harm (i.e., a third person "might foreseeably be endangered"), even when it is improbable. In law, a possibility equates with "chance" of something happening. Under *Volk*, in combination with the case's other parameters—needing to protect any foreseeable victim from a patient's dangerous propensities—the number of victims to protect increases as the level of risk (probability and specificity of violent action) needed to trigger a clinician's action decreases. In an effort to comply with *Volk*, clinicians could take measures (including breaching patient confidences by issuing warnings) that are not likely to mitigate risk and could actually have unintended

consequences of harming the patient and, in some cases, needlessly causing distress to the warned foreseeable victim.

Although *Volk* permits clinicians to take measures other than warning to protect foreseeable victims, the pressure on clinicians to issue warnings is high, especially in the outpatient context and when patients do need to meet criteria for an involuntary hold under the state's civil commitment laws. When clinicians take other protective measures (such as seeking involuntary or voluntary hospitalization or referring a patient to specialty substance use treatment), they can avoid conflict with the *AMA Code* as discussed here when the other protective measures do not require breach of patient confidences. However, the issuance of warnings might be seen by some as a safe way to discharge one's duty as it is relatively easy to prove (should there be a legal suit against the clinician) that measures to notify were taken (e.g., by obtaining phone records). Clinicians' employers and insurers commonly want to avoid litigation and could instruct (or guide) clinicians to take the safest route to demonstrate they followed the legal mandate, which is to issue warnings. When warnings are to be issued, the law commonly requires clinicians to take reasonable steps to notify both the intended victim(s) and law enforcement [7]. What constitutes reasonable efforts to notify the victim(s) and law enforcement is subject to legal determination and is based on factors such as the measures taken by the clinician (e.g., repeated phone calls, letter), timeliness of the steps taken, characteristics of the intended victim (e.g., whether he or she has a working phone), and the seriousness of the anticipated harm. It is prudent for clinicians to record these efforts.

Ramifications of *Volk* Related to Confidentiality

Applying the legal mandate of *Volk* is likely to lead to some unnecessary breaches of patient confidentiality. Despite advances in violence risk assessment since *Tarasoff*, health care clinicians are poor predictors of when a patient will act violently [19]. Even if a patient expresses violent thoughts to a clinician, it is important to recognize that the expression of violent thoughts is not altogether uncommon. To illustrate, reflect on how many times you may have heard or said things like "I'm so mad I could kill him!" or "I want to tear his head off!" Indeed, there is a weak overall association between threats and acts of violence [20]. What is more, recent studies indicate that only a small percentage of violent acts can be attributed to serious mental illness and that most violence can be attributed to risk factors other than mental illness alone, such as past history of violence and substance use [21].

Volk's requirement for clinicians to take measures to protect anyone who "might foreseeably be endangered" could encourage clinicians to make disclosures to protect themselves from liability, even if they don't believe the patient is likely to harm anyone in particular. Under *Volk*, what is best for the individual patient may be sacrificed for the perceived good of the public. When mental health clinicians take protective measures,

such as issuing warnings or seeking to hospitalize patients, patients' face real consequences, including having their private information disclosed and loss of freedom. Patients also face possible embarrassment, loss of privacy, negative impacts on their relationships and employment standing, and damage to their social standing. Issuances of broad warnings perpetuate the [misperception](#) that people with mental illnesses are typically violent.

These ramifications can also have negative effects on the treatment relationship. A canon of psychotherapy is for patients to be open and truthful about their thoughts, emotions, and behaviors so that these can be addressed through therapeutic means. As articulated by the US Supreme Court, effective treatment "depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears.... [T]he mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment" [22]. Under *Volk*, patients could be left uncertain as to what (and to whom) information they share with their therapist could be disclosed. The *Volk* decision could lead some patients to avoid or withdraw from treatment due to concerns that their private information could be revealed to others, even if they do not reasonably identify a victim or demonstrate current risk of physical harm.

To reduce stigma and engage patients in treatment, the better approach, rather than issuing broad warnings, is for clinicians to perform reasonable violence risk assessments and identify targets of intervention in collaboration with their patients. Risk management interventions are focused on identifying causes of violence for the particular patient and working to reduce each patient's modifiable risk factors for violence [4]. As such, breaching patient confidentiality by issuing warnings should occur only in narrowly tailored circumstances in order to balance other obligations clinicians have to the therapeutic relationship, ongoing treatment, and protection of the public.

Conclusion

The *Volk* case established legal precedent for outpatient mental health clinicians in Washington State. Future cases against clinicians for their patients' harm to third parties (e.g., medical negligence, wrongful death) will be tried under the *Volk* standard. It will be up to the trier of fact to determine whether the victims of a patient's violence were foreseeable and, if so, whether the clinician acted reasonably to protect them.

Without changes to this law, there is increased likelihood that future clinicians and employers in similar situations, fearful of being in Dr. Ashby's position, will more willingly (and likely unhelpfully) breach patient confidentiality. This creates a dilemma for clinicians in Washington State, who could find themselves caught between trying to meet the requirements of the legal case and also adhering to their professional ethical guidelines. Mental health clinicians have largely come to recognize a need for balancing

the interests of patients, clinicians, and potential victims with clearly and rationally defined measures. The *Code* strikes a balance in respecting confidentiality while providing an exception to allow disclosures of patient confidences under reasonable and narrow circumstances to protect identifiable third persons. Concrete legal and ethical standards are better understood and executed by clinicians [23]. A legislative remedy in Washington could better align clinicians' legal and ethical responsibilities and create a clearer standard for clinician duties.

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PEER-REVIEWED CME ARTICLE: MEDICINE AND SOCIETY

Three Perspectives on Mental Health Told through StoryCorps' "Liza Long and 'Michael'"

Jessica C. Tomazic, Joy O. Ogunmuyiwa, and Gretchen A. Ferber, MFA

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Abstract

By examining mental illness through the lens of intimate firsthand accounts of caregivers and patients, including caregiver blogposts and a conversation between Liza Long and her son as recorded by StoryCorps, we demonstrate how new media can be leveraged to shift societal perceptions of those with mental illness from blameworthy potential perpetrators of terror to vulnerable persons in need of compassion and support. Exploring patient, caregiver, and societal roles through a close reading of new media firsthand accounts, we argue for shared responsibility in caring for those with mental illness and, in particular, for physicians to leverage their unique knowledge of the patient experience by promoting media coverage of stories of mental illness recovery.

Introduction

In August 2013, after publishing a controversial online essay, Liza Long interviewed her 13-year-old son Michael (not his real name) for StoryCorps, a nonprofit founded in 2003 to house American stories in the Library of Congress. In the preceding months, Liza launched into the national spotlight as a mental illness advocate by providing her unique perspective as a mother of a boy whose violent rages and inconsistent behavior—due to bipolar disorder—frightened her. In her essay, "I Am Adam Lanza's Mother" [1], Liza imagined her life resembling that of Lanza's mother, who was killed by her son prior to his violent rampage in Newtown, Connecticut, which left 26 elementary school children and staff members dead. Lanza's untreated mental illness renewed the national debate on mental health and violence and the misconception of their connectedness [2].

National coverage of mental health disproportionately focuses on violence, rarely exploring the lived experience of mental illness [3]. StoryCorps and online essay forums offer a different type of media, free from journalistic interpretation and capable of

exploring the [firsthand thoughts and feelings](#) of those experiencing depression, mania, or anxiety as well as the experiences of those persons' loved ones. The StoryCorps interview, "Liza Long and 'Michael'" [4], is a waypoint on Liza's path to mental health advocacy and provides a rich source from which to explore mental illness in the medium of storytelling. In the spirit of StoryCorps, the interview gives rare insight into Michael, the person from whom Liza's fear springs and her strength emanates.

Through a close reading of new media firsthand accounts, including the StoryCorps narrative and blogposts, we explore perspectives of both persons with mental illness and caregivers to demonstrate how firsthand accounts can be leveraged to shift societal perceptions of those with mental illness from violent to vulnerable and in need of substantial support and services. By exploring these perspectives and the complex and misunderstood relationship between mental illness and violence, we seek to encourage responsibility sharing among physicians and members of society in caring for those with mental illness.

Perspective of Person with Mental Illness

In the StoryCorps interview, Michael gives a rare personal account that provides a rich description of his experiences of rage associated with bipolar disorder. Liza opens their dialogue referencing a violent episode when Michael threatened suicide and was admitted to the hospital two days prior to the events at Newtown. Liza elicits Michael's account of the physiological and emotional changes he experiences during a rage-filled episode: rapid heart rate; loss of control accompanied by feelings of powerfulness; and the unpredictable onset, nature, and course of the outburst. During the episode, he does not understand his feelings despite his ability to describe them vividly: "It almost feels like there's some extraterrestrial being taking control of me and making me do all these crazy things. I feel powerful, like I have control, and yet I don't" [4]. Despite this sense of powerfulness, Michael describes himself as "unlikable" because of these outbursts [4]. The vulnerability in his voice elicits sympathy from the listener—what teenager does not want to be liked?—and challenges the notion that those with mental illness are completely in control of their behaviors since Michael's actions are misaligned with how he wants to live.

Liza remains hopeful in describing his improvement while Michael displays defeat, stating he would willingly accept cure even if it dramatically changes who he is: "I'd rather be cured because I'm done" [4]. Michael's desperation, heard in his voice, implores the listener to feel sympathy for the uncontrollable nature of his mental illness, the incongruence between how he wants to act and how he acts when untreated, and his desperate desire for life to be different.

Perspectives of Caregivers

Blogposts like “I am Adam Lanza’s Mother” offer the national psyche what funerals offer individuals—a way to mourn following a tragic loss. Grief can be expressed as both secular and spiritual emotions, and Liza deftly weaves the two by employing a storytelling style that alternates between the reflective and the conversational. Heavily pulling from exchanges with Michael, Liza demonstrates this storytelling style while illuminating the relationship she has with her son, society, and herself. She writes,

On the intake form, under the question, “What are your expectations for treatment?” I wrote, “I need help.” And I do. This problem is too big for me to handle on my own. Sometimes there are no good options. So you just pray for grace and trust that in hindsight, it will all make sense [1].

Sue Klebold—the mother of Dylan Klebold, a shooter in the Columbine massacre—also employs this style in her writings about her son. Without censoring conversational tics, she uses a dialogue-heavy introduction to forcibly place her reader exactly where she was on the day of the Columbine massacre.

His [my husband’s] voice was breathless and ragged, and his words stopped my heart. “Susan—this is an emergency! Call me back immediately!”... With every cell in my body, I felt his [Dylan’s] importance to me, and I knew I would never recover if anything happened to him [5].

When told her son is the shooter, her writing is contextually haphazard and delivered in a fractured manner. This literary device allows the reader to experience the extensive range of emotions felt by Klebold and echoed by Long.

Despite the immediacy of the accounts of Klebold and Long, as caregivers, they are limited in their ability to understand the experience of the person who is ill. Liza’s writing restricts our voyeurism with her secondhand account of a person living with mental illness. She is not a third-person omniscient narrator, free to move through time and space, able to reveal the internal thoughts of those in her story. She can only write of what she knows. The blogs of Long and Klebold can be seen as a part of their autobiographical story—their story as the caregiver, their own view of *self*. They choose this medium as a tool of rationalized reflection on their own actions, thoughts, and words. In their story, as in anyone else’s, the author is the final arbiter of truth. As readers, we can only use Long’s and Klebold’s rationalizations as a way to comprehend their difficult situation, even if we only choose to resist any change in opinion and simply affirm what we think we already know.

Social Perceptions of Mental Illness

Society assumes a dual role in addressing the challenges of mental illness: it ensures the welfare and safety of the public at large and protects and serves the disenfranchised and marginalized, especially those with mental illness. However, media accounts shape societal perceptions of mental illness, with contemporary stories on mental illness often featuring mass shootings and propagating the mistaken interconnectedness of mental illness and violence [3]. Through her adept use of new media, Liza attempts to address the duality of societal roles in her interview, weaving a delicate conversation that acknowledges the [threatening public image](#) of those with mental illness while challenging us to reconsider them as vulnerable rather than violent.

Liza clearly recognizes yet subtly challenges the perceived assumption that the public needs protection from those with mental illnesses. In asking Michael if he thought her blog post accurately described his disturbing rages, she underscores the notion that those with mental illness understand that the public perceives them as threats [4]. Although some persons experiencing mental illness do commit violent crimes, only 4 percent of violent crimes are committed by persons with mental illness [6]. While media accounts link mental illness with violent acts, reality and public perception do not mesh [3].

