THE PHYSICIAN'S RESPONSIBILITY CONCERNING FIREARMS AND OLDER PATIENTS

By Marshall B. Kapp[*]

I. INTRODUCTION

The ownership, possession, and use of firearms[1] are widespread in the United States,[2] both historically[3] and today. Many American firearms owners and users are older individuals[4] and a large percentage of them frequently interact with their primary care physicians.[5] The possibility of firearms ownership and possession by an older patient raises a number of issues with potential legal ramifications for the primary care physician. This article addresses some of the most salient of those law-related issues.

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1. A "firearm" is "a weapon that expels a projectile (such as a bullet or pellets) by the combustion of gunpowder or other explosive." *Firearm*, BLACK'S LAW DICTIONARY (9th ed., 2009). *See also* 18 U.S.C. § 921(a)(3) (defining "firearm" as "(A) any weapon (including a starter gun) which will or is designed to or may readily be converted to expel a projectile by the action of an explosive; (B) the frame or receiver of any such weapon; (C) any firearm muffler or firearm silencer; or (D) any destructive device" as defined in § 921(a)(4)). Handguns are a subset of the general category "firearms."

2. This article concentrates on the firearms situation in the United States. For international comparisons, see, e.g., WENDY CUKIER & VICTOR W. SIDEL, THE GLOBAL GUN EPIDEMIC: FROM SATURDAY NIGHT SPECIALS TO AK-47S (2006).

3. THE SECOND AMENDMENT IN LAW AND HISTORY: HISTORIANS AND CONSTITUTIONAL SCHOLARS ON THE RIGHT TO BEAR ARMS (Carl T. Bogus ed., 2002). *See also* JOHN C. BURNHAM, HEALTH CARE IN AMERICA: A HISTORY 9 (2015) (noting that the European settlers brought their guns with them to the New World).

4. In this article, I follow the lead of the Medicare program and designate individuals age 65 and above as "older." *See* 42 U.S.C. § 1395o (2).

5. This article concentrates on the role of the primary care physician, defined as "a physician, such as a family practitioner or internist who is chosen by an individual to provider continuous medical care, trained to treat a wide variety of health-related problems, and responsible for referral to specialists as needed." *Primary Care Physician*, AMERICAN HERITAGE MEDICAL DICTIONARY (2007), http://medical-dictionary.thefreedictionary.com/primary+care+physician. Nonetheless, parts of the discussion may also apply to medical specialists in particular circumstances. *See, e.g.*, Marilyn Price & Donna M. Norris, *Firearm Laws: A Primer for Psychiatrists*, 18 HARV. REV. PSYCHIATRY 326 (2010).

The article commences with a brief outline of firearms regulation in the United States. An enumeration of some of the specific aspects of gun ownership and possession by older persons ensues. Next, the article provides commentary on the collective role of the medical profession regarding firearms as a public health matter, followed by an articulation of ideas about the individual physician's appropriate role at the micro level regarding firearms within the context of the physician/older patient professional relationship.[6] Specific attention is devoted to physicians' rights in this arena and to the policy arguments regarding converting those rights into legally enforceable obligations. The article concludes by arguing that it is undesirable for statutes mandating physician reporting and intervention to be enacted by state legislatures. However, it would be proper for common law to evolve through changes in professional practice and opinion in the direction of imposing affirmative requirements on physicians to inquire about firearms ownership or possession by older patients and to counsel certain patients and their family members regarding associated dangers. Additionally, the article contends that the law should recognize and encourage physician discretion to protect patients and third parties at foreseeable risk by intervening through notifications about suspected dangers to proper agencies and authorities. However, state statutes or judicial precedent should not mandate such protective actions.

II. LEGAL REGULATION OF FIREARMS IN THE UNITED STATES

In the U.S., firearms are regulated concurrently by the federal government and the individual states.[7] Such regulation must be understood against the backdrop of the United States Constitution's Second Amendment, which provides: "A well regulated Militia, being necessary to the security of a free State, the right of the people to keep and bear Arms, shall not be infringed."[8]

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6. This article focuses exclusively on the role of the older person's physician, particularly the primary care physician. The potential causal connection between an older person's access to usable firearms, on one hand, and risk to that older person or other people, on the other hand, also raises significant issues about the rights and responsibilities of other types of professionals (such as non-physician health care providers, emergency responders, social service providers, and attorneys) with whom the older person has formed a fiduciary or contractual relationship. *See, e.g.*, Amber Hollister, *Lawyers' New Mandatory Abuse Reporting Requirement*, 75 OR. ST. B. BULL. 9 (2015); Lesley A. Clement & Valerie Dawson, *The Faces of Elder Abuse*, 48 TRIAL 42 (2012) (discussing attorney responsibilities). The presence of firearms in the home also may engender legal rights and duties implications for family members. For a general discussion of family obligations to avoid abuse and neglect of their older relatives, *see* Lara Q. Plaisance, *Will You Still...When I'm Sixty-Four: Adult Children's Legal Obligations to Aging Parents*, 21 J. AM. ACAD. MATRIM. L. 245 (2008). A comprehensive discussion of issues pertaining to the firearms-related rights and responsibilities of non-physician geriatrics professionals and family members of older persons, however, is beyond the scope of this article and, therefore, must await further future exploration elsewhere.

7. *See* Alexander C. Cooper, *Fully Loaded: An Alternative View of the Gun Control Debate*, 8 ALB. GOV'T L. REV. 337, 338 (2015); Meg Penrose, *A Return to the States' Rights Model: Amending the Constitution's Most Controversial and Misunderstood Provision*, 46 CONN. L. REV. 1463 (2014).

8. U.S. CONST. amend. II.

The Supreme Court has interpreted this Amendment to prohibit both the federal government[9] and the states[10] from totally banning the possession of firearms by individual citizens, but not to preclude the promulgation and enforcement of reasonable regulations regarding firearms short of outright prohibition.

Within the constraints permitted by judicial interpretations of the Second Amendment, the United States Constitution's commerce clause[11] is the source of Congressional authority to regulate in this arena, based mainly on interstate trade in firearms and ammunition.[12] The main pillars of current federal regulation of firearms consist of:

(1) The Gun Control Act or Safe Streets Law of 1968;[13]

(2) The Firearms Owners Protection Act of 1986;[14]

(3) The Brady Handgun Violence Prevention Act of 1993;[15]

(4) The Protection of Lawful Commerce in Arms Act of 2005;[16]

(5) The NICS Improvement Amendments Act of 2007;[17] and

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9. District of Columbia v. Heller, 554 U.S. 570 (2008).

10. McDonald v. Moore, 561 U.S. 742 (2010).

11. U.S. CONST. art. I, § 8, cl. 3. The extent of the Supreme Court's deference to the breadth of Congress's Commerce Clause authority is illustrated in the partially dissenting opinion of Justices Ginsburg, Breyer, Sotomayor, and Kagan in *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S.Ct. 2566, 2609–28 (2012).

12. *But see* United States v. Lopez, 514 U.S. 549 (1995) (invalidating the Gun-Free School Zones Act).

13. Gun Control Act of 1968, Pub. L. 90-618, 82 Stat. 1213 (codified at 18 U.S.C. § 921–31). This Act limits the sale of firearms and ammunition to manufacturers, importers, and vendors who obtain a federal firearms license (FFL) and also prohibits certain individuals from buying, possessing, or transporting firearms in foreign or interstate commerce.

14. Firearms Owners' Protection Act, Pub. L. 99-308, 100 Stat. 449. This Act, among other things, reopened interstate sales of long guns on a limited basis, legalized ammunition sales through the U.S. Postal Service, removed certain record-keeping requirements for gun sales, and provided federal protection of transportation of firearms through states where possession of those firearms would otherwise be illegal.

15. Brady Handgun Violence Prevention Act, Pub. L. 103-159, 107 Stat. 1536 (codified at 18 U.S.C. § 922). This Act provides, among other things, that licensed entities must request background checks, through the Federal Bureau of Investigation's National Instant Criminal Background Check System (NICS), for sales of handguns and long guns to customers except other licensed entities. Purchasers are required to attest that they are the actual buyers, and not acting as a "straw purchaser" to buy a gun for someone else. However, "the one system that gun rights and gun control advocates agree on, the National Instant Criminal Background Check System, which is supposed to keep guns out of the hands of dangerous people, is riddled with problems[,]" largely because states vary tremendously in their provision of timely, accurate information to the central system. Richard Pérez-Peña, *Problems Plague System to Check Gun Buyers*, N.Y. TIMES, July 28, 2015, at A1.

16. Protection of Lawful Commerce in Arms Act, Pub. L. 109-92 (codified at 15 U.S.C. §§ 7901–03). This Act provides qualified immunity against civil liability for a firearms manufacturer or seller, plus trade associations, for damages or other relief regarding the criminal or unlawful misuse of a firearm by the injured party or a third party.

17. NICS Improvement Amendments Act of 2007, Pub. L. 110-180, 121 Stat. 2559.

(6) The Protection of Second Amendment Gun Rights provision of the Affordable Care Act (ACA).[18]

Despite strong advocacy efforts and substantial public support in the recent past, largely in reaction to mass public shootings,[19] firearms control proponents have not successfully persuaded Congress to pass additional statutory requirements limiting the ownership or possession of firearms.[20]

Individual states do not administer or enforce federal regulations,[21] but they do concurrently regulate the intrastate sale, possession, ownership, and use of firearms in various ways under their inherent[22] police power to protect and promote the general health, safety, welfare, and morals of the community.[23] There are significant variations among the states in this sphere,[24] including the required or permitted role of physicians as part of the process when persons diagnosed with mental illness apply for permission to own or possess firearms.[25] The cause-and-effect impact of any state's firearms laws on firearm fatalities or other injuries in that particular state is unclear.[26] Federal statutes do not preempt state statutes unless there is a direct conflict in content between the relevant statutes.[27]

III. FIREARMS AND OLDER PERSONS

In the general population, the presence of firearms in the home is positively associated with the risk for completed suicide and being the victim of

18. 42 U.S.C. § 300gg-17(c)(2), (3) (stating that no authority given to the Secretary of the Department of Health and Human Services by the ACA "shall be construed to authorize or may be used for the collection of any information relating to—(A) the lawful ownership or possession of a firearm or ammunition; (B) the lawful use of a firearm or ammunition; or (C) the lawful storage of a firearm or ammunition….[or] to maintain records of individual ownership or possession of a firearm or ammunition.") The same provision also prohibits wellness programs, otherwise encouraged by the ACA, 42 U.S.C. § 300gg-4(j)(3)(A), from requiring the collection of any information relating to the lawful use, possession, or storage of a firearm or ammunition by an individual and prohibits health insurance plans from denying insurance to lawful gun owners or charging them higher premiums or cost sharing rates. 42 U.S.C. § 300gg-17(c)(1), (4).

19. Emily Swanson, *Gun Control Laws: After Sandy Hook, Poll Finds Bump in Support for Greater Restrictions*, HUFFINGTON POST (Dec. 18, 2012), http://www.huffingtonpost.com/2012/12/16/gun-control-laws-sandy-hook-poll_n_2309324.html.

20. *See generally* Charles W. Collier, *The Death of Gun Control: An American Tragedy*, 41 CRITICAL INQUIRY 102 (2014).

21. Printz v. United States, 521 U.S. 898 (1997).

22. Regarding the inherent powers of a state government, see U.S. CONST. amend. X.

23. *See* Nathan Irvin et al., *Evaluating the Effect of State Regulation of Federally Licensed Firearm Dealers on Firearm Homicide*, 104 AM. J. PUB. HEALTH 1384 (2014).

24. *Search Gun Laws by State*, LAW CTR. TO PREVENT GUN VIOLENCE, http://smartgunlaws.org/search-gun-law-by-state (last visited Jan. 23, 2016).

25. Adam O. Goldstein et al., *Assessing Competency for Concealed-Weapons Permits—The Physician's* Role, 368 NEW ENG. J. MED. 2251 (2013); Donna M. Norris et al., *Firearm Laws, Patients, and the Roles of Psychiatrists*, 163 AM. J. PSYCHIATRY 1392 (2006).

26. Eric W. Fleegler et al., *Firearm Legislation and Firearm-Related Fatalities in the United States*, 173 JAMA INTERN. MED. 732 (2013).

27. 18 U.S.C. § 927 (2012).

homicide.[28] It is well-documented that "[g]un ownership and availability are common among the elderly"[29] and that the rate of use of guns in suicides and homicides by older Americans is significant.[30] Firearms, along with falls and motor vehicle accidents, cause the most traumatic brain injury deaths in the U.S. for people over age 75.[31]

Mental illness has been found to be strongly associated with increased risk of suicide involving firearms.[32] The disproportionate incidence and prevalence of cognitive and emotional disorders such as dementia, mild cognitive impairment,[33] and depression—often presenting themselves simultaneously and exacerbating each other[34]—among older persons has been identified clearly. However, many persons with such disorders do not receive a formal clinical evaluation for those issues.[35] Age-associated decline in health status, in combination with other factors, is a risk factor for dementia.[36] The Alzheimer's Association estimates that 5.2 million Americans are living with Alzheimer's disease, which is the single most prevalent cause of dementia. Additionally, the number of people suffering from dementia worldwide will almost double every

28. Andrew Anglemyer, Tara Horvath, & George Rutherford, *The Accessibility of Firearms and Risk for Suicide and Homicide Victimization Among Household Members*, 160 ANNALS INTERN. MED. 101 (2014); David Hemenway, *Guns, Suicide, and Homicide: Individual-Level Versus Population-Level Studies*, 160 ANNALS INTERN. MED. 134 (2014); Matthew Miller et al., *Firearms and Suicides in US Cities*, 21 INJURY PREV. e116 (2015).

29. Brian Mertens & Susan B. Sorenson, *Current Considerations About the Elderly and Firearms*, 102 AM. J. PUB. HEALTH 396, 397–98 (2012).

30. *Id.*; Lisa S. Seyfried et al., *Predictors of Suicide in Patients with Dementia*, 7 ALZHEIMER'S DEMENTIA 567 (2011). By comparison, a study of completed suicides by older Israelis found that hanging was the predominant suicide method and that jumping from height was a significant method of suicide in the "old-old." Assef Shelef et al., *Psychosocial and Medical Aspects of Older Suicide Completers in Israel: A 10-Year Study*, 29 INT'L J. GERIATRIC PSYCHIATRY 846 (2014).

31. Sterling C. Johnson, *Traumatic Brain Injury*, in HAZZARD'S GERIATRIC MEDICINE AND GERONTOLOGY (Jeffrey B. Halter et al. eds.) (Sixth ed. 2009), http://accessmedicine.mhmedical.com/content.aspx?bookid=371&sectionid=41587682.

32. Jeffrey W. Swanson et al., *Mental Illness and Reduction of Gun Violence and Suicide: Bringing Epidemiologic Research to Policy*, 25 ANNALS EPIDEMIOLOGY 366 (2015).

33. Kenneth M. Langa & Deborah A. Levine, *The Diagnosis and Management of Mild Cognitive Impairment: A Clinical Review*, 312 J. AM. MED. ASS'N 2551 (2014) (estimating the prevalence of MCI in adults aged 65 and older as 10% to 20%, and risk increasing with age).

34. *See* Jane McCusker et al., *Six-Month Outcomes of Co-Occurring Delirium, Depression, and Dementia in Long-Term Care*, 62 J. AM. GERIATRIC SOC'Y 2296 (2014); Kurt A. Jellinger & Johannes Attems, *Challenges of Multimorbidity of the Aging Brain: A Critical Update*, 122 J. NEURAL TRANSMISSION 505 (2015); Jasmin Rahimi & Gabor G. Kovacs, *Prevalence of Mixed Pathologies in the Aging Brain*, 6 ALZHEMIER'S RES. & THERAPY 82 (2014). *See also* Julius B.M. Anang et al., *Predictors of Dementia in Parkinson Disease: A Prospective Study*, 83 NEUROLOGY 1253 (2014).

35. Vikas Kotagal et al., *Factors Associated with Cognitive Evaluations in the United States*, 84 NEUROLOGY 64 (2015). *Cf.* Noelle K. LoConte et al., *Standardized Note Template Improves Screening of Firearm Access and Driving Among Veterans with Dementia*, 23 AM. J. ALZHEIMER'S DISEASE & OTHER DEMENTIAS 313 (2008).

36. Xiaowei Song et al., *Nontraditional Risk Factors Combine to Predict Alzheimer Disease and Dementia*, 77 NEUROLOGY 227 (2011).

20 years, reaching to 65.7 million people in 2030 and 115.4 million people in 2050.[37]

The correlation between dementia and firearm violence and injury has been documented.[38] "Cognitive deficits in dementia include memory loss, dyspraxia and visuospatial problems, any of which may affect capacity to safely use and maintain a firearm."[39] Dementia also may be associated with neuropsychiatric impairments characterized by "unexpected, socially inappropriate, or disinhibited behaviors"[40] such as shooting firearms. Moreover, "[d]epression or cognitive impairment may cause paranoia, delusions, disinhibition, apathy, or aggression and thereby limit the ability to safely utilize firearms."[41] Furthermore, alcohol and drug abuse are linked to dangerous behavior,[42] and the problem of alcohol and drug abuse multiplying the risk of gun-related injury is increasingly prevalent among older persons with cognitive impairment.[43]

A significant percentage of older persons with serious mental health problems are likely to be living either in their own home or that of a relative. This is because of successful efforts to deinstitutionalize the mentally ill population by getting or keeping seriously disabled individuals out of large state mental institutions and, in many cases, nursing homes or other institutional-type residences,[44] in favor of helping them to remain in both home and community-based long-term services and support settings.[45] Thus, primary care physicians are likely to encounter older patients living in home environments in which the

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37. Eitan Z. Kimchi & Constantine G. Lyketsos, *Dementia and Mild Neurocognitive Disorders*, in THE AM. PSYCHIATRIC PUB TEXTBOOK OF GERIATRIC PSYCHIATRY (David C. Steffens, Dan G. Blazer, & Mugdha E. Thaker, eds.) (5th Ed. 2015), *available at* http://dx.doi.org/10.1176/appi.books.9781615370054.ds08. *See also* James T.R. Jones, *Abuse of Elders with Mental Illness: Generally an International and Specifically a United States Perspective*, *in* INTERNATIONAL & COMPARATIVE LAW ON THE RIGHTS OF OLDER PERSONS 303–32, 309–10 (Ralph Ruebner, Teresa Do, & Amy Taylor, eds., 2015) (providing statistics on Alzheimer's disease and related forms of dementia, and also providing prevalence statistics on major depression, bipolar disorder, and schizophrenia in older adults).

38. Anne P.F. Wand et al., *Firearms, Mental Illness, Dementia and the Clinician*, 201 MED. J. AUSTRAL. 674, 674 (2014).

39. C.A. Lynch et al., *Firearms and Dementia: A Smoking Gun?*, 23 INT'L J. GERIATRIC PSYCHIATRY 1 (2008).

40. Kimchi & Lyketsos, *supra* note 37.

41. Dupal Patel et al., *Firearms in Frail Hands: An ADL or a Public Health Crisis!,* 30 AM. J. ALZHEIMER'S DISEASE & OTHER DEMENTIAS 337 (2014).

42. Richard A. Friedland & Robert Michels, *How Should the Psychiatric Profession Respond to the Recent Mass Killings?* 170 AM. J. PSYCHIATRY 455, 455 (2013).

43. Shaune DeMers et al., *Psychiatric Care of the Older Adult: An Overview for Primary* Care, 98 MED. CLIN. N. AMER. 1145, 1161 (2014); Patrick M. Lank & Marie L. Crandall, *Outcomes for Older Trauma Patients in the Emergency Department Screening Positive for Alcohol, Cocaine, or Marijuana Use*, 40 AM. J. DRUG & ALCOHOL ABUSE 118, 118–19 (2014) ("Substance abuse among older adults in the US is an increasing concern. Based on trends in survey data and population growth, the prevalence of substance abuse among older adults in the US is expected to double within the next decade.") (citations omitted).

44. Kevin M. Cremin, *Challenges to Institutionalization: The Definition of "Institution" and the Future of Olmstead Litigation*, 17 TEX. J. CIV. LIBERTIES & CIV. RTS 143 (2012).

45. Marshall B. Kapp, *Home and Community-Based Long-Term Services and Supports: Health Reform's Most Enduring Legacy?*, 8 ST. LOUIS U. J. HEALTH L. & POL'Y 9, 11 (2014).

mixture of cognitive and/or emotional impairment with the presence of firearms poses a foreseeable risk of danger to the patient or other people.

IV. THE MEDICAL PROFESSIONAL'S ROLE REGARDING FIREARMS AND PUBLIC HEALTH

There is an expanding belief that the widespread possession of firearms implicates a variety of potential public health concerns.[46] In addition to the overabundance of firearm-related fatalities (through homicide, suicide, and accident) in the United States, "firearm-related hospitalizations (FRHs) are associated with substantial physical and psychological morbidity as well as societal cost."[47] These concerns suggest a number of ways in which physicians, acting collectively as a profession through their many organizational entities, might be involved in promoting firearms safety and preventing firearms-related injuries, particularly in the case of older adult safety.

A broad spectrum of specialty and state physician organizations in the U.S. have issued formal position statements characterizing firearms safety as a public health problem and affirming the important role of physicians in promoting firearms safety.[48] Major national medical organizations have joined with the American Bar Association (ABA) in issuing a "Call to Action."[49] The American College of Physicians especially has vocally taken leadership in advocating for a vigorous medical professional effort in this sphere,[50] although not without some internal dissent.[51] Many public medical profession positions and advocacy

46. Patel et al., *supra* note 41; David Hemenway & Matthew Miller, *Public Health Approach to the Prevention of Gun Violence*, 368 NEW ENG. J. MED. 2033 (2013).

47. Ali Rowhani-Rahbar et al., *Firearm-Related Hospitalization and risk for Subsequent Violent Injury, Death, or Crime Perpetration*, 162 ANNALS INTERNAL MED. 492 , 492 (2015).

48. Nat'l Physicians Alliance and the L. Ctr. to Prevent Gun Violence, *Appendix A: Sampling of Statements from U.S. Physician Organizations Related to Gun Violence*, *in* GUN SAFETY & PUBLIC HEALTH: POLICY RECOMMENDATIONS FOR A MORE SECURE AMERICA (2013), http://smartgunlaws.org/wp-content/uploads/2013/09/appendixa.pdf. Among the organizations listed in this Appendix are the Association of Clinicians for the Underserved, American Academy of Family Practice, American Academy of Pediatrics, American Association of Neurological Surgeons, American College of Physicians, American College of Preventive Medicine, American Geriatrics Society, American Medical Association, American Medical Student Association, American Osteopathic Association, American Pediatric Association, American Psychiatric Association, American Public Health Association, Association of American Medical Colleges, Doctors for America, National Medical Association, National Physicians Alliance, and Society for General Internal Medicine.