By creating a forum for Michael, Liza delicately encourages society to accept its role in caring for vulnerable populations. Michael offers insight into a heartbreaking reality for many with mental illness: feeling “unlikable,” like he “didn’t have control,” he ultimately suffers so much that he prefers losing his personal identity in the name of a cure [4]. By allowing Michael to publicly express these appreciably human feelings, the conversation between Liza and her son lays the foundation for the public’s understanding that those experiencing mental illness share similar vulnerabilities—such as loss of control, compromised modesty—with other patient populations. However, the conversation between Liza and Michael reflects the need for changes in public perception when legal intervention is recommended as a “treatment” option for her son [7]. Regardless of the pathology, society faces a duty to provide for the health and welfare of those who are suffering.

Conclusion

In any illness, perceptions and roles—of patient, caregiver, clinician, and society—define experiences of illness. Firsthand accounts offer opportunities to reflect on the experiences of those subject to a debate so wrought with controversy that perceptions and reality exist as polar domains. The physician can serve as a rare conduit from patient to society, relaying the lived experience of persons with mental illness and caregivers through an intimate awareness of their vulnerabilities yet appreciating the impact of societal perceptions. Physicians can help bridge the divide through media training that

might make them more willing to share their insider knowledge to promote stories of mental illness recovery [8], which make up only 14 percent of news stories about mental illness [3].

While our analysis in no way brings resolution, we enrich the conversation by illustrating the complexity of patients' and caregivers' roles and perceptions. By exploring how the experience of mental illness is humanized in new media firsthand accounts, we demonstrate that stories both respond to and seek to shift societal perceptions. In this light, we encourage more inclusive sharing of responsibility for those with mental illness and caregivers like Liza Long and, ideally, providing compassionate care and support.

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FROM THE EDITOR

Violence as a Public Health Crisis

Violence, overall, has become a public health crisis. The three leading causes of death in the United States for people ages 15-34 are unintentional injury, suicide, and homicide [1]. These violent deaths are, more often than not, directly associated with firearms. The US has a homicide rate 7 times higher than other high-income countries, with homicides committed by firearms being 25 times higher than in other high-income countries [2].

According to the National Violent Death Reporting System, violence is preventable [3]. Supportive relationships can decrease violent behaviors and disrupt a “cycle of violence” [4]. Education on life skills and conflict resolution at an early age can also prevent violence [5]. The Centers for Disease Control and Prevention (CDC) states, “By understanding ... types of violence, we can take action to stop them before they start in our communities” [6].

This issue of the *AMA Journal of Ethics* examines the scope of physicians’ duty to support and counsel patients afflicted by any form of violence, as well as other ethical questions raised in the course of responding to victims of violence and preventing violence. The case commentaries and articles are meant to increase readers’ awareness of, and to provide guidance on, violence as an epidemic with features of ethical, clinical, and public health relevance.

According to Gary Slutkin, violence should be treated as a disease [7]. In this issue, he and Charles Ransford and Daria Zvetina explore the analogy between [violence and contagious processes](#). If violence is a disease, then physicians need to step in and provide preventative care, especially since physicians are among the first professionals victims present to, if they choose to seek treatment at all [8]. In the [podcast](#), Slutkin discusses what would it mean to treat violence—including mass shootings—primarily as a health problem, while Robert Torres describes the health impact of violence within communities in Chicago. But physicians also need to respond to violence on an interpersonal and ecological level. Anita Ravi explores how [drawing comics](#) has helped her to provide more sensitive care to survivors of sexual trauma. And Bandy X. Lee and John L. Young discuss the need to focus on “[caring well](#)” to reduce violence in our communities.

Research indicates that some physicians feel unqualified to hold conversations with patients about gun violence and safety protocols [9], despite feeling ethically obligated

to do so. Nicole D. Damari, Karan S. Ahluwalia, Anthony J. Viera, and Adam O. Goldstein present the results of a survey demonstrating that [continuing medical education](#) in firearm safety increases physicians' confidence in their ability to counsel their patients on the topic. And Alexander D. McCourt and Jon S. Vernick discuss legal and ethical concerns that tend to arise when speaking to patients about [firearm storage, transfer, and safety](#).

Intimate partner violence has been a public health issue since the 1960's [10]. A World Health Organization multi-country study found that the prevalence of intimate partner violence for women is 15 to 71 percent [11]. Rape is now known to occur more frequently than reported, with only 36 percent of victims reporting to police [12]. Reasons for not reporting include victims' lack trust in the justice system or not wanting others to know [13]. Michelle Bowdler and Hannah Kent discuss a [sexual assault](#) case involving a minor and argue that any victim of sexual assault should be allowed to refuse forensic-related treatment, even if the victim's legal guardian disagrees. And Melinda Manning discusses how institutions that train medical students and residents can fulfill their [Title IX obligations](#) to resolve allegations about sexual discrimination in ways that support trainees who have been victimized.

Three articles discuss physicians' roles in working with community services and law enforcement to prevent gun violence. Amy Barnhorst, Garen Wintemute, and Marian E. Betz examine the conflict between [mandatory reporting requirements](#) and the need to protect patient confidentiality in a case of a firearm-owning patient who might pose a danger to himself and others. Jennifer L. Piel and Rejoice Opara show how the Washington State case of *Volk v DeMeerleer*, which arguably encourages clinicians to breach confidentiality by broadening the definition of potential victims, conflicts with the *AMA Code of Medical Ethics'* opinions on clinicians' ethical obligations to [preserve patient confidentiality](#). Taking a normative position, Nora Jones, Jenny Nguyen, Nicolle K. Strand, and Kathleen Reeves argue that physicians should not serve as "[gatekeepers](#)" of gun privileges by assessing a patient's fitness to carry a concealed weapon; rather, they suggest physicians should advocate for policies and interventions that reduce gun violence.

Injuries and deaths might be prevented if there were more education about gun safety protocols, but studies are not being conducted with federal funds, as Congress has ensured that no Centers for Disease Control and Prevention funds can be applied toward gun violence research [14]. Kelsey Hills-Evans, Julian Mitton, and Chana A. Sacks focus on the need to develop gun safety guidelines and violence risk assessment tools while also discussing the importance of resuming and continuing [research](#) on the implementation of gun violence prevention interventions in clinical practice.

Finally, two contributions to this issue address representations of violence. Jessica C. Tomazic, Joy O. Ogunmuyiwa, and Gretchen A. Ferber examine how physicians, with their intimate awareness of the vulnerabilities of patients with mental illness and their caregivers, can help to combat popular [misconceptions of the mentally ill](#) as violent by promoting stories of mental illness recovery. Finally, Dino Maglic explores how clinicians—such as the University of Utah Hospital nurse Alex Wubbels—serve patients well by [protecting those patients' rights](#), even when doing so puts them in harm's way.

This issue brings attention to the ethical dilemmas clinicians encounter when responding to victims of violence. It seeks to provoke thought about the ethical, legal, and policy dimensions of violence reduction and prevention efforts, with the aim of helping clinicians to consider how to draw upon their social and cultural influence to promote patient- and community-centered policy and legislation.

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ETHICS CASE

How Should Physicians Make Decisions about Mandatory Reporting When a Patient Might Become Violent?

Commentary by Amy Barnhorst, MD, Garen Wintemute, MD, MPH, and Marian E. Betz, MD, MPH

Abstract

Mandatory reporting of persons believed to be at imminent risk for committing violence or attempting suicide can pose an ethical dilemma for physicians, who might find themselves struggling to balance various conflicting interests. Legal statutes dictate general scenarios that require mandatory reporting to supersede confidentiality requirements, but physicians must use clinical judgment to determine whether and when a particular case meets the requirement. In situations in which it is not clear whether reporting is legally required, the situation should be analyzed for its benefit to the patient and to public safety. Access to firearms can complicate these situations, as firearms are a well-established risk factor for violence and suicide yet also a sensitive topic about which physicians and patients might have strong personal beliefs.

Case

After a painful breakup with his long-time girlfriend, Thomas struggled to get over feeling angry about his girlfriend's decision to end their relationship. Specifically, Thomas was unable to sleep well, despite trying numerous over-the-counter sleep aids. He decided to make an appointment with Dr. B to get a prescription for something that might help.

Dr. B asked, "How long have you had insomnia, Thomas? Can you tell me a little more about when this started?"

Thomas explained, "I just moved here. I started a new job. But I had trouble sleeping before that." He added, his tone becoming angry, "when my girlfriend dumped me."

"That sounds really hard for . . ." Dr. B began, but Thomas cut her off.

"Then she called the cops because she was freaked out about my gun. She told the cops I was threatening her and threatening to kill myself."

"And had you?" Dr. B asked. Thomas was silent. Dr. B continued, "I see on the form you completed that you checked 'yes' about having been admitted to a psychiatric hospital. Does that have anything to do with what happened during your argument with your ex-girlfriend?"

Thomas sighed and then responded, "Yes, I was taken that night by the police to the hospital and evaluated briefly." He continued, "But I'm not crazy. I just can't sleep now. Every time I think about her ... I just want to make her go away. Get rid of her forever. And maybe get rid of myself too," he muttered, as his anger became evident again.

"And your gun? Is it still in your possession?" Dr. B asked.

"Yes," Thomas responded.

Dr. B began, "Thomas, what you've shared with me makes me concerned about your own and your ex-girlfriend's safety. In this state, I'm required to report concerns like that."

Thomas stared at Dr. B. "What!?" he exclaimed. "I thought this was confidential!"

Commentary

Since the beginnings of Western medicine in the days of Hippocrates, patient confidentiality has been an important ethical responsibility of the physician. In the Hippocratic Oath, considered by many to be the first known guidelines written for medical ethics, physicians vow that "What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about" [1]. Various, more modern versions of ethical codes for physicians, like the American Medical Association's *Code of Medical Ethics*, have reinforced the Hippocratic Oath's emphasis on confidentiality [2, 3]. In this article, we discuss a case in which the physician is faced with a situation in which breaking confidentiality might result in reducing her patient's risk of violence and suicide.

Disclosing Protected Health Information

In 1996, the federal government passed the Health Insurance Portability and Accountability Act ([HIPAA](#)) to standardize the expectations of patient confidentiality surrounding protected health information (PHI), which comprises any health care information that can be linked to a specific individual, such as diagnostic or treatment information [4]. With this increased regulation came increased sanctions for violations and physicians' growing concerns about both their ethical and legal duties concerning confidentiality [5]. However, HIPAA's implementing regulations describe particular exceptions in which it is appropriate to break confidentiality, particularly in circumstances

when a failure to do so could result in harm to the patient or to society [6].

One type of exception involves threats made by a patient to harm him- or herself or another person. HIPAA's implementing regulations allow disclosure of PHI when disclosure "is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and ... is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat" [6]. The persons "reasonably able to prevent or lessen the threat" might be law enforcement, family members, or the victims themselves. The key term "imminent" is not defined, but in studies of violence prediction, imminence has been taken to mean time measured in days to months [7]. In addition to the HIPAA exception for imminent danger, most states have laws that mandate or permit [disclosure](#) of PHI in the event of a threat [8].

In determining whether the risk is serious, access to firearms should be taken into account, as guns are an important risk factor for both violence and suicide. One study showed that having a firearm in the home was associated with a nearly fivefold increase in risk of suicide, and another showed that having a firearm in the home was associated with a nearly threefold increase of risk of homicide, after controlling for other factors [9, 10]. Firearms are a particularly important factor in domestic violence, as roughly forty percent of female homicide victims are killed by an intimate partner (i.e., spouse, ex-spouse, lover) [11], and roughly 60 percent of those homicides involve guns [11].

Counseling Patients about Firearm Safety

Despite their importance in risk assessments, firearms can be a difficult and anxiety-provoking topic for physicians, particularly when they are not personally familiar or comfortable with guns. In such situations, physicians must consider how the firearm might affect their [risk assessment](#). Depending on their personal experience with guns, physicians might have varying levels of concern about or comfort with the implications of a firearm's involvement in a given case. They might also be hesitant to question a patient further on the topic, as they might be concerned about offending the patient by asking about what many perceive to be a private issue. However, ascertaining the types of guns owned, how they are stored, and if the patient has any intentions of using them are important components of risk assessment.

In general, approaches used with other sensitive topics apply in asking about guns as well [12]. Introductory statements that normalize the discussion can be useful, such as "Many of my patients are firearm owners, and, as a physician, I try to address any related health or safety concerns." It is helpful to focus on statements that emphasize collaboration, respect for Second Amendment rights, and the goal of changing access temporarily (rather than permanently) [13]. For example, the physician could say, "Some gun owners with suicidal thoughts choose to make their gun less accessible. Are you interested in talking about that?" [14]. Use of the "designated driver" analogy might be

helpful, as this concept—of not having the car keys while temporarily at risk of crashing—is one most have heard of. When faced with an analogous situation of a person temporarily at increased risk of violence or suicide, a physician could consider counseling the patient without directly asking about firearm access, as the questioning (and recording of responses in the medical record) might be particularly uncomfortable for some patients [15].

Counseling about reducing firearm access should be collaborative and focused on supporting the patient's autonomy in choosing a safe storage option. Options for storage include out-of-home storage with a family member or friend or at a range, gun shop, or other business, although state laws may dictate which of these options is legal or requires a background check [16]. In-home strategies to reduce firearm access include the use of various locking devices and disassembling the firearm. If Thomas is unwilling to temporarily turn his guns over to someone else for safekeeping, Dr. B could bring up options such as lockboxes, cable locks, or gun safes to reduce immediate access [17].

When Is Reporting Required?

Physicians also face the difficult task of deciding whether or not the situation constitutes enough of a risk to breach the patient's confidentiality. In many cases, physicians might choose to tell the patient, as Dr. B did, that the information will be shared with another party. However, in situations in which this information might further agitate or anger the patient, physicians might decide not to disclose that they are reporting in the interest of their own safety or that of a third party.

Some states mandate that confidentiality be broken to report a threat of harm under certain circumstances. For example, California Civil Code 43.92, known as the "Tarasoff statute," requires that if a patient makes "a serious threat of physical violence against a reasonably identifiable victim" to a psychotherapist, that psychotherapist is required to take steps to protect the intended victim [18]. This statute was based on a 1974 lawsuit against the university that employed a therapist whose patient had confided to him that he planned to kill a woman he had formerly dated, Tatiana Tarasoff [19]. The patient then acted on his threat. Many other states followed suit with similar reporting laws for mental health professionals or physicians in various circumstances in which there is a threat of violence. These laws vary from state to state as to whether disclosure of PHI is mandatory or permissible [8]. There is also considerable variation in the specificity of the threat the laws address. Some state laws require a clearly identifiable victim, while others refer only to threats to the public in general [8].

Despite their attempts at specificity, these laws often do not fit neatly onto real-life patient cases. In some jurisdictions, the statements made by the patient can meet the threshold at which a physician is mandated to report in order to warn or protect a potential victim. But where they do not, they would likely qualify as permissible reporting

under HIPAA [6]. At that point, it is up to the physician to determine whether or not the potential harm of breaking confidentiality is outweighed by the potential harm of maintaining it. It might be helpful for the physician to approach this evaluation using the principles of beneficence and autonomy.

Beneficence in this case depends on what good may come from the decision to report these threats to a third party. If the threat falls into a gray area but appears unrealistic and so poses little danger, there might be little benefit in sacrificing patient rapport and autonomy. An example of a situation of this kind would be a patient in an institutionalized setting threatening to hurt someone in a different country whose whereabouts he is unsure of. However, in the particular situation specified in the case scenario, the patient knows the whereabouts of his potential victim and has the means (a gun) to inflict harm. While Dr. B might drastically reduce her rapport with her patient and the patient's autonomy by not allowing him to make his own choices, disclosing information about his threats to his former girlfriend and exploring options to reduce his access to his gun in a time of crisis might save a life.

Conclusion

Physicians might be faced with difficult legal and ethical decisions in cases in which patients appear at risk of violence or suicide, particularly when firearms are involved. Discussions about the risks of firearms should be approached collaboratively so as not to diminish patient rapport. Additionally, physicians should be cognizant of when they are required to report concerns for violence or suicide and when they are permitted to do so. In situations in which such reporting is permitted, they should balance patient autonomy and beneficence with patient and public safety.

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ETHICS CASE

Should a Physician Comply with a Parent's Demands for a Forensic Exam on a 16-Year-Old Trauma Patient?

Commentary by Michelle Bowdler, MSPH, and Hannah Kent

Abstract

Physicians must remain vigilant about their ethical duties to patients, especially in high-stakes situations. The question raised by this case—whether a physician should comply with a parent's demand for treatment against her underage child's wishes—is not one of life or death in which a guardian might more credibly argue her judgment should stand. Given that forcing a rape kit exam on a patient who refuses to give assent could be further traumatizing, we argue that the physician should not comply. Deciding upon a course of action in this situation will involve considering what is in the patient's best interest and what constitutes a physician's appropriate role in gathering evidence for criminal investigations.

Case

Awakened by the loud, repetitive calling of her name, Anu squinted at the sight of the bright ceiling lights of the emergency department. Trying to make sense of where she was, she heard her mother crying. Dr. K stated loudly, "Anu, nod your head if you can hear me." Anu nodded.

Brought by ambulance after being found by a stranger late that night outside of a concert venue, Anu had sustained multiple blows to her face and head. Blood visibly ran down her neck and torn clothing, which smelled of alcohol and vomit. Anu's mother, Ms. Raina, rushed to her side as her daughter responded to Dr. K. "Honey, sweetheart, everything is going to be okay. I'm going to make it better for you," she gently spoke as she grabbed her daughter's hand. "Anu, did that boy do this to you?"

Ms. Raina motioned to talk to Dr. K a few steps away from Anu, "I can tell you it was her ex-boyfriend who did this to her, Dr. K. He beat her. He raped her. We need evidence to put him in prison. I want you to do a rape kit, collect evidence, and give her emergency contraception."

"Mom, no, I don't want any of that," Anu stated softly but clearly, "Please, no."

Ms. Raina motions for Dr. K to speak with her off to the side of the room, "She is 16 and traumatized. I am her mother. You must do these things."

Dr. K suggests to Ms. Raina that they do not need to act immediately. "We have some time before we miss opportunities to collect evidence or administer emergency contraception. Anu needs some time. I'll admit her to the unit and there'll be time to revisit these questions tomorrow."

The next day, Dr. K met again with Anu and Ms. Raina. Anu continued to refuse the pelvic exam that would be required for evidence collection, and she was unwavering in her refusal of emergency contraception. Ms. Raina steadfastly insisted on both. Dr. K explained to Ms. Raina privately, "Since Anu does not assent to the pelvic exam or to administration of emergency contraception, we would need to restrain her to do what you want us to do, Ms. Raina. Do you understand that our doing that could retraumatize her?"

Ms. Raina paused and looked away. "Can't you just put her to sleep for that?"

"Yes," Dr. K clarified, "But that's chemical restraint. That's still a use of force against a patient that can have very serious consequences for a trauma survivor."

Regretful but certain, Ms. Raina said, "Do it. That boy must pay for what he did to Anu. I could never forgive myself for letting him go without punishment."

Dr. K listened, considering what to do.

Commentary

In this case, we observe the clinician considering the option of chemical restraint to meet a mother's plea that her 16-year-old daughter, who has been sexually assaulted, receive a rape kit and emergency contraception, which she has refused multiple times. A rape kit goes beyond a pelvic examination. It is a multihour exam that includes head and pubic hair combings; vaginal, anal, and oral swabs; saliva or blood samples; and fingernail clippings. A rape kit is considered a forensic exam and can only be done by trained clinicians [1]. The answer as to whether the physician should chemically restrain this patient against her will to perform this exam is a resounding "no." The reasons why the physician should not comply involve multiple ethical standards, any one of which would be sufficient to decline this request. These ethical principles will be discussed in the context of the legal landscape and patient-centered, [trauma-informed care](#).

Legal Issues

If Dr. K. is unsure about whether to use force (chemical or physical) against the will of the patient, he might wish to consult legal counsel before proceeding. Who are the

responsible parties, and who gets to decide about medical intervention when the patient is underage and the patient and guardian disagree? Might courts give trauma victims more leeway in deciding their own care? Are there legal aspects the physician should be aware of as he ponders his course of action? These are reasonable questions to consult hospital counsel about concurrently with ethical considerations.

The mother is the patient's legal guardian and therefore has the authority to give consent for medical treatment up to the age of majority in most states [2]. Moreover, in states where a minor's assent is required for drug or mental health treatment, allowing parents to compel such treatment against a teenager's wishes might not succeed. Kerwin et al. note:

When families live in a state that requires a minor to consent to treatment ... parents ... can: (a) try to 'force' their unwilling child into treatment; however, even if they succeed in getting the child in the treatment door, minors in these states would be allowed legally to refuse the treatment and to discharge themselves at any point during treatment [3].

There is little precedent in literature or law that supports a parent forcing a procedure on an adolescent patient against her will, particularly if it is specific to sexual health or sexual assault [4]. By explaining to the mother that [chemical restraint](#) is the only way to perform a rape kit against the daughter's will, the physician might now benefit from legal advice if he decides he cannot proceed with the guardian's wishes.

Ethical Issues

The ethical issues raised by this case scenario include respect for autonomy, shown by seeking informed assent; medical necessity; and support of surrogates.

Consent and assent. Although Anu is legally a minor and a proxy makes medical decisions for her (unless she resides in a state that recognizes a "mature" or "emancipated" minor status [4]), she is still an autonomous person and her explicit refusal of the procedure over a period of time is a crucial factor in the situation. The law determines whether or not she is competent, and, by virtue of her age, she has not yet attained that legal status. However, ethically, Anu might very well have capacity to decide to refuse the procedure; the capacity for voluntary consent or refusal varies over time and with the severity of the treatment decision [5], so while patients may not be legally competent, they still might have the capacity to decide in certain situations what their preferences are. The physician in this case should seek Anu's assent to perform the rape kit and should do so independently of the mother's views. Obtaining a minor's assent, or expressed voluntary participation, has been shown to empower minors and give them a means and sense of control, making it easier for them to cope with the treatment or procedure [6]. In

obtaining Anu's assent, the care team should ensure that both the mother and Anu understand the risks, benefits, and consequences of each possible action.

However, this assent must be truly voluntary. Even if Anu assented to the exam because of pressure from her mother, and perhaps fearing the possibility of chemical restraint, the physician could decline to perform the examination if he determined the assent was only given under duress. As is well understood in the field of ethics, a minor's assent or an adult's consent must be made voluntarily by a patient with decision-making capacity who understands the risks, benefits, and alternative approaches. The American Academy of Pediatrics affirmed in its ethical guidelines, "When obtaining assent from older adolescents, it is reasonable to assume that an adequate assent process would be viewed the same as the informed-consent process for adults, although parental permission is still required" [7]. Moreover, the Academy [8] recommends that informed assent should be obtained in most cases of "performance of a pelvic examination in a 16-year-old" [9], which specifically addresses the case in question and would therefore prohibit restraining Anu and forcibly conducting the rape kit [10].

Medical necessity. The fact that a rape kit entails obtaining multiple hair, skin, and body fluid samples provides insight into the invasive nature of the procedure. Given that this procedure is not medically necessary and could actively harm the patient through retraumatization (as will be discussed below), ethically, the burden of proof would be on the mother to explain how the benefits outweigh the risks and harms to her daughter. Anu is not requesting medical care without her mother's consent, nor is she requesting a procedure that is medically inappropriate. Rather, she is refusing a procedure that is designed to obtain forensic evidence and is not required for her health. And often, in our experience, it is easier to honor a request to refuse an intervention than to conduct an intervention against the wishes of a patient. These considerations align with the American Academy of Pediatrics, which recognizes refusal to assent based on the lack of medical necessity as a valid objection to treatment, as the refusal should "carry considerable weight" when it is not essential to welfare [11].

Support of surrogates. The mother in this case scenario has explicitly requested that the rape kit be done because "We need evidence to put him [the ex-boyfriend] in prison" and because she could never forgive herself "for letting him go without punishment." The underlying reasons for the rape kit are to address the needs of the mother, while only possibly benefitting Anu. In cases in which the wishes of the surrogate are not in line with the best interest of the patient, the American Academy of Pediatrics states that the clinician's duty should be "based on what the patient needs, not what someone else expresses ... the pediatrician's responsibilities to his or her patient exist independent of parental desires or proxy consent" [12]. The physician should consider the mother's request in the context of the well-being of her daughter and recognize that the mother's trauma in experiencing this ordeal is affecting the goals of care. To support her, the

physician should introduce resources such as social work and counseling before complying with a request that might originate from the mother's devastation and pain and that could ultimately harm her daughter.

Patient-Centered Response

Responses to trauma survivors in the literature reveal that their experiences are relatively negative, both within the legal and medical systems [13-15]. Survivors often find that the criminal justice system has outcomes quite unfavorable to them; most sexual assault cases are never prosecuted, and, on average, in 12 percent of reported cases the offender is convicted [16]. Some behaviors that personnel might exhibit exacerbate the survivor's experience—including expressing disbelief that the survivor was raped, blaming the survivor for the assault, and treating her coldly—and are classified as secondary victimization [17, 18]. This reality is important for medical personnel to keep in mind, as the physician in this case demonstrates when he asks the mother, "Do you understand that our doing that [chemical restraint] could retraumatize her?"