49. Steven E. Weinberger et al., *Firearm-Related Injury and Death in the United States: A Call to Action from 8 Health Professional Organizations and the American Bar Association*, 162 ANNALS INTERNAL MED. 513 (2015).

50. Darren B. Taichman & Christine Laine, *Reducing Firearm-Related Harms: Time for Us to Study and Speak Out*, 162 ANNALS INTERNAL MED. 520 (2015); Renee Butkus et al., *Reducing Firearm-Related Injuries and Deaths in the United States: Executive Summary of a Policy Position Paper from the American College of Physicians*, 160 ANNALS INTERN. MED. 858 (2014); Christine Laine et al., *A Resolution for Physicians: Time to Focus on the Public Health Threat of Gun Violence*, 158 ANNALS INTERNAL MED. 493 (2013).

51. James F. Bush, *Letter*, 158 ANNALS INTERNAL MED. 850, 850–51 (2013) ("Gun control laws are outside the mandate of the ACP, and because of everyone's strong opinions, it would

initiatives regarding firearms and public health could exert particular influence pertaining to the older population given the extent to which older persons utilize health care services and the expertise and experience that medical professionals have in dealing with older health care consumers.

A. Firearms Education for the Public

One relatively uncontroversial avenue for collective medical professional activity lies in the arena of public education regarding firearms safety, specifically including efforts to disseminate accurate, timely information to individuals about risks and precautions through a popular media campaign informed and assisted by medical professionals. This information blasted to the public on television, radio, and in newspapers and magazines should be married to useful protective instructions, like always keeping a gun unloaded until ready to use,[52] that individual gun owners and/or their families can voluntarily implement in their own households and other places where risks are present. Education targeted at enhancing public health literacy and changing social norms, and thereby inducing positive individual behavioral change on a voluntary basis, is a traditional and often effective public health option falling at the nonintrusive end of the strategic spectrum.[53] Any public health literacy initiatives pursued through the media should pay special attention to issues pertinent to households containing older, mentally or physically impaired members. Those literacy initiatives would act as a complement to counseling of individual older patients by the particular physician or physicians with whom that patient is involved in a dyadic, fiduciary professional relationship.[54]

B. Professional Education and Public Policy Changes

Beyond an education campaign to improve public health literacy about the risks associated with firearms, the medical profession could advocate for professional education initiatives and public policy modifications that facilitate and encourage health care and human services providers to assess and identify in a timely manner geriatric patients' mental health problems.[55] Particular

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divide the College."); Jeffrey Johnson, *Letter*, 158 ANNALS INTERNAL MED. 851 (2013) ("The ACP has seriously overstepped its bounds by advocating gun control."); E. Lee Murray, *Letter*, 158 ANNALS INTERN. MED. 852 (2014) ("Using physicians to push a largely political argument diminishes our ability to practice medicine in the most objective and evidence-based manner.").

52. *NRA Gun Safety Rules*, NAT'L RIFLE ASS'N, http://training.nra.org/nra-gun-safety-rules.aspx (last visited Jan 19, 2016).

53. *See, e.g.*, Dariush Mozaffarian et al., *Curbing Gun Violence: Lessons from Public Health Successes*, 309 J. AM. MED. ASS'N 551 (2013); David Hemenway, *Preventing Gun Violence by Changing Social Norms*, 173 J. AM. MED. ASS'N INTERNAL MED. 1167 (2013); Elizabeth A. Rogers et al., *Development and Early Implementation of The Bigger Picture, a Youth-Targeted Public Health Literacy Campaign to Prevent Type 2 Diabetes*, 19 J. HEALTH COMM. 144 (2014).

54. Regarding the role of the individual physician within specific physician/patient relationships, see *infra*, Part IV. *But see* Cristine D. Delnevo & Alice J. Hausman, *Injury-Prevention Counseling Among Residents of Internal Medicine*, 19 AM. J. PREVENTATIVE MED. 63 (2000) (finding low rates of physician counseling about injury prevention).

55. Dan G. Blazer, *The Psychiatric Interview of Older Adults*, *in* THE AMERICAN

attention should be devoted to mental health problems such as mild cognitive impairment,[56] dementia,[57] and depression[58] that might increase the dangers associated with firearms possession by older patients. In a closely related vein,[59] there are questions concerning the widespread assumption that mental illness, including those mental impairments that disproportionately affect older persons, causes gun violence and that psychiatric diagnosis can predict gun crime.[60] The medical profession should exert leadership as a proponent of public policies promoting better and more timely access to voluntary modes of treatment for mentally compromised geriatric patients[61] and to persons of all ages with mental health problems, including but not limited to those who own or possess firearms.[62] As one commentator inquires, "[w]hy is it easier to get a gun than to get treatment for a mental illness?"[63] Patients of any age with severe or recurrent major depression, bipolar disorders, schizoaffective disorders, behavioral complications of dementia, anxiety disorders, late life psychoses, substance abuse, and personality disorders are likely to encounter clinical complexity, financial disincentives, and other factors that impede easy access to appropriate mental health care.[64]

1. Restricting or Prohibiting Access to Firearms

Arguably at the more intrusive end of the strategic spectrum, physicians collectively could lobby for the passage of paternalistic statutes that would more

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PSYCHIATRIC PUBLISHING TEXTBOOK OF GERIATRIC PSYCHIATRY (Fifth ed. 2015), http://dx.doi.org/10.1176/appi.books.9781615370054.ds04.

56. YongSoo Shim et al., *Literacy Independent Cognitive Assessment: Assessing Mild Cognitive Impairment in Older Adults with Low Literacy Skills*, 12 PSYCHIATRY INVESTIGATION 341 (2015) (discussing assessment of MCI in individuals with low literacy skills).

57. *See generally* Kimchi & Lyketsos, *supra* note 37. *Cf.* David B. Carr & Desmond O'Neill, *Mobility and Safety Issues in Drivers with Dementia*, 27 INT'L PSYCHOGERIATRICS 1613 (2015) (discussing the assessment of fitness-to-drive in patients with dementia).

58. Blazer, *supra* note 55.

59. *See* E. Elizabeth McGinty et al., *Using Research Evidence to Reframe the Policy Debate Around Mental Illness and Guns: Process and Recommendations*, 104 AM. J. PUB. HEALTH e22 (2014) (finding that restricting firearm access on the basis of certain dangerous behaviors is supported by the evidence, but restricting access on the basis of mental illness diagnosis is not).

60. Jonathan M. Metzl & Kenneth T. MacLeish, *Mental Illness, Mass Shootings, and the Politics of American Firearms*, 105 AM. J. PUB. HEALTH 240 (2015); Douglas Mossman, *The Imperfection of Protection Through Detection and Intervention: Lessons from Three Decades of Research on the Psychiatric Assessment of Violence Risk*, 30 J. LEGAL MED. 109 (2009); Alison Knopf, *Untreated Mental Mental Disorders, Unchecked Guns: The Combination Poses a Clear Threat to Our Children, But Not the One We Thought*, 34 BEHAV. HEALTHCARE 32 (2014).

61. Lucy Y. Wand et al., *Common Psychiatric Problems in Cognitively Impaired Older Patients: Causes and Management*, 30 CLINICS GERIATRIC MED. 443 (2014).

62. David B. Kopel et al., *Reforming Mental Health Law to Protect Public Safety and Help the Severely Mentally Ill*, 59 HOWARD L.J. 715 (2015); Weinberger et al., *supra* note 49, at 514 ("Access to mental health care is critical for *all* persons who have a mental or substance abuse disorder.").

63. Anand Pandya, *The Challenge of Gun Control for Mental Health Advocates*, 19 J. PSYCHIATRIC PRAC. 410, 412 (2013).

64. Robert C. Abrams & Robert C. Young, *Crisis in Access to Care: Geriatric Psychiatry Services Unobtainable at Any Price*, 121 PUB. HEALTH REPS. 646 (2006).

stringently restrict[65] or even prohibit access to firearms by individuals who have been diagnosed with specific forms of mental illness.[66] However, credible skeptics of this approach point to the potential stigmatization, stereotyping, and discrimination that could accompany a restrictive public policy based on diagnostic labeling.[67] These dangers would be especially troubling, and even susceptible to constitutional challenge under the Fourteenth Amendment's equal protection clause,[68] if legislation used chronological age as one basis—let alone *the* basis—for restricting or prohibiting access to firearms by certain persons.

The American Psychiatric Association (APA) has evolved in its analysis to the position that restricting the firearm related rights of individuals exclusively on the basis of a diagnosis of a mental disorder or acceptance of voluntary treatment, either inpatient or outpatient, discourages or deters future treatment acceptance, prematurely ends or prevents altogether the formation of therapeutic relationships, and therefore is likely to bring about a counterproductive result.[69] This claim is echoed by a commentator with extensive experience representing clients in involuntary commitment hearings and firearm rights restoration proceedings[70] and by other authors sharing their own anecdotal experiences.[71] Although the APA did not specifically consider patient age in formulating its position, its logic applies with full force to the older population and older patients' families. Commentators suggest that, "[i]nstead of legislation that identifies categories of people as inherently and forever dangerous because of mental illness, we should encourage legislators to enact measures that restrict the ability to purchase or possess firearms based on a demonstrable risk of dangerousness."[72]

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65. Federal regulations of the Bureau of Alcohol, Tobacco, Firearms and Explosives already restrict the sale of firearms to people who have been "adjudicated as a mental defective." *See* Commerce in Firearms and Ammunition, 27 C.F.R. § 178 (2015).

66. Fredrick E. Vars & Amanda Adcock Young, *Do the Mentally Ill Have a Right to Bear Arms?*, WAKE FOREST L. REV. 1 (2013).

67. *See, e.g.*, Duncan Chappell, *Firearms Regulation, Violence and the Mentally Ill: A Contemporary Antipodean Appraisal*, 37 INT'L J. L. & PSYCHIATRY 399 (2014).

68. U.S. CONST. amend. XIV, § 1 (provides in pertinent part that no state may "deny to any person within its jurisdiction the equal protection of the laws.").

69. Richard J. Bonnie et al., *The Evolving Position of the American Psychiatric Association on Firearm Policy (1993-2014)*, 38 BEHAV. SCI. & L. (2015 In Press), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2559944. *See also* Paul S. Appelbaum & Jeffrey W. Swanson, *Gun Laws and Mental Illness: How Sensible Are the Current Restrictions?*, 61 PSYCHIATRIC SERV. 652 (2010).

70. Robert Luther III, *Mental Health and Gun Rights in Virginia: A View From the Battlefield*, 40 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 345, 358 (2014) (expressing concern "that an individual who might otherwise be willing to seek voluntary treatment is likely to forgo it because he does not want to lose his firearm rights").

71. Debra A. Pinals, *Firearms and Mental Illness: Preventing Fear and Stigma from Overtaking Reason and Rationality*, 40 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 379, 394 (2014) ("In this author's experience, there have been individuals who have declined inpatient and other mental health treatment specifically because of knowledge that their right to own a firearm might be limited if their mental health history became known.").

72. Liza H. Gold, *Gun Violence: Psychiatry, Risk Assessment, and Social Policy*, 41 J. AM. ACAD. PSYCHIATRY & L. 337, 340 (2013).