Respecting rape survivors' agency is key to survivors' successful interactions with the legal and medical systems because these institutions often retraumatize women and can have a significant impact on their help-seeking experiences [18]. During a rape, a person has control taken from her or him. In the immediate aftermath of rape, one of the most important factors for the victim is to be able to re-establish some sense of control and safety, and it is important that people around the victim understand that need [18]. Anu has declared repeatedly that she does not want the exam that her mother is advocating she obtain. Moving forward regardless of the daughter's wishes could impact Anu's relationship with both her mother and health professionals for years to come.

Given what the patient has just been through and the American Academy of Pediatrics' recommendations, it is unwise for the physician to restrain Anu against her will and perform an intrusive multihour exam. This action would be uncomfortably similar to her assault and potentially harm the patient. The physician should ask the mother to consider the emotional consequences of proceeding as well as the injury it would cause to her relationship with her daughter. The family could certainly benefit from speaking to a rape crisis counselor or social worker who could listen to the mother's concerns but ultimately remind her that her daughter has made her wishes known and that those wishes must be respected. The counselor or social worker could also talk to Anu about the window of time available to get the rape evidence collected and the reality that once this window has passed, evidence can no longer be obtained, which would adversely affect her ability to press charges against her perpetrator in the future, should she change her mind. Helping Anu understand the long-term consequences of her decision is important in this situation to ensure that she is making an informed choice.

Conclusion

To conflate a parent's desire to pursue criminal justice with medical care is a serious error that could have negative consequences for the patient. [Emergency physicians](#) often are confronted with victims of violence and must sensitively address the difficult and complex dynamics that affect the victim and family members. In some states, a volunteer from a rape crisis center will come to the hospital to support the patient and could help address parents' concerns about their daughter's physical and emotional needs as well as answer some of their questions about the criminal justice system [19-21]. A physician should develop a discharge plan for the patient, which can include counseling from a trauma specialist. For the family in this case scenario, a discharge plan would be especially important and might help the parent and child work together on the difficult healing ahead.

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THE CODE SAYS

AMA Policies and AMA *Code of Medical Ethics'* Opinions Related to Responding to Violence

Danielle Hahn Chaet, MSB

The American Medical Association has several policies regarding physician response to [violence](#) (“Firearms as a Public Health Problem in the United States—Injuries and Death,” H-145.997 [1]; “Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care,” H-145.975 [2]; “Addressing Sexual Assault on College Campuses,” H-515.956 [3]; “Rape Victim Services,” H-80.998 [4]; “Family and Intimate Partner Violence,” H-515.965 [5]; and “Alcohol, Drugs, and Family Violence,” H-515.975 [6]). These policies specifically encourage awareness and prevention on local, state, and national policy levels as well as physician education in these areas. The *Code of Medical Ethics* also addresses violent harm to patients. The following paragraph is reprinted (with the exception of changes in citation numbers) from the January 2017 issue, 19(1), of the *AMA Journal of Ethics*.

Specifically, Opinion 8.10, “Preventing, Identifying and Treating Violence and Abuse,” states that “physicians have an ethical obligation to take appropriate action to avert the harms caused by violence and abuse” [7]. Outlined in this opinion is the physician’s obligation to familiarize him- or herself with strategies for violence and abuse detection, resources available to the patient, and legal [requirements for reporting](#). The opinion further states that physicians should “obtain the patient’s informed consent when reporting is not required by law.” In the case of minors, reporting to an appropriate agency, with or without the consent of the child, is required by law in all 50 states [8]. When the patient is an adult, however, physicians should inform the patient about his or her legal requirements to report any suspected violence or abuse and should obtain the adult patient’s informed consent to do so [7]. Exceptions are appropriate when a physician believes that an adult patient’s refusal to authorize reporting is coerced. As always, physicians should protect adult patient privacy when reporting by disclosing only the minimum necessary information. This information might vary depending on what applicable laws or policies are valid where the physician is practicing. (See also Opinion 3.2.1, “Confidentiality” [9].)

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IN THE LITERATURE

How the Health Sector Can Reduce Violence by Treating it as a Contagion

Gary Slutkin, MD, Charles Ransford, MPP, and Daria Zvetina

Abstract

Violence is best understood as an epidemic health problem, and it can be effectively prevented and treated using health methods to stop events and outbreaks and to reduce its spread. This health framing is important because it recognizes that violence is a threat to the health of populations, that exposure to violence causes serious health problems, and that violent behavior is contagious and can be treated as a contagious process. Relatively standard and highly effective health approaches to changing behaviors and norms are increasingly being applied to the problem of violence and are showing strong evidence of impact among individuals and communities. We need to mobilize our nation's health care and public health systems and methods to work with communities and other sectors to stop this epidemic.

Introduction

Because of its pervasiveness and far-reaching effects, violence is one of the most devastating national and global challenges we face. In the United States, homicide is the fifth leading cause of death for those under age 45 [1]. Violence not only causes injury and death; it also erodes the physical, psychological, social, and economic health and development of nearly everyone in affected communities, reducing life expectancy, inflicting trauma, limiting opportunity and achievement, and further entrenching inequities [2-10].

Recent advances in neuroscience, behavioral science, and epidemiology demonstrate that violence behaves like other contagious epidemics [11], yet violence is not primarily managed by the health sector, and health professionals are not the principal spokespersons or policy advocates on the issue. While health and [public health methods](#) for stopping violence exist and have been proven effective, they are underutilized and under-resourced [12, 13].

Health professionals have ethical responsibilities to fully understand violence; to convey accurate information to patients, families, and the community; to provide the best care and follow-up to ensure recovery from violence; and to help prevent violence. We health professionals also have an ethical obligation to educate the public and policymakers

about the new scientific understanding of violence as a contagious process that has emerged. It is our job to share this new understanding to shift the world's thinking toward scientifically grounded solutions for violence prevention. This paper outlines what is known about violence as a health issue and contagious process, effective programs for reducing violence, and practitioners' obligations to reverse this epidemic by acting on this new knowledge.

Violence Is a Contagious Health Problem

It is now scientifically clear that violence behaves like a contagious and epidemic disease [11]. Violence meets the dictionary definition of disease (characteristic signs and symptoms causing morbidity and mortality [14]) and of contagious (transmissible, causing more of itself [11]). Violence also exhibits the population and individual characteristics of [contagious epidemics](#)—clustering, geo-temporal spreading, and person-to-person transmission [11, 15-21]. Incubation periods, defined as the time from infection to evidence of clinical disease, are variable in both infectious diseases and violence. Some other infectious diseases such as malaria and tuberculosis have incubation periods that range from weeks to years. Incubation periods for violence can also vary greatly. They can be rapid (as with cholera) for riots, gang wars, or the genocide in Rwanda [22], or they can be longer (as with tuberculosis) for family or community violence, where the period between being subjected to child abuse, for example, and becoming a perpetrator of violence may be years or decades [23, 24].

People at heightened risk for violence have acquired this susceptibility in the same way that people acquire other contagious diseases—through *exposure*. The particular contagion of violence is initiated by victimization or visual exposure and mediated by the brain, just as the lungs mediate replication of tuberculosis or the intestines cholera. The brain processes violence exposure into scripts, or copied behaviors, and unconscious social expectations. This processing can also lead to several situationally adaptive responses including aggression, impulsivity, depression, stress, exaggerated startle responses, and changes in neurochemistry [12]. The result in each case is production of more of what there was an exposure to, i.e., transmission to subsequent person(s) or groups.

Past exposure to violence is the strongest predictor of violent behavior [25], and each violent event represents missed prior opportunities for prevention and current opportunities to stem progression and spread. Studies have shown that exposure to violence from victimization or direct visual exposure increases the risk of chronic violent behavior thirtyfold [15]. Exposure to peers who are victims in one's social network also increases the risk of violent victimization [25], similar to the elevated infection risks of close contacts of persons with tuberculosis [26].

As is the case in most contagious processes, not all persons exposed express the clinical condition of violent behavior, as there are factors that influence uptake—in particular, proximity, dose, and age. Other factors, such as poverty, poor education, and family structure, should be understood as modulating factors [12]. As with other diseases, these modulating factors are important, but specific strategies for interrupting progression in a person or transmission in the community provide the best opportunities for reversal of the problem. These processes, whereby persons exposed to violence are at heightened risk for perpetration of violence, are thought to be responsible for contagions of child abuse, intimate partner violence, street violence, suicide, mass shootings, riots, and terrorism [27]. These types of violence should be understood as syndromes of the same disease process that differ by context.

Health and Public Health Methods to Prevent Violence

New methods are now available for stopping the spread of violence that are tailored to its disease-like characteristics. The public health sector has a strong record of effectively preventing disease—including stopping epidemic disease—changing norms and behaviors, and reaching high-risk populations. The epidemic control approach to reducing violence will be highly recognizable to those who have worked in infectious and epidemic control. Community-based health workers are selected, trained, supervised, and supported under the guidance of the health sector. Health workers map out areas of highest transmission and symptom manifestation, reach out to and intervene with those displaying clinical signs to reduce further transmission using methods tailored to the infectious agent at play, detect close contacts and others with emergent symptoms or at highest risk of future contraction, and render all those at highest risk less symptomatic and likely to transmit. Through these methods, health workers reduce spread of the contagion and reverse the epidemic process. As with other contagious health problems such as AIDS and Ebola, new protective behaviors and norms are then promoted and supported at the community level [28].

Over the last 15 years, Cure Violence (the initiative with which the authors are affiliated) and other organizations have used these epidemic control methods to reduce community violence in dozens of communities in the US and around the world [27, 29]. The Cure Violence approach employs violence interrupters, outreach workers, and hospital responders to prevent violent events and retaliations, reduce risk among those most likely to become violent, and shift norms to discourage the use of violence. Violence interrupters work to detect and interrupt conflicts to prevent them from escalating into potentially fatal violence. Outreach workers identify those at highest risk and work to decrease their likelihood of violence by addressing their risk factors. Community-based hospital responders provide immediate crisis intervention to victims of violence at hospital trauma centers, work to prevent retaliation or subsequent re-injury, and address psychological trauma that the victims experience as a result of their violent victimization. Each of these workers is hired from the communities being served based

upon their credibility with those at highest risk and is extensively trained in techniques needed for the work, including methods of conflict detection and mediation, behavior change, norm change, and epidemic control strategies. This approach to violence reduction is complementary to and augments the vital public safety role of law enforcement.

Independent multisite evaluations of programs using this approach have found significant reductions in violence. An evaluation of the Cure Violence approach implemented in Chicago found that the Chicago program was associated with an up to almost 70 percent reduction in shootings and killings in some areas and an up to 100 percent reduction in retaliatory homicides across seven sites over a 33-79 month period [30]. In Baltimore, one historically violent neighborhood had a 56 percent decrease in killings and 34 percent decrease in shootings over a two-year period [31]. In New York City, two evaluations found significant reductions in shootings and killings, including a recent evaluation that found a 63 percent reduction in shootings in the Bronx over a four-year period [32, 33]; and one site surpassed 1,000 days without a gun killing in the community [34]. Similar results are being reported in several other cities in the US and abroad [35].

Ethical Implications of Understanding Violence as a Health Issue

Given evidence of the contagious nature of violence and the effectiveness of violence prevention programs using the epidemic control approach, our understanding of our role as health practitioners in relation to the problem of violence must now evolve. First, as part of our ethical obligations, we must more fully understand the essential components for providing competent care and follow up to victims of violence, including those with physical injuries, those traumatized by exposure, and communities as a whole. In some instances, and particularly in the case of community violence, victims of violence are at greater risk to be involved in future violence. Thus, in addition to acute care, we must provide intervention aimed at reducing risk of patients' re-injury, retaliation, or engagement in subsequent violence. Persons traumatized from exposure to violence must be identified and treated based upon the severity of their trauma. There is a role for all health practitioners who come into contact with people exposed to violence in providing screening, trauma-informed care, and follow up.

Health professionals should also provide information on violence as a contagious health problem to patients and the community so that individuals can limit their own exposure and seek treatment for trauma when needed. Patient education is a regular role for health practitioners in working to change behaviors, such as dietary behaviors, encouraging safe sex practices, or recommending other types of preventative interventions.

Finally, as health practitioners, we have credibility as spokespersons and thus need to step into this role more proactively and with greater visibility. We have the ability to provide a health framework on violence and its transmission, as we did for AIDS and Ebola, and to encourage more effective policies and practices that will lead to better outcomes. During most epidemics, fear is prevalent, but accurate information provided by health professionals helps ensure the best responses to and outcomes for those affected and the general public.

Conclusion

Violence is best understood as an epidemic health problem. It is transmitted through exposure, which is mediated by the brain and social processes, and can be effectively prevented and treated using health methods. This scientifically grounded understanding of violence holds potential for a fundamental shift in how violence and persons who show symptoms of it are treated. Recognition and treatment of violence as a health crisis is long overdue. To date, the health sector and health professionals have been highly underutilized for the prevention, treatment, and control of violence [36]. Health practitioners—from pediatricians to emergency medical personnel, from nurses to public health professionals, from mental health professionals to trauma specialists, and especially community health workers—need to step up and use new detection and intervention methods to treat violence and to advocate for competent care for all, both through existing health care institutions and a more robust community health system. These new methods should be widely used and supported within the health sector and in the community through trainings, curricula, and standards of practice, and further advanced through a reprioritization of resources to support health-based approaches to reducing and preventing violence. Now is the time to for our nation’s health care and public health systems to work with communities and other sectors to stop this epidemic. Each of us has a role in making this happen.

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STATE OF THE ART AND SCIENCE

Continuing Medical Education and Firearm Violence Counseling

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Abstract

Firearm violence is a significant and increasing cause of mortality. Although physicians view firearm counseling as their professional obligation, few engage in the practice. This study examines medical education and firearm counseling among physicians in North Carolina. While 65 percent of physicians reported knowing how to counsel patients about gun safety, only 25 percent reported having conversations with patients about firearms or firearm safety often or very often. Physicians reporting continuing medical education (CME) attendance on gun safety, however, were more likely to report providing patients with firearm safety counseling and asking patients with depression about firearms. Increasing availability of and physician participation in firearm violence prevention CME could significantly increase physicians' knowledge of and engagement in firearm counseling.

Introduction

Firearm violence is a significant cause of mortality that has increased as an important ethical and public health issue. Data from 2014 revealed over 33,000 firearm-related deaths in the United States, accounting for 16.8 percent of all injury-related deaths, 49.6 percent of all completed suicides, and 69.2 percent of homicides [1]. In 2014, North Carolina, the state in which the authors reside, ranked seventh among states [2], with 1,146 firearm deaths, representing 59.3 percent of all violent death in the state that year [3].

Many medical organizations and physicians have discussed the [roles clinicians should play](#) in preventing firearm injury and deaths [4-13]. Surveys of family physicians, internists, psychiatrists, pediatricians, and surgeons have revealed that between 65 to 93 percent believe gun safety counseling is within a physician's scope of practice [14-20]. Many physicians also believe firearm safety counseling is effective at reducing rates of firearm-related suicides and homicides [21, 22].

Although physicians view such counseling as part of their professional obligations, few appear to engage in the practice. Chart reviews from internal medicine and pediatric

emergency departments demonstrate that 3 percent or less document gun access or [firearm safety counseling](#) [23, 24]. While chart review may not capture every service delivered, documentation likely serves as proxy for what physicians believe is important from treatment planning and medical-legal perspectives [24]. A survey of 573 internists revealed that 58 percent had never asked patients about gun ownership, and 77 percent had never counseled patients on risks of firearm-related injury or death [20]. Similarly, less than half of surveyed pediatricians reported regularly providing firearm safety screening or counseling [18, 25-27]. At the medical student level, 66 percent of 1,469 seniors across 16 schools reported counseling patients about firearm safety “never” or “rarely,” with only 4 percent reporting doing so “usually” or “always” [16].

Discrepancies between medical professional beliefs and behaviors with respect to firearm safety counseling signal an opportunity for intervention should their cause be identified. Existing literature suggests that physician training in firearm safety education is woefully inadequate [16, 18, 20-22, 28]. When asked directly whether there was a need for physician education on firearm injury prevention counseling, 74 percent of 573 internists answered “somewhat” or “to a great extent” [20]. While two-thirds of 1658 medical students reported receiving any training on firearm safety counseling, only 12 percent considered the training “extensive” [16]. At the residency level, a survey of pediatric residency programs revealed that only one-third include formal training on firearm safety counseling [18]. Similarly, among psychiatric residency directors, 79 percent of respondents had not considered including training to address firearm injury prevention, citing lack of standardized material, faculty expertise, and training guidelines as key barriers [21], echoing the sentiments of preventive medicine programs [22]. A recent review found that only four firearm safety training programs report targeting medical education, none of which targeted psychiatrists or psychiatry residents [28].

While the existing literature addresses the need for firearm safety training in undergraduate and graduate medical education, little research has been conducted on the role of continuing medical education (CME) for physicians about firearm violence prevention counseling. This survey-based study of North Carolina internists, psychiatrists, and family medicine physicians examines how various criteria, including CME, affect firearm safety counseling confidence and behaviors for clinicians in practice. Other questions that examined physician experiences with and attitudes toward concealed weapon permits, which showed that physicians were often unsure of and had little confidence in determining competence for concealed weapons’ permitting, were previously published [29, 30].

Methods

Survey. The survey questions addressed physician attitudes, beliefs, and behaviors about various issues related to firearm safety, including patient counseling and self-reported CME on firearm safety education. Physician attitudes and beliefs were assessed by four

categories of response (strongly agree, agree, disagree, and strongly disagree), and physician behaviors were assessed by five categories of response (never, rarely, sometimes, often, and very often). Respondent demographic information included age, sex, specialty, political affiliation, years in practice, gun ownership, and experience shooting a gun.

Participants. The survey was mailed to 600 physicians registered with the North Carolina Medical Board and in active practice at the time of the survey (September and October of 2013), including 200 physicians identified as family physicians, psychiatrists, and internists who were randomly selected to receive the survey. Participants in the second and third of three survey waves received nominal incentives (<\$1) to participate. Of the 600 surveys mailed, 45 were returned because of incorrect addresses and 223 were completed, for an adjusted response rate of 40.2 percent. The pool of respondents included psychiatrists (38 percent), family physicians (35 percent), and internists (27 percent). The majority of respondents were men (66 percent), over age 51 (55 percent), and had been in practice more than 15 years (64 percent). Most self-described as Democrat (47 percent), with the remaining being Republican (20 percent), Independent (25 percent), or "other," including libertarian (8 percent). Seventy-six percent of physicians in the sample reported having shot a gun, and 36 percent identified as gun owners.

Analyses. The Pearson chi-square test was used to examine the relationships between survey response variables and responses to three of the attitude and behavior questions, with significance judged by Bonferroni corrected alpha levels of 0.006 (0.05/9) or 0.005 (0.05/10). For attitude and belief questions, agree/strongly agree and disagree/strongly disagree were combined to yield two response categories. Similarly, for behavior questions, never/rarely and often/very often were combined to yield three responses categories. Logistic regression was used to estimate the odds of associations between CME and aspects of gun safety counseling.

Results

Descriptive statistics. Most physicians agreed or strongly agreed that gun violence was a major public health issue that should be part of medical training (80 percent). Almost two-thirds (65 percent) of physicians reported knowing how to counsel patients about gun safety, but only 25 percent reported having conversations with patients about firearms or firearm safety often or very often. With regard to suicide prevention, only 52 percent of physicians reported asking depressed patients if they had a firearm in their home. Furthermore, only 12 percent of physicians reported having attended any continuing medical education (CME) seminars or lectures on gun violence in the last five years. CME attendance was not related to political party affiliation.

Factors associated with knowledge of gun safety counseling. As shown in Table 1, physicians' self-reported knowledge of how to counsel patients about gun safety was significantly related to physician specialty, with psychiatrists most likely to report knowledge of how to counsel about gun safety compared to family physicians and internists (78.6 percent vs. 66.7 percent vs. 45.0 percent respectively; $p < 0.001$). Those who reported attending CME on gun safety were more likely to say they knew how to counsel about gun safety, but this was of borderline significance (88.9 percent vs. 61.7 percent; $p = 0.006$). Sex, age, years in practice, political affiliation, gun ownership, and having shot a gun were not significantly associated with knowledge of gun safety counseling.

Table 1. Bivariate associations for “knowing how to counsel patients about gun safety”

Variable	Agree/strongly agree (%)	p -value ^a
Sex ($N = 222$)		
Male	68.5	0.17
Female	59.2	
Specialty ($N = 222$)		
Family medicine	66.7	< 0.001
Psychiatry	78.6	
Internal medicine	45.0	
Age ($N = 222$)		
< 35	51.2	0.09
36-50	74.0	
> 51	63.1	
Years in practice ($N = 222$)		
< 5	55.2	0.46
5-15	68.2	
> 15	66.4	
Political affiliation ($N = 220$)		
Democrat	56.7	0.04
Republican	70.5	
Independent	78.3	
Other	70.6	
Shot a gun ($N = 222$)		
Yes	65.7	0.84
No	64.2	

Owns a gun (<i>N</i> = 222)		
Yes	75.0	
No	59.9	0.02
Gun violence should be part of medical student training (<i>N</i> = 219)		
Agree/strongly agree	67.4	
Disagree/strongly disagree	61.4	0.45
CME attendance (<i>N</i> = 223)		
Yes	88.9	
No	61.7	0.006

^a Bonferroni corrected alpha level = 0.006.

Factors associated with counseling frequency. As shown in Table 2, reported knowledge of gun safety counseling was significantly related to reported frequency of counseling about gun safety (33.1 percent vs. 10.3 percent counseling very often/often; $p < 0.001$). Frequency of counseling differed significantly by specialty, with psychiatrists reporting higher rates of counseling “very often or often” compared to family physicians and internists (48.8 percent vs. 15.0 percent vs. 7.7 percent; $p < 0.001$). Those who reported attending CME on gun safety counseling were more likely to say they counseled patients often or very often compared to those who did not attend CME (59.3 percent vs. 20.4 percent; $p < 0.001$). Reports on counseling frequency were not associated with sex, age, years in practice, political affiliation, gun ownership, or having shot a gun.

Table 2. Bivariate associations for “counseling frequency about gun safety”

Variable	Never/ rarely (%)	Some- times (%)	Often/very often (%)	<i>p</i> -value ^a
Sex (<i>N</i> = 222)				
Male	50.7	27.4	21.9	
Female	36.8	31.6	31.6	0.12
Specialty (<i>N</i> = 222)				
Family medicine	59.0	33.3	7.7	
Psychiatry	25.0	26.2	48.8	
Internal medicine	58.3	26.7	15.0	< 0.001
Age (<i>N</i> = 222)				
< 35	62.9	18.5	18.5	
36-50	32.9	37.0	30.1	
> 51	50.0	26.2	23.8	0.06

Years in practice (<i>N</i> = 222)				
< 5	55.2	20.7	24.1	
5-15	32.0	38.0	30.0	
> 15	49.0	27.3	23.8	0.22
Political affiliation (<i>N</i> = 220)				
Democrat	46.2	28.9	25.0	
Republican	54.6	22.7	22.7	
Independent	38.2	32.7	29.1	
Other	41.2	35.3	23.5	0.80
Shot a gun (<i>N</i> = 222)				
Yes	46.8	30.8	22.5	
No	43.4	22.6	34.0	0.21
Owns a gun (<i>N</i> = 222)				
Yes	46.3	33.8	20.0	
No	45.8	26.1	28.2	0.30
Gun violence should be part of medical student training (<i>N</i> = 219)				
Agree/strongly agree	41.7	29.7	28.6	
Disagree/strongly disagree	63.6	22.7	13.6	0.03
I know how to counsel patients about gun safety (<i>N</i> = 223)				
Yes	36.6	30.3	33.1	
No	64.1	25.6	10.3	< 0.001
CME attendance (<i>N</i> = 223)				
Yes	14.8	25.9	59.3	
No	50.5	29.1	20.4	< 0.001

^a Bonferroni corrected alpha level = 0.005.

Factors associated with asking depressed patients about firearm access. Factors associated with reports on the frequency of asking depressed patients about access to firearms are shown in Table 3. Asking depressed patients about access to firearms was positively associated with reported knowledge of how to counsel (58.6 percent vs. 39.7 percent; $p < 0.001$), specialty (72.6 percent vs. 41.0 percent vs. 38.3 percent; $p < 0.001$), and CME attendance on gun counseling (85.2 percent vs. 47.5 percent; $p < 0.001$). Reports on counseling frequency were not associated with sex, age, years in practice, political affiliation, gun ownership, or having shot a gun.