Similarly, a coalition of medical organizations and the ABA have advocated for laws and policies intended to reduce firearm-related violence and suicide by keeping firearms out of the hands of persons who may harm themselves or others, but caution against limiting access solely on the basis of a mental or substance abuse disorder.[73] Instead of targeted restrictions stigmatizing those with a mental disorder diagnosis, the coalition has pushed for general requirements for criminal background checks for all firearm purchases and "a common-sense approach compel[ling] restrictions for civilian use on the manufacture and sale of large-capacity magazines and firearms features designed to increase their rapid and extended killing capacity."[74] This position is properly age-blind on its face.

Going even further with the anti-diagnostic labeling theme, a former president of the APA has argued for a redirect of the medical profession's collective efforts in the following manner:

Violence is a complex, multi-causal phenomenon, and its prevention requires attention to the means used to perpetuate violence; in the United States in the 21st century, that means guns. Pointing the finger at people with mental illness as the cause of the problem of violence in this country is misleading, counterproductive, and just plain mean.[75]

2. Involuntary Commitment and Treatment

Even more intrusively, the medical profession could support legislative initiatives to facilitate involuntary confinement and treatment of persons diagnosed with mental illness,[76] as a prophylactic strategy to prevent those individuals from injuring themselves or others with firearms. Such legislative initiatives would involve, *inter alia*, statutory changes at the state level to make it easier for mental health professionals to share otherwise confidential information about a patient with family members and other third parties. Physicians already are permitted under the federal Health Insurance Portability and Accountability Act (HIPAA) and its regulations to share a patient's information with family, friends, or others involved in the patient's care or payment for care, so long as the physician determines, based on professional judgment, that doing so is in the best interests of the patient.[77] However, state

73. Weinberger et al., *supra* note 49, at 514.

74. *Id.* at 515.

75. Paul S. Appelbaum, *Public Safety, Mental Disorders, and Guns*, 70 J. AM. MED. ASS'N PSYCHIATRY 565, 566 (2013). *Cf.* Henry J. Steadman et al., *Gun Violence and Victimization of Strangers by Persons with a Mental Illness: Data from the MacArthur Violence Risk Assessment Study*, 66 PSYCHIATRIC SERV. 11 (2015), http://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.201400512 (documenting that instances of persons with mental illness inflicting gun violence on strangers are very infrequent).

76. Collin Mickle, *Safety or Freedom: Permissiveness vs. Paternalism in Involuntary Commitment Law*, 36 L. & PSYCHOL. REV. 297 (2012).

77. U.S. Dep't of Health & Human Servs., *Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and the National Instant Criminal Background Check System (NICS)*, Final Rule, 81 Fed. Reg. 382 (proposed Jan. 6, 2016) (amending 45 C.F.R. Part 164, modifying federal health privacy rules by clarifying that certain healthcare organizations can report to NICS

mental health confidentiality provisions vary, and some may be interpreted by physicians and the courts as more restrictive on information sharing than HIPAA.[78]

Additionally, involuntary prophylactic or anticipatory confinement and treatment of persons diagnosed with mental illness in inpatient[79] or outpatient[80] treatment facilities or programs could be utilized more readily to keep those individuals physically away from firearms.[81] Some commentators contend that "reversing deinstitutionalization while ensuring that mental hospitals are humane places will serve both the mentally ill and prevent a significant amount of public violence."[82] That strategy would involve relaxation of the present

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the identities of individuals who are subject to a federal "mental health prohibitor" that prevents those individuals from possessing a firearm); *HIPAA Privacy Rule and Sharing Information Related to Mental Health*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Feb. 20, 2014), http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidancepdf.pdf; Off. Civ. Rts., *A Health Care Provider's Guide to the HIPAA Privacy Rule: Communicating With a Patient's Family, Friends, or Others Involved in the Patient's Care,* U.S. DEP'T OF HEALTH & HUMAN SERVS., http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/provider_ffg.pdf (last visited Jan. 19, 2016).

78. Timothy S. Jost, *Appendix B: Constraints on Sharing Mental Health and Substance-Use Treatment Information Imposed by Federal and State Medical Records Privacy Laws*, in INST. OF MED., IMPROVING THE QUALITY OF HEALTH CARE FOR MENTAL AND SUBSTANCE-USE CONDITIONS (2006). *See also* Stephanie E. Pearl, *HIPAA: Caught in the Cross Fire*, 64 DUKE L.J. 559 (2014) (discussing concerns about a tension between HIPAA and the national Instant Criminal Background Check system of the Gun Control Act of 1968).

79. *See* Dominic A. Sisti et al., *Improving Long-Term Psychiatric Care: Bring Back the Asylum*, 313 JAMA 243 (2015); *Long-Term Involuntary Commitment Law Map*, LAW ATLAS, http://lawatlas.org/query?dataset=long-term-involuntary-commitment-laws&utm_source=March+27%2C+2015+Newsletter&utm_campaign=Newsletter&utm_medium=email (last visited Jan. 24, 2016).

80. *See generally Involuntary Outpatient Commitment Map*, LAW ATLAS, http://lawatlas.org/query?dataset=outpatient-committment&utm_source=September+10%2C+2015+Newsletter&utm_campaign=Newsletter&utm_medium=email (last visited Jan. 24, 2016); Richard C. Boldt, *Perspectives on Outpatient Commitment*, 49 NEW ENG. L. REV. 39 (2014). *Cf.* Namkee G. Choi et al., *Relationship Between the Types of Insurance Coverage and Outpatient Mental Health Treatment Use Among Older Adults*, 34 J. APPLIED GERONTOLOGY (Mar. 23, 2015 epub.), doi: 10.1177/0733464815577143 (awaiting print publication). For a critique of involuntary outpatient commitment, recommending that its use be severely limited, *see* Candice T. Player, *Involuntary Outpatient Commitment: The Limits of Prevention*, 26 STAN. L. & POL'Y REV. 159 (2015). *But see* Guillem Lera-Calatayud et al., *Involuntary Outpatient Treatment in Patients with Severe Mental Illness: A One-Year Follow-Up Study*, 37 INT'L J.L. & PSYCHIATRY 267 (2014) (concluding that involuntary outpatient treatment may be effective for patients with serious mental disease who are unaware of their illness and for whom treatment discontinuation carries a high risk of relapse).

81. The distinction between voluntary and involuntary treatment, particularly for older persons, may be much more form than substance. *See* Richard C. Boldt, *The "Voluntary" Inpatient Treatment of Adults Under Guardianship*, 60 VILL. L. REV. 1 (2015).

82. Clayton E. Cramer, *Mental Illness and the Second Amendment*, 46 CONN. L. REV. 1301, 1309 (2014). *See also* Jonathan Simon & Stephen A. Rosenbaum, *Dignifying Madness: Rethinking Commitment Law in an Age of Mass Incarceration*, 70 U. MIAMI L. REV. 1, 3 (2015) (critically examining the arguments of "a new group of reformers" that "people with psychiatric disabilities have been abandoned to even worse forms of incarceration than they asylums from which they were emancipated").

stringent dangerousness standards and burden of proof[83] required by most American jurisdictions[84] to justify use of the state's police and *parens patriae*[85] powers in this context. Loosened confidentiality laws[86] and a more relaxed involuntary confinement and treatment approach would encounter even stronger legitimate policy objections than have been raised against the less intrusive strategy of restricting the firearms rights of persons diagnosed with mental illness.[87] Those kinds of legal changes would also engender serious due process objections as a deprivation of property rights..[88] Older individuals have special vulnerabilities in this context that must be taken into account in formulating the best policy agenda.[89]

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83. Dan Moon, *The Dangerousness of the Status Quo: A Case for Modernizing Civil Commitment Law*, 20 WIDENER L. REV. 209 (2014); Adam G. Gerhardstein, *A First Episode Standard for Involuntary Treatment*, 10 ST. THOMAS L.J. 469 (2012). *But see* Svetlana Walker, *The Failure of the Federal Courts to Incorporate O'Connor's Dangerousness Requirement into the Standards Utilized in Actions Challenging Wrongful Civil Commitments*, 31 TOURO L. REV. 149 (2014) (arguing that current civil commitment standards, as applied in practice, are not stringent enough to protect individual liberty rights).

84. FLA. STAT. § 394.467(1) (2015) (is typical, in requiring for involuntary civil commitment a finding by the court of clear and convincing evidence that the individual "is mentally ill and because of his or her mental illness***[t]here is substantial likelihood that in the near future he or she will inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm and [a]ll available less restrictive alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate").

85. Sara Gordon, *The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People With Serious Mental Illness*, 2015 UTAH L. REV. (2015), http://scholars.law.unlv.edu/facpub/911 (submitting that civil commitment be permitted when an individual is unable to provide for his or her basic needs but does not otherwise pose a danger to himself or herself); Dora W. Klein, *When Coercion Lacks Care: Competency to Make Medical Treatment Decisions and Parens Patriae Civil Commitments*, 45 U. MICH. J.L. REFORM 561 (2012).

86. *See, e.g.*, Katherine L. Record & Lawrence O. Gostin, *Dangerous People or Dangerous Weapons: Keeping Arms Away from the Dangerous in the Wake of an Expansive Reading of the Second Amendment*, 37 ADMIN. & REG. L. NEWS 8, 10 (2012) ("A system of gun control that relies on accessing mental health records threatens medical privacy. The confidentiality of mental health records is of paramount importance due to the stigma associated with mental illness; disclosure can result in personal embarrassment or even discrimination.").

87. *See, e.g.*, Appelbaum, *supra* note 75; Katie Rose Guest Pryal, *Heller's Scapegoats*, 93 N.C. L. REV. 1439 (2015) (contending that involuntary commitment and gun control work together to scapegoat people with psychiatric disabilities).

88. *See* Addington v. Texas, 441 U.S. 418, 432–33 (1979) (holding that civil commitment proceedings must use a standard of evidentiary proof greater than "preponderance of the evidence" when determining whether the individual is mentally ill and requires confinement to protect that individual or others). Thus, the Due Process minimum standard of proof for civil commitment is "clear and convincing evidence."

89. Ashley Dus, "*But I'm Not Dangerous, Judge, I Promise!" Evaluating the Implications of Involuntary Civil Commitment Criteria and Outpatient Treatment Methods on the Elderly*, 23 ELDER L.J. 453 (2016); Elizabeth A. McGuan, *New Standards for the Involuntary Commitment of the Mentally Ill: "Danger" Redefined*, 11 ELDER L.J. 181, 181–83 (2009).

V. THE PHYSICIAN-OLDER PATIENT PROFESSIONAL RELATIONSHIP AND FIREARMS

Medical professionals function both as individual practitioners and as part of a professional community. "Reducing gun injury is not only amenable to action at the level of policy and public health initiatives, but that of individual physicians."[90] At the individual physician level, such action may take the form of collecting information about injury risk pertaining to specific older patients and then taking appropriate steps, in terms of counseling the patient and/or family and notifying third parties, in response to the information obtained. Because regulation of the physician/patient relationship traditionally has been a matter of state concern, principles of federalism suggest that the legal parameters of physician rights and responsibilities in this area will be developed by the individual states.[91]

A. The Physician's Right to Inquire and Counsel

The First Amendment guarantees Americans freedom of speech.[92] This includes the right to communicate with other people without government interference. Consequently, a physician should have a legal right to query his or her older patients about their ownership and possession of firearms.[93] This inquiry should extend to include information about the presence and accessibility in a patient's home of firearms that are owned by someone other than the patient. If a relative, friend, or other party is acting as a surrogate decision maker and/or spokesperson on behalf of the patient, the inquiry may be directed to that surrogate.[94] With the exception of one state legislature (Florida),[95] there is general consensus that a physician's right to inquire about this subject within the physician-patient relationship is protected by the First Amendment provision relating to freedom of speech."[96] This provision applies to the states because it has been incorporated into the Fourteenth Amendment Due Process clause by judicial decision.[97]

In 2011, the Florida legislature, with the political support of the National Rifle Association (NRA),[98] attempted to constrain the unfettered right of

90. Anupam B. Jena & Vinay Prasad, *Primary Care Physicians' Role in Counseling About Gun Safety*, 90 AM. FAM. PHYSICIAN 619, 620 (2014).