Table 3. Bivariate associations for “asking depressed patients about access to firearms”

Variable	Never/ rarely (%)	Some- times (%)	Often/very often (%)	<i>p</i> -value ^a
Sex (<i>N</i> = 222)				
Male	28.8	19.2	52.1	0.62
Female	23.7	23.7	52.6	
Specialty (<i>N</i> = 222)				
Family medicine	32.1	26.9	41.0	< 0.001
Psychiatry	9.5	17.9	72.6	
Internal medicine	45.0	16.7	38.3	
Age (<i>N</i> = 222)				
< 35	25.9	29.6	44.4	0.78
36-50	27.4	17.8	54.8	
> 51	27.1	20.5	52.5	
Years in practice (<i>N</i> = 222)				
< 5	27.6	27.6	44.8	0.25
5-15	20.0	14.0	66.0	
> 15	29.4	21.7	49.0	
Political affiliation (<i>N</i> = 220)				
Democrat	25.0	23.1	51.9	0.54
Republican	36.4	18.2	45.5	
Independent	23.6	21.8	54.6	
Other	17.7	11.8	70.6	
Shot a gun (<i>N</i> = 222)				
Yes	26.6	18.3	55.0	0.22
No	28.3	28.3	43.4	
Owns a gun (<i>N</i> = 222)				
Yes	28.8	22.5	48.8	0.73
No	26.1	19.7	54.2	
Gun violence should be part of medical student training (<i>N</i> = 219)				
Agree/strongly agree	22.3	21.7	56.0	0.007
Disagree/strongly disagree	45.5	18.2	36.4	

I know how to counsel patients about gun safety (N = 223)				
Yes	19.3	22.0	58.6	
No	42.3	18.0	39.7	0.001
CME attendance (N = 223)				
Yes	3.7	11.1	85.2	
No	30.6	21.9	47.5	0.001

^a Bonferroni corrected alpha level = 0.005.

Association between CME attendance and outcomes. After adjustment for specialty, gun ownership, and political party, physicians reporting CME attendance had 3.2 times the odds of reporting providing patients with gun safety counseling (aOR 3.23; 95 percent CI 1.2-8.5; $p = 0.018$) and 4.4 times the odds of reporting asking depressed patients about firearms (aOR 4.37; 95 percent CI 1.38-13.8; $p = 0.012$). CME attendees also had 3 times the odds of reporting knowledge of how to counsel (aOR 3.01; 95 percent CI 0.84-10.8; $p = 0.092$), although this last result had a wide confidence interval and was not statistically significant.

Discussion

It is increasingly clear that addressing firearm safety in clinical situations constitutes an ethical imperative that physicians should satisfy, particularly as physician skills in counseling patients about firearm violence prevention are increasingly considered key to helping prevent firearm deaths [12, 31]. Fulfilling this imperative requires the cultural competence and nuance necessary to have dedicated and respectful conversations with patients [13]. While low rates of gun safety counseling and lack of physician training to provide counseling are established [6, 12, 28, 30, 32], the present research is the first to illuminate the potent role that CME may play in increasing counseling. CME was strongly associated with providing firearm counseling often or very often, including asking patients with depression about their firearm access as well as increased knowledge of how to counsel.

Just as educational experiences have been shown to positively impact physician knowledge of addressing adolescent violence or geriatric suicide risk [15, 33-35], CME likely provides a critical opportunity for practicing physicians to acquire ongoing practical skills that significantly improve their firearm counseling behaviors. While the causal relationship could be reversed, with physicians who already prioritize gun safety seeking related CME, it seems unlikely that physicians who already have significant gun safety knowledge and counseling skills would invest in CME on that topic. Furthermore, since 80 percent of respondents in the current study agreed or strongly agreed that gun violence is a major public health problem that should be part of medical education, a

large gap exists in skill levels between the minority of respondents who do regularly provide gun safety counseling and the great majority of respondents who do not do so.

Our findings extend the literature on physicians' role in addressing firearm violence spanning individual specialties and geographic locations [18, 20, 29, 30, 32], providing a glimpse of the current landscape on primary care and specialty involvement in firearm counseling practices. Psychiatrists in our sample appeared to report higher knowledge of how to counsel, higher frequency of counseling, and asking patients with depression more often about access to firearms. Three-quarters of psychiatrists did endorse that they possessed knowledge of how to counsel patients, indicating that psychiatrist training or practice breeds more knowledge of counseling behaviors.

The ethical imperative to not neglect firearm safety in clinical situations is particularly relevant to suicide prevention, as suicide by firearms accounts for one-half of recorded suicides, and depression is strongly linked with suicidality [2]. Intra-specialty analysis reveals that few family physicians (7.7 percent) or internists (15 percent) reported asking patients with depression about firearm access either very often or often. Even among psychiatrists, who were significantly more likely to report asking their depressed patients about firearm access, less than half reported counseling patients with depression about their firearm access.

Physicians' provision of gun safety counseling is often highlighted as a polarizing political issue, particularly in light of legislative attempts to block physicians from discussing firearm violence prevention with patients [36]. However, our research counters this narrative, as neither political party nor gun ownership was significantly associated with self-reported counseling knowledge, counseling frequency, or rates of asking patients with depression about firearm access. These findings are promising, as they suggest that the provision of firearm safety counseling need not be a partisan issue; instead, our findings provide an opportunity for physicians across party lines to sensibly unite behind the need to provide accurate and effective firearm counseling to patients, as has been done before with safety issues like domestic violence, seatbelts, biking helmets, and smoking cessation. Perhaps the disparity between belief and low CME attendance rate is not driven by a lack of interest or perceived benefit but by the paucity of available CME firearm safety opportunities [28].

Conclusion

While research to replicate and extend our findings to other physician populations and states is needed, our study suggests that increasing availability of, and physician enrollment in, firearm safety-focused CME could impact knowledge of and counseling on firearm violence prevention. Firearm safety educational interventions could empower the great majority of physicians who have not had exposure to this type of training to

provide vital safety counseling for their patients, ultimately contributing to fulfillment of physicians' obligations to help reduce firearm injury and death.

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HEALTH LAW

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—analogue, at least in part, to other harm-reduction strategies such as needle exchange programs. Yet, as noted previously, a patient who stores his or her 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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POLICY FORUM

Stop Posturing and Start Problem Solving: A Call for Research to Prevent Gun Violence

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Abstract

Gun violence is a major cause of preventable injury and death in the United States, leading to more than 33,000 deaths each year. However, gun violence prevention is an understudied and underfunded area of research. We review the barriers to research in the field, including restrictions on federal funding. We then outline potential areas in which further research could inform clinical practice, public health efforts, and public policy. We also review examples of innovative collaborations among interdisciplinary teams working to develop strategies to integrate gun violence prevention into patient-doctor interactions in order to interrupt the cycle of gun violence.

An Ethical Obligation to Address Gun Violence

More than twenty survivors of the Pulse nightclub massacre traveled together to Boston, Massachusetts, in the days before the one-year anniversary of that horrific night. They met with a group of physicians, nurses, social workers, administrators, and others at our hospital to talk about their experience. They recounted their memories of the sounds of gunfire, the screams of those around them, and the moans from those felled beside them. They described the ups and downs that have characterized their attempts to rebuild in the year since gunfire shattered their sense of normalcy. They shared their stories in the hopes that if more people could understand what it means to be affected by gun violence, then we, as a nation, would be compelled to act.

Gun violence is an enduring public health crisis in the United States, and, by now, many of the statistics are well known: firearm-related violence results in more than 33,000 deaths each year, or an average of 93 deaths every day. Nearly two-thirds of those deaths are the result of suicide [1]. Firearm-related violence is the third leading cause of death for children in America [2] and the twelfth leading cause of death for Americans of all ages [3]. While devastating, these statistics still underestimate the human toll of this violence because for the tens of thousands of people who are killed every year as a result of gun-related injuries, more than twice as many suffer nonfatal gunshot wounds [1]. These injuries can result in long-term physical disabilities, are a leading cause of spinal cord injuries in the United States, and can lead to mental health problems, including

posttraumatic stress disorder (PTSD) [4]. When viewed through this lens, the issue of gun violence and its sequelae is clearly a medical problem—and one that health care professionals must be better prepared to confront.

We clinicians have an ethical obligation to approach gun violence in the same ways that we do other health concerns facing our patients, no matter the politics. For heart disease, sepsis, and fatalities from car crashes—to name just a few examples—the medical and public health communities have been successful in reducing mortality through a research-driven approach, grounded in the implementation of evidence-based practices [5-7]. Efforts to reduce morbidity and mortality from firearm-related violence should be no different. Our conversations with survivors from Pulse brought into specific focus how we in the medical community can learn from and partner with those affected by gun violence. In this article, we will review the barriers to research in the field of gun violence prevention, outline a research agenda, and discuss innovative interventions that can serve as models in efforts to effect change and reduce the complex toll that firearm-related violence takes on our society.

Gun Violence: A Politicized Public Health Problem

As a major cause of preventable injury and death in the United States, gun violence should be an important focus of research to inform clinician counseling, public health efforts, and public policy. Yet research remains scarce. In a recent study, investigators quantified the funding and the number of research publications for the top 30 causes of death based on the Centers for Disease Control and Prevention (CDC) mortality statistics between 2004 and 2014 [8]. Relative to mortality rates of other leading causes of death in the United States, gun violence is the least researched and the second least funded (only falls were funded less). Although gun violence killed approximately the same number of people annually as sepsis, gun violence received less than 1 percent of the funding allocated to sepsis research and resulted in 1/25th the number of publications [8].

This lack of funding for gun violence research at the federal level reflects political, not scientific, priorities. In the 1990s, CDC-funded research showed that having a gun in the home was associated with increased risks of homicide and suicide [9, 10]. In response, the National Rifle Association lobbied Congress to end this line of research [11]. In 1996, Congressman Jay Dickey of Arkansas included language in an appropriations bill stating that no CDC funds for injury prevention and control “may be used to advocate or promote gun control” [12]. The Consolidated Appropriations Act of 2012 used similarly restrictive language with regard to funding from the National Institutes of Health (NIH) [13]. While not outlawing gun violence research explicitly, this language had the intended effect: since 1996, federal funding for research dedicated to gun violence has plummeted [14]. Controlling for the growth of scientific literature over time, publications related to gun violence fell more than 60 percent between 1998 and 2012 [15].

Consistent financial and leadership support from academic and private sector institutions is currently lacking but desperately needed to overcome this lack of federal funding for research. Other disease-specific organizations, from breast cancer to suicide prevention, have been successful in raising public awareness and research funding [16, 17]; gun violence prevention foundations could learn from this model to raise the financial resources needed to attract research interest and proposals, to motivate communities to stand in solidarity to address this public health crisis, and to help initiate collaborative research teams in hospitals, clinics, and communities around the country. Without reliable funding, motivated investigators will continue to be unable to build careers dedicated to gun violence prevention research.

A Gun Violence Prevention Research Agenda

There are many concrete ways that research can inform clinical efforts. When caring for patients with a history of suicidal ideation or mental illness that increases the risk of suicide, how often do clinicians [screen](#) for access to firearms? How comfortable do clinicians feel discussing gun ownership and counseling on [safe storage](#)? If counseling does take place, does this reliably lead to safer gun storage and improve patient outcomes? Survivors from Pulse remind us that while the toll of gun violence is often measured by the numbers of people who died, our work must also be grounded in understanding how we can best support those who witness and survive this type of violence. What measures can we institute, initially and over time, to decrease the risk of developing posttraumatic stress disorder (PTSD) among survivors? Many of these basic questions remain unanswered. And these questions are just a start: Ranney and colleagues have outlined an extensive research agenda for gun violence prevention in the field of emergency medicine [18]; other specialties can follow this lead.

Gun violence touches nearly every field in medicine: from emergency department clinicians, nurses, and surgical teams who face the grueling initial presentations of penetrating trauma to social workers, mental health professionals, rehabilitation specialists, and primary care clinicians who manage the downstream consequences of spinal cords severed by bullets or survivors' struggle with depression. And so our response must be rooted in interdisciplinary action.

While we should advocate strongly for increased CDC and NIH research funding, we cannot allow the lack of federal funds to continue to be the excuse for not doing this work. Medical and scientific research enterprises have been increasingly funded by the private sector over the past two decades [19], and the field of gun violence prevention would benefit by following suit. Support from nonfederal sources, including academic institutions, the private sector, state governments, and foundations, can bring together resources to fund this research enterprise. Some efforts in this space are growing, but more are urgently needed.

Community-Based Efforts Underway

As we build a movement for community leadership and implementation science research to study the uptake of gun violence prevention interventions in routine clinical practice, we can learn from those engaged in developing best practices. At Drexel University College of Medicine, the Hahnemann University Hospital Emergency Department and the Center for Nonviolence and Social Justice have responded to a rise in urban youth violence with an interdisciplinary hospital-based violence intervention program called Healing Hurt People. By bringing mentorship and support for victims into the emergency department, this innovative program attempts to reduce re-injury and retaliatory violence among youth who present to the hospital after a violent episode that often involves a firearm [20]. At our own institution, we brought together a multidisciplinary group of nurses, attending physicians, resident trainees, social workers, physical therapists, and administrators to recognize routine clinical encounters as opportunities to screen for risk factors for violence or misuse of a firearm. As an initial step, we drafted informational documents for clinicians that offer guidance for counseling and outline local resources to promote safe gun practices.

State government can be an important source of partnerships. In Massachusetts, the office of Attorney General Maura Healey partnered with the Massachusetts Medical Society to develop guidelines for health care professionals to discuss gun safety with patients. The end products were endorsed by state police organizations [21]. In a statement introducing this initiative, Attorney General Healey highlighted its nonpartisan, public health approach: “While the vast majority of gun owners are responsible and deeply committed to gun safety, this remains a public health issue, and conversations between patients and health care providers are critically important to preventing gun-related injury and death” [21]. These are examples of how local academic collaborations are attempting to bring innovative models of gun violence prevention into clinical practice. But more work is needed, starting with rigorous research on how best to integrate gun violence prevention practices into clinicians’ workflow and to understand the effectiveness of these programs as they are implemented.

Moving Forward on Common Ground

Recognizing gun violence as a public health issue allows the conversation to be redirected from political posturing toward problem solving. We need to define specific research needs, build broad interdisciplinary coalitions, call on diverse funding sources for research to answer these questions, and partner with community leaders to implement change. Although the Dickey Amendment stripped federal funding and had a chilling effect on gun violence research, its namesake later became an advocate for the idea that research is essential in reducing gun violence. Forming perhaps an unlikely friendship, Jay Dickey partnered with Mark Rosenberg, a former director of CDC’s National Center for Injury Prevention and Control, who claimed he had been fired as a

result of his commitment to advancing gun violence prevention research. Together, they authored a *Washington Post* editorial, "How to Protect Gun Rights While Reducing the Toll of Gun Violence," that described the vast common ground that exists and called for research funding to "let science thrive and help us determine what works" [22]. Dickey reiterated this sentiment in a letter he wrote to the US House of Representatives Gun Violence Prevention Task Force: "Doing nothing," he wrote, "is no longer an acceptable solution" [23].

Survivors from Pulse echo this call for action. When asked how he thought the medical community could best support survivors of gun violence, one survivor who was just 18 years old the night that gun violence changed his life forever did not hesitate. "Don't forget about us," he replied. "Do something."

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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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MEDICINE AND SOCIETY

Clinicians' Need for an Ecological Approach to Violence Reduction

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Abstract

We now know that harmful social policies, such as those that deny health care to some people, can generate structural violence and be far more harmful than any type of direct violence. A health professional who engages in public health promotion must thus consider the adverse effects of structural violence generated by bad policies. On this view, the dictum, "first, do no harm," can be interpreted as a mandate to protect patients from injustice. Health care professionals' responsibilities extend to motivating policies that prevent avoidable deaths and disabilities. As we exist within an ecology, we must each recognize our responsibility to care for one another and for the larger human community.

And that we are all responsible to all for all
Fyodor Dostoevsky [1]

Introduction

We now know that weak health systems, poor education, defective social services, and harsh criminal justice systems are not just potent stimulants of violence but are forms of *structural violence* [2]. Structural violence, according to Johan Galtung, is violence "built into the structure" that "shows up as unequal power and consequently as unequal life chances" [3], which is distinct from simple, behavioral violence [2]. The fundamental principle of the Hippocratic Oath, *primum non nocere*, or "first, do no harm," in some versions refers to an ethical mandate to keep from injustice [4]. The oath has greater implications for justice in the contemporary context, since we now understand better that unjust social structures give rise to insidious harm. The deleterious effects of structural violence are in fact staggering: by one estimate, it causes up to 18 million deaths around the world per year [5], more than ten times greater than all the deaths from suicides, homicides, and warfare combined [6]. If the World Health Organization counted it among causes of death [7], it would certainly fall within the top ten. These are deaths that would have been prevented in a global system of perfect equality; they are caused "by poverty and unjust social, political, and economic institutions, systems, or structures" [8].

While perfect equality might not be achievable, it is useful for health professionals to be mindful of the immense implications of social injustice, or structural violence, for health. Each generation must redefine what “doing no harm” means for its time, and we try to do this here with the knowledge we now have about the violence that is embedded in social structures, including the unequal distribution of health care. Doing no harm may require preventing the occurrence of further harm and learning how to transform destructive social structures into caring ones.

The Meaning of “Do No Harm”

Doing no harm can reasonably be taken to mean avoiding committing obvious harms—that is, direct violence, such as murder, assault, or verbal abuse. However, the multidetermined nature of violence, no matter the scale, suggests that causes of violence are not always direct. For example, a critical predictor of interpersonal violence levels is income inequality [9]. In the twentieth century, the rate of homicide similarly paralleled increases in economic disparities between rich and poor [10]. Economic inequalities within nations also correlate with rises in civil strife and terrorism [11, 12]. Even the rate of suicide, or self-directed violence, increases with rises in unemployment [13]. Scientific evidence increasingly supports that violence is the result not just of individual dynamics but of relationships, family, community, and society [14]. Risk factors for violence operating on all these levels interact in what is called the *ecological model* of violence described by the World Health Organization (WHO) [14].

Once we recognize that ecology connects every person with everyone else as well as with the environment that we create through our collective decision making, we must accept the words of the wise elder of *The Brothers Karamazov*: “For no one can judge a criminal, until he recognizes that he is just such a criminal as the man standing before him” [15]. Labeling violence as an individual problem can no longer hold with what we now know; scientific evidence forces us to look at the larger social and economic structures that give rise to waves of violence, locally and throughout the globe. Doing no harm thus means preventing further—and, if possible, reducing— structural violence.

Similarly, the attempt to treat every ill patient is an uphill battle if we do not address the [ecological factors](#) involved in healthful living, health education, and health care access that influence whether someone gets ill in the first place. Working to prevent avoidable deaths and disabilities—which unjust social structures create—by advocating for just distribution of health care and other social resources should, therefore, become an integral part of a physician’s role [16].

Policy, Structural Violence, and Health Care

With the knowledge and technological capacities we now have, and with the resources at our disposal, we can no longer justify ignoring forms of structural violence that produce greater mortality than direct violence [5]. While wars, genocides, and massacres might

grab headlines, these are not as lethal or as insidious as the violence that social structures generate, as we suggested earlier. Perhaps most illustrative of this situation is the recent political push to “repeal and replace” the Patient Protection and Affordable Care Act, or the Affordable Care Act (ACA), instituted into law on March 23, 2010 [17]. Despite the ACA’s achieving historically high rates of health insurance coverage in the US [18], in 2017 it was repeatedly in danger of being repealed without a satisfactory replacement. By most analyses, this is occurring for reasons of political structure. If successful, the consequences of partial repeal through the American Health Care Act would have been the loss of health insurance for up to 24 million people [19] and avoidable deaths estimated at 27,700 to 96,200 annually by 2026 as a direct result [20]. Through one legislative change, millions of lives would be at risk, and while politicians may see repeal as a matter of partisan ideology, health professionals consider its implications for health and disease, or life and death. The ACA and attempts to repeal it is just one illustration of how a simple adjustment of structure can be life changing for millions [21].

Not only is politics “nothing but medicine at a larger scale,” as Rudolf Virchow noted [22]; bad politics can become a generator of poor health. It is an anomaly that the US, the earth’s wealthiest nation, has not joined 58 other (developed and developing) nations in providing health coverage for all its citizens [23]. It is also an anomaly that the US is the only nation on the planet that has not agreed to join the Paris Climate Agreement [24], which is intended to prevent the climate devastations that could affect numerous lives and have direct and indirect health effects [25]. Structural violence operates through the institution and acceptance of unjust social structures, such as the denial of health care or the right to fair living conditions to certain segments of the population. And we have greater power in deciding how to organize our social structures—and what we are willing to accept—than we commonly believe [26]. Legislation that reduces inequities and destitution, on the other hand, can also reduce vast needs for welfare assistance, resentments and competition, and epidemics of violent deaths [27]. Health injustice usually operates in conjunction with other forms of structural violence, such as [inequalities in education](#), so that those who are deprived might not recognize the sources of their deprivation—or worse, their own contributions to it—with the result that economic, political, legal, and social disadvantages exacerbate and perpetuate health injustice.

Reducing Structural Violence in Health Care and the Human Ecology

Amid changing conditions, active health advocacy for equal access to health care has become one of health professionals’ primary obligations [28]. As we wrote elsewhere, physicians, “who have a negative duty not to harm and a positive duty to promote health, must pay attention to the larger social and cultural forces that determine who will fall ill in the first place and who will be provided relief” [29]. We further noted, citing Arya and Santa Barbara [30], “When health professionals work for optimal health care delivery,

they are working against violence and participating in the struggle for peace” [29]. What might be called “caring well” is at the heart of justice. Such caring arises from a sense of the ethical duty that informs decisions about how to distribute education and resources within a society to facilitate the health and well-being of its members [29]. As agents endowed with moral capacity and not mere technicians, clinicians must have a wider sense of ethical responsibility than is called for by their work role [31]. For the physician who “cares well,” doing no harm means not participating in legally authorized executions [32] or forced interrogation [33], as well as discouraging their use in the first place. Caring well in mental health [34], in criminal justice [35], and even in international security—where the United Nations has declared that the key to development and peace is in creating a more inclusive society in which “no one will be left behind” [36]—is also an effective preventative for all forms of violence.

Caring Well through Reducing Structural Violence

Any reforms in health care delivery would be incomplete without taking into account the wider ecology—relationships, family, community, and society—to which we all belong. We can shape and contribute to this ecology in ways that either help to [promote justice and health](#) or worsen our overall condition by benefiting some over the thriving of all. Since we do not start in a neutral state given the presence of structural violence, we need to develop and establish a foundation for caring well. This concept of doing no harm, or calibrating to a state of no harm, includes an active caring for all. It is none too soon: our capacity for violence has reached unacceptable levels, as we are the first species on earth to threaten its own extinction—either instantaneously through thermonuclear war or insidiously but permanently through the destruction of our habitat. If we are not overly concerned about this fact, then that should be a cause for greater concern. Not treating others well, dividing ourselves into in-groups and out-groups, and allowing for lethal injustices and inequities to continue can only worsen the threat to our collective survival.

We as physicians can extend our model for caring for the individual into the areas of health advocacy and good governance. The ultimate prevention model in health care is not just to alleviate suffering but to keep it from arising in the first place; hence, alleviating harm involves understanding the ripple effect that social structures have through our human ecology and how we are all responsible for all. What the World Health Organization has advocated—to help attain for all people “the highest possible level of health” [37]—thus promises to bring about enhanced health for each individual.

Ethics involves a continual application of principles to changing circumstances. While perfect justice may not be attainable, health professionals can engage in a continual effort to improve societal conditions, including injustices and inequality, which literally translates into saving lives. In a state of society wherein stasis is not an option, doing no

harm might mean preventing the occurrence of further harm by thinking creatively about how to transform unjust social structures into caring ones.

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IMAGES OF HEALING AND LEARNING

Vialation

Artwork and caption by Dino Maglič, MD

Editor's Note: Dino Maglič earned honorable mention in the 2017 AMA Journal of Ethics Conley Art of Medicine Contest.



Figure 1. *Vialation*, by Dino Maglič

Media

Graphite on Strathmore® Bristol smooth surface.

Caption

As the recent heroism and wrongful arrest of University of Utah Hospital nurse, Alex Wubbels, suggests, one way health care professionals serve patients is through stewardship of patients' rights. Despite that, protecting those rights can place us in harm's way.

Dino Maglič, MD, is a first-year integrated plastic surgery resident at the University of Utah in Salt Lake City. In addition to academics, he has an interest in photorealistic illustration.

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MEDICAL NARRATIVE

Smiles, Apologies, and Drawing Trauma-Informed Care in the PurpLE Clinic

Anita Ravi, MD, MPH, MSHP

Abstract

This medical narrative highlights ways in which comics reflect the author's experience as a primary care physician striving to offer sensitive care to people who have experienced sexual violence.

Comics in the Clinic

A few years ago, I started the PurpLE (Purpose: Listen and Engage) Clinic. Nested within a federally qualified health center network in New York City, the PurpLE Clinic provides longitudinal care for survivors of sexual violence and human rights-related abuses. The patients I work with have experienced [human trafficking](#), domestic violence, [sexual assault](#), and political violence. They come from the United States and abroad, are of all genders, are sometimes undocumented and uninsured, and face stressful social circumstances including homelessness and food insecurity. And all of them have experienced trauma.

As the sole physician at the PurpLE Clinic, my lens on "routine" primary care was necessarily, incrementally, adjusted and refocused to accommodate the breadth of violence and socioeconomic and medical circumstances impacting patients' health. It became increasingly detached from the medicine that I had been taught and tested on in my training. Straightforward tasks such as: "use motivational interviewing to counsel on smoking cessation" would result in disclosures of "I smoke cigarettes to deal with the stress of my family being taken hostage back home. I'm not ready to quit," which translates into the sterile electronic medical record verbiage of "tobacco cessation: precontemplative." These unanticipated answers to routine questions became my new normal.