91. *See Federation of State Medical Boards,* FED. OF STATE MED. BOARDS, www.fsmb.org (last visited Jan. 24, 2016).

92. U.S. CONST. amend. I.

93. *See* New York State Bar Assoc. v. Reno, 999 F.Supp. 710 (N.D.N.Y. 1998) (invalidating a federal restriction on discussions between attorneys and clients regarding Medicaid planning).

94. A full discussion of the subject of decisional capacity and the role of decision-making surrogates is beyond the scope of this article. *See, e.g.*, Jalayne J. Arias, *A Time to Step In: Legal Mechanisms for Protecting Those With Declining Capacity*, 39 AM. J.L. & MED. 134 (2013).

95. FLA. STAT. § 790.338 (2011).

96. U.S. CONST. amend. I.

97. U.S. CONST. amend. XIV; Gitlow v. New York, 268 U.S. 652 (1925).

98. The National Rifle Association filed an Amicus Curiae brief on October 1, 2013 in the Eleventh Circuit in defense of the statute in *Wollschlaeger v. Governor of Fla.*, 760 F.3d 1195 (11th

physicians to ask their patients about gun availability in the home by enacting the Firearms Owners' Privacy Act[99] ("FOPA") (popularly dubbed the "Docs versus Glocks" law). This statute preemptively required that licensed health care practitioners and facilities:

> (1) omit information concerning a patient's ownership of firearms from the patient's medical record unless that information is relevant to the patient's medical care or safety, or the safety of others;
>
> (2) respect a patient's right to privacy and refrain from inquiring as to whether a patient or his or her family owns firearms, unless the practitioner or facility believes in good faith that the information is relevant to the patient's medical care or safety, or the safety of others;
>
> (3) not discriminate against a patient on the basis of firearm ownership; and
>
> (4) refrain from harassing a patient about firearm ownership.[100]

Supported by substantial scholarly commentary,[101] a physician in private medical practice quickly launched a First Amendment challenge to the FOPA in federal court. The District Court granted plaintiff's motion for a preliminary injunction,[102] but that ruling was later overturned on a 2-1 decision by the Eleventh Circuit Court of Appeals.[103] In upholding the validity of the challenged statute, the Eleventh Circuit rejected traditional theories of free expression[104] and held specifically that—because the FOPA primarily regulated physicians' conduct rather than their speech—the FOPA's: (1) inquiry and record-keeping provisions were valid regulations of professional conduct, with only incidental effect on plaintiffs' free speech rights;[105] (2) discrimination and harassment provisions were valid regulations of professional conduct, with only an incidental effect on plaintiffs' free speech rights;[106] (3) plain language belied the argument that it violated First Amendment free speech rights by targeting and prohibiting physicians' speech on the topic of firearms;[107] (4) the FOPA's language was not overbroad;[108] and (5) neither the inquiry and record-keeping provisions[109] nor the discrimination and harassment provisions[110] were

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Cir. 2015).

99. FLA. STAT. § 790.338 (2011).

100. *Id.*

101. *E.g.*, Gayland O. Hethcoat II, *In the Crosshairs: Legislative Restrictions on Patient-Physician Speech About Firearms*, 14 DEPAUL J. HEALTH CARE L. 1 (2011).

102. Wollschlaeger v. Farmer, 814 F.Supp.2d 1367 (S.D. Fla. 2011).

103. Wollschlaeger v. Governor of Fla., 760 F.3d 1195 (11th Cir. 2015).

104. *See* Clay Calvert et al., *Physicians, Firearms & Free Expression: Reconciling First Amendment Theory with Doctrinal Analysis Regarding the Right to Pose Questions to Patients*, 12 FIRST AMEND. L. REV. 1 (2013).

105. *Id.* at 1219–20.

106. *Id.* at 1221.

107. *Id.* at 1225.

108. *Id.* at 1225–26.

109. *Id.* at 1227.

110. *Id.* at 1228–29.

unconstitutionally void for vagueness in violation of physicians' due process rights.

The 11th Circuit subsequently *sua sponte* vacated and reconsidered its original opinion in this matter and, on July 28, 2015, substituted in its place a 2-1 opinion once again reversing the District Court's grant of summary judgment in favor of the plaintiffs and vacating the injunction issued by the District Court.[111] Less than a month later, the petitioners filed a Petition for Rehearing *En Banc* in the 11th Circuit.[112] On December 14, 2015, the 11the Circuit issued its third decision upholding the Florida statute,[113] and three weeks later the plaintiffs filed another petition seeking rehearing before the full 11th Circuit.[114]

As a matter of public policy, major health care professional organizations and the ABA "oppose state and federal mandates that interfere with physician free speech and the physician-patient relationship, including laws that forbid physicians to discuss a patient's gun ownership."[115] Whatever its ultimate fate in the courts or subsequent legislatures,[116] the FOPA clearly qualifies as a legal anomaly,[117] although similar "gag law" bills have been introduced unsuccessfully in a few other states.[118] Looking at the rest of the country, there is no legal barrier preventing a physician from asking patients whether they have access to firearms and, when they respond affirmatively, prompting them to agree to store their guns safely. This might include temporarily transferring the guns out of the home if the patient or his or her loved ones are in danger of using the guns to harm themselves or others.[119]

Under current law, physicians, with the possible exception of those practicing in Florida, have latitude to act according to their own discretion when

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111. Wollschlaeger v. Governor of Fla., 797 F.3d 859 (11th Cir. 2015); Maryanne Tomazic, *Recent Case Developments, Docs v. Glocks: Restricting Doctor's Professional Speech in the Name of Firearm Owner Privacy*, 41 AM. J. L. & MED. 680 (2015).

112. Wollschlaeger v. Governor of Fla., Case No. 12-14009-FF, Petition for Rehearing *En Banc* (11th Cir. Aug. 18, 2014).

113. Wollschlaeger v. Governor of Fla, No. 12-14009, 2015 U.S. App. LEXIS 21573 (11th Cir. 2015).

114. Jim Saunders, *Doctors Take Aim at "Docs vs. Glocks" Law Again*, ORLANDO SENTINEL (Jan. 6, 2016), http://www.orlandosentinel.com/news/politics/os-docs-vs-glocks-fight-20160106-story.html.

115. Weinberger et al., *supra* note 49, at 514.

116. One commentator argues that the Firearms Owners Privacy Act does not go far enough in limiting physician conduct, and should be amended to limit legitimate physician inquiries about firearms availability in the home to instances where there is a substantial likelihood of serious bodily harm to the patient or others, not merely relevance. Chad A. Pasternack, *Wollschlaeger, a Patient's Right to Privacy, and a Renewed Focus on Mental Health Treatment*, 23 U. MIAMI BUS. L. REV. 451 (2015).

117. *See* Janet L. Dolgin, *Physician Speech and State Control: Furthering Partisan Interests at the Expense of Good Health*, 48 NEW ENG. L. REV. 293, 313–17 (2014).

118. Mobeen H. Rathmore, *Physician "Gag Laws" and Gun Safety*, 16 VIRTUAL MENTOR 284 (2014). Montana does have legislation requiring medical providers to treat patients regardless of whether the patients are willing to discuss their ownership, possession, or use of firearms. H.B. 459, 61st Leg., Reg. Sess. (Mont. 2009).

119. J. Michael Bostwick, *A Good Idea Shot Down: Taking Guns Away from the Mentally Ill Won't Eliminate Mass Shootings,* 88 MAYO CLINIC PROC. 1191, 1194 (2013).

it comes to questioning their patients about guns in the home.in this context. According to a coalition of leading health professional organizations and the ABA, physicians are able to intervene with patients whose access to firearms puts them at risk of injuring themselves or others.[120] Such intervention may entail speaking freely to patients in a nonjudgmental way, giving them safety-related factual information, answering patients' questions, advising them about behaviors that promote health and safety, and documenting these conversations in the patient's medical record (just as the physician would document conversations with their patients regarding other kinds of health-related behaviors).

Assuming the physician has a right to inquire about an older patient's access to firearms in the home, there must be a concomitant right to act on the results of that inquiry and counsel the patient and/or family about associated dangers to self or others. Once pertinent, risk-related information comes into the physician's possession, it would be counterproductive to deny the physician a right to converse with the patient and/or family in the context of counseling about firearms-related dangers. "[E]ven when known, family members may not appreciate safety concerns and remove guns from the household of adults deemed incompetent to use them. . . . [C]aregivers of people with dementia (especially when slowly progressive) may find it difficult to determine and manage risk concerns."[121] Studies have documented that most older adults are comfortable with physicians initiating discussions about firearms in the home in the context of depression, suicidality, or cognitive impairment,[122] and that physician counseling can exert a substantial positive impact on firearm safety practices in the patient's home.[123]

B. The Physician's Right to Notify Third Parties

Even when a physician learns that an older patient has access to firearms in the home and counsels the patient and/or family about potential dangers, there is no guarantee that the physician's admonitions will be heeded. Particularly in situations involving a patient with severe cognitive and/or emotional deficits, risky behaviors associated with the handling of firearms may persist in the face of recommendations and counseling to the contrary. Thus, a question arises regarding the physician's right to notify certain third parties of the potential danger in order to prevent or reduce the likelihood of harm materializing. There is an obvious problem with legally recognizing such a right for physicians. Personal information about a patient that becomes known to a physician in the course of the physician-patient relationship ordinarily is treated under federal[124]

120. Weinberger et al., *supra* note 49, at 514.

121. Anne P.F. Wand et al., *Firearms, Mental Illness, Dementia and the Clinician*, 201 MED. J. AUSTL. 674, 674 (2014).

122. Marian E. Betz et al., *Older Adult Openness to Physician Questioning About Firearms*, 63 J. AM. GERIATRICS SOC'Y 2214 (2015).

123. Teresa L. Albright & Sandra K. Burge, *Improving Firearm Storage Habits: Impact of Brief Office Counseling by Family Physicians*, 16 J. AM. BOARD FAM. PRAC. 40 (2003).

124. Health Insurance Portability and Accountability Act (HIPAA), Pub. L. No. 104-191, 110

and state[125] statute, as well as state common law,[126] as confidential and may not be revealed to third parties in the absence of a valid exception to the physician's confidentiality obligation.[127]

State law should create a public policy-based exception to the normal confidentiality rules in this situation, analogous to the statutory exceptions many states have carved out to permit physicians to report reasonable suspicions of dangerous older drivers to state motor vehicles officials or to report reasonable suspicions of elder abuse or neglect to designated Adult Protective Services (APS) agencies.[128] When an older person's primary care physician believes, in reliance on the physician's professional judgment, that the older person's potential access to firearms poses a foreseeable danger[129] to that patient or others, state law should recognize the physician's right to report that reasonable belief to appropriate civil authorities.

The concept of "reasonable belief" as the basis for action admittedly is vague in this context and in many other legal contexts. In the abuse and neglect arena, reasonable suspicion ordinarily is interpreted very broadly to favor liberal reporting; in other words, false positive reports are preferred by policy makers over failure to report resulting in false negatives (i.e., actual cases of abuse going unreported). The question of what constitutes a "reasonable belief" that firearms in the home pose a risk of injury to an older patient or others might be substantively guided by evidence-based, consensus-supported Clinical Practice Guidelines (CPGs) to be devised by major professional organizations in geriatrics, gerontology, and public safety.[130] Such CPGs might specify particular factual situations as Safe Harbors, such that physicians are automatically protected against legal repercussions for reporting in those circumstances.

State law to this effect would be fully consistent with HIPAA, which permits a covered entity, such as a physician's practice organization, to disclose

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Stat. 1936 (1996) (codified as amended in scattered sections of 18, 26, 29, and 42 U.S.C.).

125. *E.g.*, FLA. STAT. § 456.057(7) (2011).

126. *E.g.*, Biddle v. Warren Gen. Hosp., 715 N.E.2d 518 (Ohio 1999).

127. Regarding common law exceptions to the confidentiality rule, *see, e.g.*, Bernard Friedland, *Physician-Patient Confidentiality: Time to Re-Examine a Venerable Concept in Light of Contemporary Society and Advances in* Medicine, 15 J. LEGAL MED. 249, 257–59 (1994).

128. *See, e.g.*, AM. MED. ASSOC. & NAT'L HIGHWAY TRAFFIC & SAFETY ADMIN., THE PHYSICIAN'S GUIDE TO ASSESSING AND COUNSELING OLDER DRIVERS (David B. Carr et al. eds. 2010); Kristen Snyder & Joseph D. Bloom, *Physician Reporting of Impaired Drivers: A New Trend in State Law?*, 32 J. AM. ACAD. PSYCHIATRY & L. 76 (2004); FLA. STAT. § 322.126(2) (2011) (permitting, but not mandating, physician reports); Maureen Cleary, *Driving With Dementia: The Necessity of a Comprehensive Reporting Scheme*, 23 ELDER L.J. (forthcoming 2016).

129. It is important to distinguish the physician's determination of potential dangerousness from the physician's diagnosis of mental illness, since the two are not necessarily synonymous. *See* Jeffrey Swanson, *Firearms Laws, Mental Disorder, and Violence*, PUBLIC HEALTH LAW RESEARCH, http://publichealthlawresearch.org/project/firearms-laws-mental-disorder-and-violence (last visited Jan. 24, 2016); Ryan C.W. Hall & Susan H. Friedman, *Guns, Schools, and Mental Illness: Potential Concerns for Physicians and Mental Health Professionals*, 88 MAYO CLINIC PROC. 1272, 1278–79 (2013).

130. *See infra* note 163 (regarding evidence-based CPGs).

personal health information (PHI) when the covered entity has a good faith belief that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or others and is made to a person reasonably able to prevent or lessen the threat, such as law enforcement, family members, and identifiable targets of threat. When such a disclosure is made, good faith is presumed.[131]

Statutes should authorize the physician to notify local law enforcement agencies and/or the local APS agency regarding the perceived potential danger.[132] The APS is empowered to investigate allegations of adult abuse and neglect, including self-neglect.[133] State statutes could encourage physician notifications by explicitly providing physicians who notify third parties in good faith with immunity against any civil and criminal liability as well as regulatory (for example, professional licensure-related) sanctions; just as physicians who report potentially dangerous drivers to their jurisdiction's DMV are protected by statute against any liability for making the report.[134]

C. The Physician's Duties

In light of the foregoing, the controversial question is whether physician latitude or permissiveness in this context is the optimal public policy response. An alternative to affording physicians latitude to inquire about their older patients' access to firearms could be having the law impose an affirmative, enforceable obligation on the physician to make a firearms-related inquiry. If so, how deep or extensive an inquiry should be mandated? Further, should such obligations include the duty to affirmatively follow up on the information gleaned from the response to that inquiry? More particularly, does a physician's right to inquire necessarily imply a duty to inquire, a responsibility to counsel the patient or others about the dangers of firearms in the hands of that patient, and/or an obligation to the patient or third parties, or both, to protect them by positively intervening (for example, by reporting the potential danger) to prevent injury that might be caused by the mentally impaired patient's use of a firearm?

The best answer to these queries is that affirmative statutory duties associated with firearms ownership and possession by older patients should not be imposed on physicians by the states in the context of specific physician/older patient relationships. Conversely, however, it could be appropriate for physicians to be required to carry out affirmative duties in this context under the common law even when statutory compulsion is not present.[135] In the litigation

131. 45 C.F.R. § 164.512(j) (2013).

132. *See National Adult Protective Services Association*, NAT'L ADULT PROTECTIVE SERVS. ASSOC., http://www.napsa-now.org/ (last visited Jan. 19, 2016).

133. *See* William White, *Elder Self-Neglect and Adult Protective Services: Ohio Needs to Do* More, 27 J.L. & HEALTH 130, 143–44 (2014). *See generally* Alexander K. Smith et al., *Elder Self-Neglect—How Can a Physician Help?*, 369 NEW ENG. J. MED. 2476 (2013); Carlos A. Reyes-Ortiz et al., *Medical Implications of Elder Abuse: Self-Neglect*, 30 CLIN. GERIATR. MED. 807 (2014).

134. *E.g.*, FLA. STAT. § 322.126(3) (2016).

135. *See* Mark A. Geistfeld, *Tort Law in the Age of Statutes*, 99 IOWA L. REV. 957 (2014), for a discussion on the relationship of statutes and common law duties in the tort context.

context, whether a physician has acted negligently is a question of fact to be determined by the jury or a judge who is acting in a fact-finder capacity.[136] A common law responsibility should be recognized if, but only if, inquiry, counseling, and/or warning about firearms related dangers become such prevalent professional behaviors within mainstream medicine that those behaviors are incorporated at a future point in time into the fiduciary[137] standard of care owed as a matter of tort law by the physician to his or her patients. Alternatively, a common law responsibility should be recognized if juries, or judges acting in a fact-finder capacity, begin finding that reasonable care under the circumstances includes inquiry, counseling, and/or warning about firearms related dangers even before those behaviors become prevalent among practicing physicians. Otherwise, the physician's fear of adverse tort law consequences should not be permitted to undermine the physician's usual duty to protect patient privacy.[138]

1. Duty to Inquire and Counsel

A physician's duty to inquire about an older patient's access to firearms in the home might be imposed by the enactment of state statutes that essentially create an affirmative mirror image of the FOPA's negative restraints. If state statutes like the FOPA's would inspire objections on the grounds that those statutes interfere with physicians' freedom of speech, then statutes imposing an affirmative obligation on physicians to make specific gun-related inquiries and engage in accompanying counseling likewise would raise serious issues about compelled speech. Just as the First Amendment limits the authority of government to prohibit or restrain a person's[139] exercise of freedom of speech, so too, government's authority to compel the uttering of specific political or ideological[140] speech (for example, by statutorily obligating a physician to make certain gun-related inquiries and to counsel the patient and/or family on the basis of information yielded by those inquiries) raises First Amendment questions.

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136. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL HARM § 8 (AM. LAW INST. 2010)

137. *See generally* TAMAR FRANKEL, FIDUCIARY LAW (1st ed. 2011); *and* Gabriel Lázaro-Muñoz, *The Fiduciary Relationship Model for Managing Clinical Genomic "Incidental" Findings*, 42 J.L. MED. & ETHICS 576, 578–79 (2015), for a discussion regarding the fiduciary nature of the physician/patient relationship.

138. *See generally* Eugene Volokh, *Tort Law vs. Privacy*, 114 COLUM. L. REV. 879, 935–36 (2014).

139. *See* Citizens United v. Federal Election Commission, 558 U.S. 310, 342 (2010) (holding that nonprofit corporations qualify for protection), for a discussion of who qualifies as a "person" for First Amendment freedom of speech purposes.

140. *See generally* Samantha Rauer, *When the First Amendment and Public Health Collide: The Court's Increasingly Strict Constitutional Scrutiny of Health Regulations that Restrict Commercial Speech*, 38 AM. J.L. & MED. 690, 692-–93 (2012), for a discussion on the First Amendment relationship between political and commercial speech; Jennifer M. Keighley, *Can You Handle the Truth? Compelled Commercial Speech and the First Amendment*, 15 U. PA. J. CONST. L. 539 (2012). A full discussion of constitutional aspects of commercial speech is beyond the scope of this article. See, e.g., Jennifer Pomeranz, *Compelled Speech Under the Commercial Speech Doctrine: The Case of Menu Label Laws*, 12 J. HEALTH CARE L. & POL'Y 159 (2009), for a discussion regarding compelled commercial public health speech.

Both prohibited and compelled speech are afforded significant protected status in First Amendment jurisprudence, and that status is not diminished in importance because of a claim that the involved compelled speech is commendably intended to promote valuable public health interests.[141]

The courts thus far are split in their responses to First Amendment challenges to compelled medical speech brought by physicians *qua* physicians in their role as patient fiduciaries or trust agents (as opposed to claims brought by physicians seeking protection in their capacity as ordinary citizens).[142] Nevertheless, there is a strong argument for requiring that state laws compelling particular speech by physicians in their physician role be examined under at least a strict scrutiny standard.[143]

A state statute mandating that physicians engage in specific conversation with their older patients or their families about firearm access would be a form of compelled speech.[144] Such compelled speech properly ought to be classified as ideological (conveying a particular point of view) rather than non-ideological. Quite arguably, a state statute compelling physician inquiries and follow up counseling directed at older patients or their families regarding firearm dangers conveys to the recipients of those inquiries and associated counseling an inescapable, negative ideological message directed by the state regarding firearm ownership and possession.[145] "When there are close cases where the ideological content of the compelled speech is unclear on the statute's face, the courts will need to evaluate the state's actual purpose in order to discern whether the statute forces the physician to engage in ideological speech."[146] The only conceivable purpose of a state statute compelling physician inquiry and counseling about an older patient's firearms access is to try to curtail such access for certain older patients by using the physician to send a negative message about the safety of firearms.

The Supreme Court has applied strict scrutiny analysis to the ideological category of compelled speech, but has not yet spoken on the level of analysis appropriate to non-ideological compelled speech.[147] Under strict scrutiny analysis, a state statute would survive constitutional challenge only if the state

141. R.J. Reynolds Tobacco Co. v. Food and Drug Admin., 696 F.3d 1205, 1211 (D.C. Cir. 2012) (invalidating an FDA requirement of graphic warning labels on cigarette packages).

142. Scott W. Gaylord & Thomas J. Molony, *Casey and a Woman's Right to Know: Ultrasounds, Informed Consent, and the First Amendment*, 45 CONN. L. REV. 595 (2012).

143. Jennifer M. Keighley, *Physician Speech and Mandatory Ultrasound Laws: The First Amendment's Limit on Compelled Ideological Speech*, 34 CARDOZO L. REV. 2347 (2013); Aimee Furdyna, *Undermining Patient Autonomy by Regulating Informed Consent for Abortion*, 6 ALB. GOV'T L. REV. 638 (2013); Martha Swartz, *Physician-Patient Communication and the First Amendment After Sorrell*, 17 MICH. ST. U.J. MED. & L. 101 (2012).

144. Keighley, *supra* note 143.

145. *Id.* at 2364 ("Speech that adopts a moral position or argument with respect to a matter of opinion that is debated in the public sphere qualifies as ideological speech.").

146. *Id.* at 2387–88.