So I began creating [cartoons](#) to depict exactly this: a new normal. The opportunity to draw and share lessons learned, to advocate for underrepresented viewpoints, and to put forth clinical scenarios I struggle with ties me back to the clinical world of medicine that at times abandons me to algorithms and guidelines that are stubbornly inapplicable to the clinical scenarios I encounter.

Trauma-Informed Care Informed by Comics

Example 1. In the early days of the PurpLE clinic, a therapist contacted me to refer her client, Ms. X, for care. "I think it's important for you to know that Ms. X is one of the most extreme cases of sex trafficking I have ever encountered," she prepared me. It had taken two years of working together before Ms. X felt comfortable addressing the extensive traumas in her life with her therapist—multiple broken bones often misdiagnosed as fibromyalgia, psychological torture, and sexual violence. I had primed our staff that she would be arriving and would need particularly sensitive care. Anxiously looking at my schedule, I stepped into the waiting room to introduce myself when I saw that she had checked in. But I couldn't find her. I peeked into each of the triage stations; our nurse was taking the vitals of a woman laughing with her child, and in the adjoining cubicle the medical assistant was offering an HIV test to an elderly man. But where was my patient? I grew concerned—was she in the bathroom? Had she left because she was too nervous? Running through a differential of possibilities for where she could be, I returned to the clinic room, and found the patient sitting there, waiting for me. And she was still laughing with her child. My misstep became clear as the encounter evolved. Ms. X continued smiling as we reviewed her medical history, but when her child stepped outside of the room her smile vanished, as she grasped the moment of privacy to share the symptoms of her mental and physical pain, her exhaustion manifesting as tears.

So why had I missed Ms. X in the triage area? I realized that I was trained to look for trauma, but I didn't know how to look for resilience. I had assumed that Ms. X's laughter precluded a history of pain. But she wore her smiles for her child. With each clinic, new functions of smiles emerged: a mask for shame, a vehicle for conveying disbelief of past experiences, a reflex when recounting happier times, and so on. Disconnecting smiling from assumed happiness relieved the cognitive dissonance I would experience after watching my non-English speaking patients smile while talking to an interpreter, only to hear back translations of graphic abuse perpetrated by traffickers or violent partners.

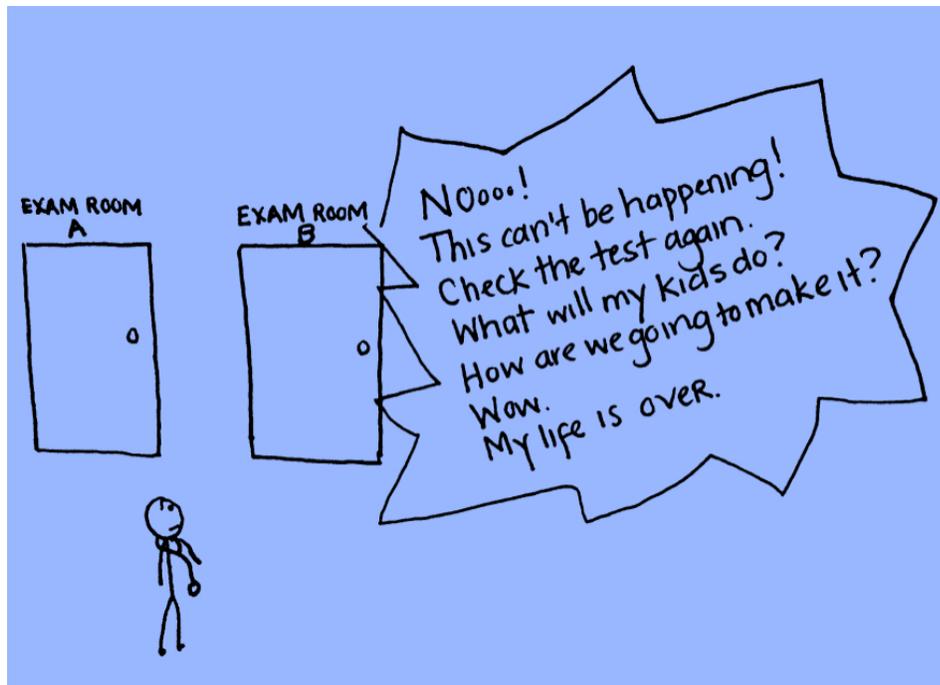
With the hope of being more in tune with the issues patients communicate to me, I have attempted to create a new normal, by training myself to stop assuming smiles are "one size fits all." And to help others bypass my mistakes, I created this ever-evolving diagnostic chart for a smile.



Figure 1. *The Smile Spectrum*, by Anita Ravi

In some medical scenarios, cultural norms not only lead us to misinterpret smiles but also teach us to expect smiles, which is equally problematic.

Example 2. The following scenario is not infrequent in the hallways of our safety net clinic.



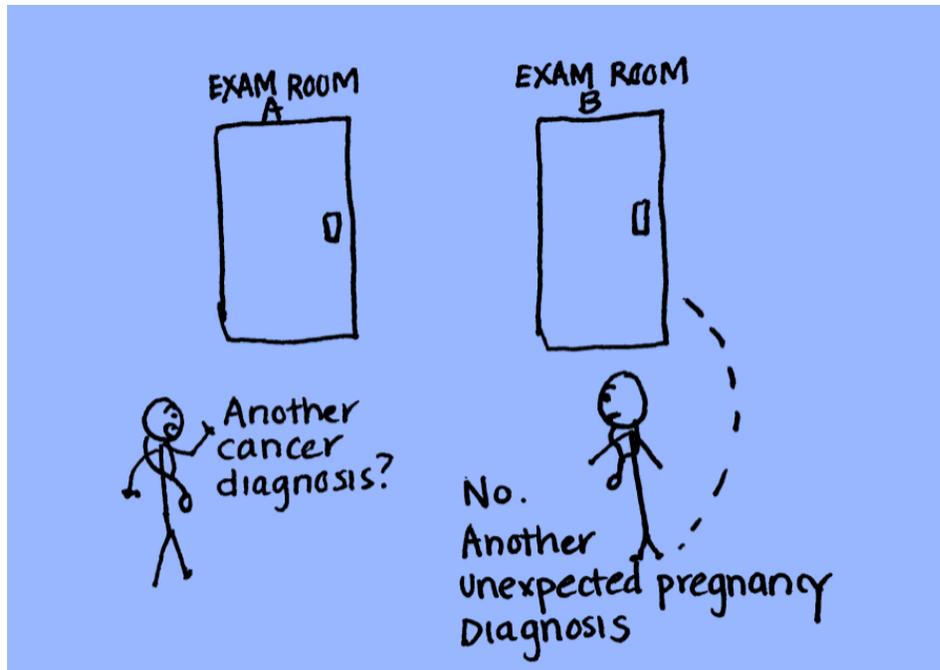


Figure 2. *Positive Test*, by Anita Ravi

I was taught early in my family medicine training to unlearn the habit of saying “congratulations” when meeting a new patient who had a positive pregnancy test. As not all pregnancies are planned or desired, understanding the context of a pregnancy is essential in creating and preserving a patient-clinician partnership, especially when working with those experiencing abusive relationships.

This was indeed my experience with Ms. A. She was a new patient on my schedule, and all I knew was that “wants pregnancy test” was listed as the reason for her visit. So when I told her the test was positive, she smiled in relief—“Thank God! I was worried I was pregnant.” When I clarified the results with her, she screamed. It took me a few moments before I understood what had just occurred. “Positive” meant “positive news” for this mother of three with a six-month-old infant. Positive news meant not having an unplanned pregnancy following a recent sexual assault by her ex-husband. Positive news meant leaving the clinic with the same challenging circumstances she faced coming in, and nothing more. But instead, she found herself at a physician’s office, inconsolably blaming herself for becoming pregnant from a rape.

To counter a culture saturated with pregnancy test commercials equating happiness with a plus sign on a stick, I draw comics like this one to depict the complex, emotionally challenging scenarios that are also part of routine clinical care, with the hope of expanding our perceptions of “normal.”

Example 3. Even when pain and discomfort are anticipated during a clinic visit, they can present in unexpected ways. In our medical training, we are taught how to help patients feel more comfortable during gynecologic exams:

- "Encourage deep breaths."
- "Use a smaller speculum."
- "Add more lube."

While these are helpful tips, I have found one area of discomfort during these exams that I did not receive guidance on managing: patient apologies.

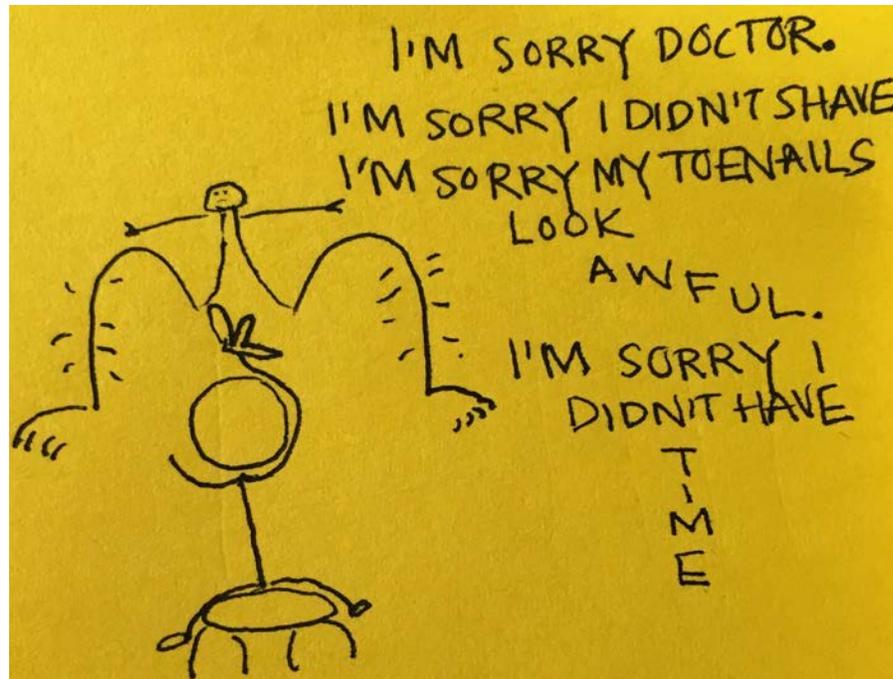


Figure 3. "I'm Sorry, Doctor", by Anita Ravi

Unmanicured toenails or legs and pubic areas with hair commonly trigger a preemptive, "I'm sorry, Doctor," from patients as soon as I reach for the speculum. These sentiments have been challenging for me to process—particularly when working with sexual trauma survivors who already express concerns that their appearance was a reason for their rape. When people share with me, "Now I try to dress in baggy clothes so people won't harass me," "I've stopped wearing make-up," and "I gained weight because I didn't want anything to do with my body anymore," I do my best to listen, understand, and offer reassurance when appropriate.

But these revelations have also made me sensitive to the way that pelvic exams re-engage this complex relationship of physical appearance, violence, and shame. Women apologizing for their natural body hair and nails—essentially apologizing for being themselves—has caught me off guard and without a "gold standard" response to fill the void during these invasive exams. I find myself wishing I could refer to a clinical trial that

studied the risks and benefits of responding to these apologies by saying nothing at all, reassuring the patient with an instructive “Please don’t apologize,” or, even better, trialing an affirming or empowering response. Until I come across that study, however, sharing these situations with friends and colleagues through comics helps spark conversation. And, to my surprise, common responses have included: “Yes! I always apologize to my doctor but I don’t know why” or “I never know how to respond either.” Such responses normalize the insecurity of both patient and physician in these scenarios as our profession seeks to find a best communication practice.

Reflections

Providing longitudinal care for people who have experienced sexual violence has changed my perception of normal medical practice. It has heightened my awareness of the versatility of facial expressions, the sensitivity of language, and the subtle ways in which culture, trauma, and health collide. Comics have become my vehicle for describing these flashpoints of learning: the moments inspired by a single influential patient encounter or the moments when repeated patterns finally come to consciousness. Depicting and sharing these moments through simple drawings protects the fragile strings that connect me to my patients and my profession.

Anita Ravi, MD, MPH, MSHP, is the founder and medical director at the Institute for Family Health’s PurpLE (Purpose: Listen and Engage) Clinic, a primary care clinic for people who have experienced sexual violence and human rights-related abuses. She is a family medicine physician, a public health researcher, and an assistant professor in the Department of Family Medicine and Community Health at the Icahn School of Medicine at Mount Sinai.

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