147. Wooley v. Maynard, 430 U.S. 705, 716–17 (1977); *See* Ryan J.F. Pulkrabek, *Clear Depictions Promote Clear Decisions: Drafting Abortion Speech-and-Display Statutes that Pass First and Fourteenth Amendment Muster*, 15 MARQ. ELDER'S ADVISOR 1 (2013).

could show that the means chosen by the legislature (the compelled speech) was not only necessary, but also narrowly tailored (not merely rationally related) to accomplish a compelling (and not merely a legitimate) state interest.

Although there could be serious problems with a statutorily-imposed physician duty to inquire and counsel, evolving state common law doctrine may eventually lead to recognition of these gun inquiry-related legal duties on the part of older patients' primary care physicians. The negligence branch of tort law imposes upon individuals an obligation to act reasonably to avoid injuring other persons. [148] Reasonableness under any particular set of circumstances ordinarily[149] is determined in terms of whether a reasonable person in the actor's situation (or a similar situation) should have been expected to foresee that his or her conduct, through an act or omission, would have endangered the person who, indeed, suffered an injury.[150]

In the context of a medical malpractice lawsuit contending that the defendant physician should be held liable because that physician was at fault, through a negligent act or omission, and that the defendant's negligence proximately caused[151] injury[152] to the patient to whom a duty of reasonable or due care was owed,[153] the trier-of-fact may take into consideration several factors to determine the reasonableness of the defendant physician's conduct. The traditional test of medical professional reasonableness has involved assertions about empirical evidence. Expert witnesses testify about the customary or usual practice of a defendant's specialty peers in the same or similar circumstances.[154] In characterizing the customary or usual practice of the defendant physician's peers, expert witnesses testify about a national, rather than a local, standard of care.[155] In other words, physicians today are compared legally to the practice patterns of their peers throughout the United States, not just in their own surrounding area.[156] Many states are moving "gradually,

148. "A person acts negligently if the person does not exercise reasonable care under all the circumstances." RESTATEMENT (THIRD) OF TORTS: PHYS. & EMOTIONAL. HARM § 3 (AM. LAW INST. 2010). In addition to negligence, civil tort law also encompasses intentional wrongdoing that injures another party, RESTATEMENT (THIRD) OF TORTS: INTENTIONAL TORTS TO PERSONS (AM. LAW INST., Discussion Draft Apr. 2014), as well as strict or no-fault liability, RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL HARM (BASIC PRINCIPLES) § 24 (AM. LAW INST. 2001).

149. There are exceptions to the ordinary requirement of reasonable conduct under the circumstances. *See, e.g.*, FLA. STAT. § 768.13(2)(b) (providing immunity against civil liability for emergency medical care provided in a hospital unless a plaintiff can prove the defendant's "reckless disregard for the consequences so as to affect the life of health of another").

150. *See* David G. Owen, *Figuring Foreseeability*, 44 WAKE FOREST L. REV. 1277 (2009).

151. *See* Kevin F. O'Malley et al., 3 FED. JURY PRAC. & INSTR.—CIVIL § 120:60 (6th ed. 2014), for a discussion regarding proximate causation.

152. *See Id.* at § 155:20 (regarding the required element of injury to the plaintiff).

153. *See* Alani Golanski, *A New Look at Duty in Tort Law: Rehabilitating Foreseeability and Related Themes*, 75 ALB. L. REV. 227 (2011-2012).

154. Tim Cramm, Arthur J. Jartz, & Michael D. Green, *Ascertaining Customary Care in Malpractice Cases: Asking Those Who Know*, 37 WAKE FOREST L. REV. 699, 699 (2002).

155. Michelle H. Lewis et al., *The Locality Rule and the Physician's Dilemma: Local Medical Practices vs. the National Standard of Care*, 297 J. AM. MED. ASS'N 2633, 2634 (2007).

156. Hall v. Hilbun, 466 So. 2d 856 (Miss. 1985).

quietly, and relentlessly" away from a customary-based standard of care[157] toward a "reasonable physician practice" under the circumstances test, which requires the fact finder to ask what physicians ought to be doing instead of what the bulk of the medical mainstream may actually be doing right now.[158]

As physicians gradually learn more about the dangers associated with cognitively and emotionally compromised older patients having access to firearms, it is likely that more primary care physicians will begin inquiring about this matter, and subsequently will follow up with patient-family counseling, as part of their ongoing care of older patients.[159] For example, the realization that older males are one of the highest risk groups for committing suicide by using a firearm[160] will become more commonplace. Inquiries and counseling about firearms-related dangers will become, if they are not already,[161] a customary aspect of geriatric practice. Physicians who do not engage in these kinds of inquiry and counseling will be considered practice—and hence, legal—outliers.

Moreover, as public and professional education in this arena expands beyond its present low baseline[162] and becomes more sophisticated, making inquiries and conducting counseling about an older patient's access to firearms may be seen as part of reasonable physician practice even before the practice becomes customary among the physician mainstream. This trend may be accelerated if respected physician organizations promulgate evidence-based[163] CPGs recommending to clinicians that they (a) ordinarily ask older patients, families, and other housemates and caregivers about the patient's access to firearms, and then (b) counsel the affected individuals about possible dangers

157. Philip G. Peters, Jr., *The Role of the Jury in Modern Malpractice Law*, 87 IOWA L. REV. 909, 913–14 (2002).

158. Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163 (2000); *See also* Jalayne J. Arias, *Becoming the Standard: How Innovative Procedures Benefitting Public Health Are Incorporated into the Standard of Care*, 39 (Supp. 1) J. L., MED. & ETHICS 102, 103 (2011). Both of these standards, which allow the fact finder (ordinarily a jury) to determine whether negligence took place as a question of fact, must be distinguished from the extremely rare occurrence of judicial standard setting as a matter of law, as took place in *Helling v. Carey*, 519 P.2d 981, 83 Wash.2d 514 (Wash. 1974). *See* Meghan C. O'Connor, *The Physician-Patient Relationship and the Professional Standard of Care: Reevaluating Medical Negligence Principles to Achieve the Goals of Tort Reform*, 46 TORT TRIAL & INS. PRAC. L.J. 109, 123–26 (2010).

159. *Cf.* James H. Price et al., *Psychiatrists' Practices and Perceptions Regarding Anticipatory Guidance on Firearms*, 33 AM. J. PREVENTIVE MED. 370 (2007) (finding that when psychiatrists are provided with relevant information about firearm related dangers and mental illness, they were significantly more likely to engage in anticipatory guidance).

160. Am. Psychiatric Assoc., *Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors*, 160 AM. J. PSYCHIATRY 11, 46 (2003).

161. *See* Mark S. Kaplan et al., *Prevention of Elderly Suicide: Physicians' Assessment of Firearm Availability*, 15 AM. J. PREV. MED. 60 (1998) (finding that 42% of physicians do not ask their older patients about access to firearms, meaning that 58% do make an inquiry).

162. One 2013 commentator states: "[W]e physicians generally do not know enough about firearms to have an informed conversation with our patients, let alone counsel them about gun safety." J. Michael Bostwick, *A Good Idea Shot Down: Taking Guns Away from the Mentally Ill Won't Eliminate Mass Shootings*, 88 MAYO CLINIC PROC. 1191, 1191 (2013).

163. *See* John Tucker, *A Novel Approach to Determining Best Medical Practices: Looking at the Evidence*, 10 HOUS. J. HEALTH L. & POL'Y 147 (2009).

and safety measures to take. CPGs are increasing their influence on the standards of care to which fact finders in civil litigation are holding medical professionals accountable.[164] An overwhelming majority of internists surveyed in 2013 agreed that there was a need for educational programs designed to increase the knowledge and skills of physicians with regards to how to counsel patients in the prevention of firearms injury.[165] Additionally, the medical literature is beginning to burgeon with detailed guidance for physicians about dealing with older patients and the dangers posed by access to firearms.[166] Thus, recognition of a physician's common law duty to make and follow up on firearms-related inquiries of older patients has become increasingly likely in the near future under either the customary or reasonable practice standards of care. So, too, does a finding of negligence liability for breach of that duty.

2. Duty to Protect

As previously explained,[167] states should explicitly allow and encourage physicians to report to designated public agencies[168] their reasonable suspicions[169] that a particular older patient poses a serious risk of harm to self or others by virtue of that cognitively and/or emotionally impaired patient's access to firearms. The state is justified in granting physicians this permission under its inherent paternalistic power to protect people who cannot protect themselves from harm[170] and its police power to promote the general health, safety, welfare, and morals of the community.[171] However, it is not very advisable for states, either by enacting statutes or creating common law precedent, to go further and affirmatively require physicians to make such reports, under pain of criminal prosecution[172] or civil liability for non-compliance with the requirement.

States contemplating the imposition of a positive obligation on physicians to notify designated public agencies might do so by building upon existing

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164. *See* Ronen Avraham, *Overlooked and Underused: Clinical Practice Guidelines and Malpractice Liability for Independent Physicians*, 20 CONN. INS. L.J. 273 (2013-2014).

165. Renee Butkus & Arlene Weissman, *Internists' Attitudes Toward Prevention of Firearm Injury*, 160 ANNALS INTERNAL MED. 821, 823–24 (2014).

166. *See, e.g.*, Ellen M. Pinholt et al., *"Is There a Gun in the Home?" Assessing the Risks of Gun Ownership in Older Adults*, 62 J. AM. GERIATRIC SOC'Y 1142 (2014) (suggesting as guidelines for risk assessment: locked, loaded, little children, feeling low, and learned owner).

167. *See supra* Part IV(B).

168. A duty to protect a patient or others at risk by notifying public authorities is distinguishable from a duty to warn specifically identifiable potential victims of harm. This article is concerned with the duty to protect. *See* Robert Weinstock, *No Duty to Warn in California: Now Unambiguously Solely a Duty to Protect*, 42 J. AM. ACAD. PSYCHIATRY & L. 101 (2014).

169. "Reasonable suspicion" is the generally used threshold specified for mandatory or permissive reporting in elder abuse and neglect statutes, FLA. STAT. § 415.1034(1)(a) (2015), as well as child abuse and neglect statutes, N.M. STAT. § 32A-4-3 (2015).

170. Alfred L. Snapp & Son, Inc. v. Peurto Rico, 458 U.S. 592, 607-608 (1982) (setting out the parameters of the modern *parens patriae* power in the United States).

171. New York v. Miln, 36 U.S. (11 Pet.) 102, 139 (1837) ("[I]t is not only the right, but the bounden and solumn duty of a state, to advance the safety, happiness and prosperity of its people, and to provide for its general welfare, by any and every act of legislation, which it may deem to be conducive to these ends.").

172. *See, e.g.*, FLA. STAT. § 415.111(1) (2015) (making failure to report a criminal offense).

judicial precedent and statutes that have spawned from the California Supreme Court's decision in *Tarasoff v. Board of Regents of the University of California*.[173] The two famous *Tarasoff* decisions imposed on clinicians a duty to warn[174] foreseeable victims about the credible dangers posed by a mentally ill patient and a duty to go beyond warning to affirmatively protect[175] a foreseeable victim from the credible danger presented by a mentally ill patient.

Other states have reacted to the broadly-publicized and powerful *Tarasoff* holding in a wide variety of ways.[176] A number of states have either enacted "dangerous person" statutes compelling health care professionals to warn or protect identifiable third parties about the suspected risks posed by mentally ill patients, or they have produced judicial opinions to the same effect.[177] Other states, however, have intentionally and explicitly rejected this sort of affirmative duty,[178] while a significant cohort of states permit but do not require reporting or notification of suspected patient dangerousness on the part of covered health care providers (in other words, statutorily provide immunity against liability for both reporters and non-reporters).[179] It is this latter, permissive third-party notification model, already in place elsewhere in the world,[180] that ought to be universally emulated in individual U.S. jurisdictions in the context of physicians, firearms, and cognitively and/or emotionally impaired older patients.

Despite the widely accepted view that *Tarasoff* revolutionized the field of mental disability law[181] and that "no court ruling has had a broader or more enduring impact on day-to-day mental health practice,"[182] some commentators have questioned the effectiveness of *Tarasoff*-required notifications in achieving the judicial decision's goals.[183] Questions also have been raised about whether

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173. The pros and cons of applying and extending the *Tarasoff* rationale to other fact situations have been discussed in depth by commentators. *See, e.g.*, Wendy E. Parmet, *Unprepared: Why Health Law Fails to Prepare Us for a Pandemic*, 2 J. HEALTH & BIOMEDICAL L. 157, 175 (2006); Michelle R. King, *Physician Duty to Warn a Patient's Offspring of Hereditary Genetic Defects: Balancing the Patient's Right to Confidentiality Against the Family Member's Right to Know—Can or Should Tarasoff Apply*, 4 QUINNIPIAC HEALTH L.J. 1 (2000); Christine E. Stenger, *Taking Tarasoff Where No One Has Gone Before: Looking at "Duty to Warn" Under the AIDS Crisis*, 15 ST. LOUIS U. PUB. L. REV. 471 (1996).

174. Tarasoff v. Regents of the Univ. of California, 529 P.2d 553 (Cal. 1974).

175. Tarasoff v. Regents of the Univ. of California, 551 P.2d 334, 345 (Cal. 1976); Ann Hubbard, *Symposium Introduction, The Future of "The Legal Duty to Protect": Scientific and Legal Perspectives on Tarasoff's Thirtieth Anniversary*, 75 U. CINN. L. REV. 429 (2006).

176. *See generally* Matthew F. Soulier et al., *Status of the Psychiatric Duty to Protect, Circa 2006*, 38 J. AM. ACAD. PSYCHIATRY & L. 457 (2010); *See also* Rebecca Johnson et al., *The Tarasoff Rule: The Implications of Interstate Variation and Gaps in Professional Training*, 42 J. AM. ACAD. PSYCHIATRY & L. 469 (2014).

177. Mark A. Rothstein, *Tarasoff Duties After Newtown*, 42 J. L., MED. & ETHICS 104 n.24 (2014).

178. *Id.* at n.26.

179. *Id.* at n.25; *See, e.g.*, FLA. STAT. § 456.059 (2015) (pertains to psychiatrists).

180. This is the approach taken in Australia. Wand et al., *supra* note 38, at 676.

181. Douglas Mossman, *Critique of Pure Risk Assessment or, Kant Meets Tarasoff*, 75 U. CIN. L. REV. 523, 524 (2006).

182. *Id.* at 526.

183. Hall & Friedman, *supra* note 129, at 1273–74.

required notifications produce socially optimal incentives for the involved parties.[184] Others, including a former president of the American Psychological Association in his presidential address, have gone so far as to characterize *Tarasoff* and its progeny as "bad law, bad social science, and bad social policy."[185] One empirical study even purports to demonstrate that mandatory duty-to-warn laws cause an increase in a state's homicide rate of up to 5 percent.[186] Moreover, legally mandating a physician's duty to protect is inconsistent with the American approach to regulating attorney practice in analogous circumstances.[187]

Strong public policy considerations argue against states expanding current clinician *Tarasoff* duties to circumstances in which there is a combination of firearms access and older patients with cognitive and/or emotional deficits. Expansion of mandatory reporting requirements in this sphere may turn out to be counterproductive to the ends sought, namely, greater safety of older patients and the public.

Even assuming[188] that mental health professionals, let alone primary care providers, could accurately predict which specific patients pose a serious danger to themselves or others, notifying the police or APS agency will, at the least, trigger an investigation. That investigation, in turn, could result in an objected-to removal of firearms from the older person's home. Or, the investigation could result in an even more intrusive intervention in the form of guardianship imposition on the patient (ordinarily including the ward's loss of the right to possess firearms)[189] and/or forced physical relocation from the home environment. Forced relocation could include involuntary placement in an unwanted institutional setting.

If information about this chain reaction possibility becomes widely known amongst older firearms owners, there is a real risk that they will avoid seeking primary care medical attention and/or their families will keep them away from

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184. Brian D. Ginsberg, *Therapists Behaving Badly: Why the Tarasoff Duty is Not Always Economically Efficient*, 43 WILLAMETTE L. REV. 31, 63 (2007).

185. Donald N. Bersoff, *Protecting Victims of Violent Patients While Protecting Confidentiality*, 69 AM. PSYCHOLOGIST 461, 463 (2014) [hereinafter *Protecting Victims*]; Donald N. Bersoff, *Some Contrarian Concerns About Law, Psychology, and Public Policy*, 26 L. & HUMAN BEHAV. 565, 570 (2002).

186. Griffin Edwards, *Doing Their Duty: An Empirical Analysis of the Unintended Effect of Tarasoff v. Regents on Homicidal Activity*, 57 J. L. & ECON. 321, 322 (2014). *See also* Griffin Edwards, *Recent Advances in the Empirical Evidence Surrounding mental Health Laws and Crime*, 8 ALB. GOV'T L. REV. 508, 516 (2015).

187. *Protecting Victims*, *supra* note 185, at 466.

Permitting discretion [would] align therapists' duty to warn with that of attorneys. Under Section 1.6 of the American bar Association's *Model Rules of Professional Conduct*, lawyers have the discretion to reveal confidences uttered by their clients if they reasonably believe it necessary to prevent death or substantial bodily harm.

188. Douglas Mossman, *The Imperfection of Protection Through Detection and Intervention: Lessons from Three Decades of Research on the Psychiatric Assessment of Violence Risk*, 30 J. LEGAL MED. 109 (2009).

189. Carla-Michelle Adams, *Grandparents, Guns, and Guardianship: Incapacity and the Right to Bear Arms*, 87 FLA. B.J. 48 (Dec. 2013).

primary care physicians. Such excessive deterrence of regular, timely medical care likely would exert a deleterious effect on the health of older individuals and the overall health status of the geriatric population. Alternatively, older persons may continue to consent to the receipt of primary care, but will dishonestly answer the physician's inquiries about firearms availability and/or their own mental health symptoms[190] and perhaps engage in stealthy behavior to keep the physician from learning the truth. "The general public health of communities may be harmed if patients do not trust physicians enough to seek care when they need it or feel they must guard private information in a doctor-patient relationship to avoid police [or other external agency] involvement."[191]

In addition, some commentators contend that mandatory reporting laws imposed by the overwhelming majority of states in the elder abuse context (and their resulting state intrusions) have the unintended but serious consequence of infringing on the civil rights of older people about whom suspicions of mistreatment are reported.[192] Most persuasively, elder law scholar Nina Kohn, drawing in part on feminist legal theory,[193] has maintained that mandatory elder mistreatment reporting requirements predicated on a paternalistic characterization of older persons as invariably vulnerable and needy violates those older persons' rights to autonomy, self-determination, and dignity of choice.[194] The logic of Kohn's position applies to the case of the state compelling a physician to formally report perceived firearms risks in an older patient's home environment, since the state's concern about possible elder abuse or neglect is the predicate for the mandatory reporting requirement in both situations and the accompanying potential jeopardy to the older individual's civil rights is equally serious as well.

Consequently, physicians should be allowed, and indeed encouraged, to exercise professional judgment in each case, without fear of negative legal repercussions. That would be more desirable than an alternative legal approach compelling physicians and other health care professionals to report patients who exhibit some potential to harm themselves or others. Despite the best of intentions, compulsory reporting laws risk stigmatizing people with mental or substance abuse disorders, discouraging those people from seeking treatment,

190. *See* Jonathan S. Bor, *Among the Elderly, Many Mental Illnesses Go Undiagnosed*, 34 HEALTH AFF. 727 (2015) (observing that many older patients do not tell their physicians about symptoms of clinical depression).

191. Chris Conway, *Mandatory Physician Reporting of Gunshot Wounds: A Chicago Perspective*, 23 ANNALS HEALTH L. ADVANCE DIRECTIVE 51, 61 (2014).

192. *E.g.*, Joan Harbison et al., *Understanding "Elder Abuse and Neglect": A Critique of Assumptions Underpinning Responses to the Mistreatment and Neglect of Older People*, 24 J. ELDER ABUSE & NEGLECT 88, 95 (2012).

193. Nina A Kohn, *Vulnerability Theory and the Role of Government*, 26 YALE J. L. & FEMINISM 1 (2014) (focusing particularly on the work of Martha Fineman); *see, e.g.*, Martha A. Fineman, *The Vulnerable Subject: Anchoring Equality in the Human Condition*, 20 YALE J. L. & FEMINISM 1 (2008).

194. Nina A. Kohn, *Elder Rights: The Next Civil Rights Movement*, 21 TEMP. POL. & CIV. RTS. L. REV. 321, 323–24 & 327–28 (2012); Nina A. Kohn, *The Lawyer's Role in Fostering an Elder Rights Movement*, 37 WM. MITCHELL L. REV. 49, 53–4 & 56 (2010); Nina A. Kohn, *Outliving Civil Rights*, 86 WASH. U. L. REV. 1053 (2009).

and jeopardizing the trust that lies at the heart of a productive professional/patient relationship. [195]

VI. CONCLUSION

The access that a sizeable number of older individuals with substantial mental deficits have to operational firearms in the home comprises a significant contemporary public health issue in the United States. Primary care physicians caring for older patients with access to firearms have an important role to play in this matter, both in the public policy arena and in the context of particular physician/patient relationships, and those physicians need to strike an ethically tolerable balance between pressing but sometimes conflicting societal and individual patient interests.[196] The law can help establish the parameters within which that balance may be achieved.[197]

State statutes should authorize physicians to inquire of and about their older patients regarding patient access to firearms in the home and to counsel the patient, family members, and housemates about firearms safety, up to and including recommending that firearms be kept away from the patient. However, the states should not enact legislation that positively requires the physician to make such inquiries and engage in counseling, although states should consider a tort standard of care evolving through the common law in a direction that imposes an affirmative obligation on the physician to inquire and counsel.

Similarly, depending upon the physician's professional assessment of possible danger to the patient or others posed by a specific older patient's access to firearms, state statutes should authorize the physician to notify appropriate law enforcement and APS agencies about the physician's good faith suspicions of danger. However, both public policy and patients' rights dictate that whether or not physicians choose to avail themselves of this authority should remain discretionary, rather than legally mandatory, in each particular case.[198]

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195. Weinberger et al., *supra* note 49, at 514.

196. Brian K. Cooke et al., *Firearms Inquiries in Florida: "Medical Provacy" or Medical Neglect?*, 40 J. AM. ACAD. PSYCHIATRY & L. 399, 405 (2012) ("Weighing the risks and benefits of whether to inquire about firearms ownership is not a simple task.").

197. *See* Mary I. Wood, *Protective Privilege Versus Public Peril: How Illinois Has Failed to Balance Patient Confidentiality with the Mental Health Professional's Duty to Protect the Public*, 29 N. ILL. U. L. REV. 571 (2009).

198. *Protecting Victims*, *supra* note 185.