

Understanding the Role of Law in Reducing Firearm Injury through Clinical Interventions

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Introduction

Firearm injury in the United States is a public health crisis. Approximately 38,000 people are killed, and 73,300 people are injured, by firearms each year in the United States.¹ Between 2014 and 2018, firearm suicide rates increased by 10% in the past five years, while firearm homicide rates increased by 25%.² Americans have a significantly higher risk of firearm injury compared to citizens of other high-income countries.³ Physicians are uniquely situated to act as upstream interveners to prevent firearm injury. They can identify patients at risk of harming themselves or others as well as patients at risk of being harmed by firearm violence.⁴ However, their ability to mitigate harm is limited. Laws and regulations that shape physicians' roles in the context of firearm injury prevention interact in complex ways, and, in many cases physicians are unaware of, or have misconceptions about, how and whether these laws affect their clinical practice.

Using clinical scenarios to illustrate how firearm laws and regulations interact to directly impact physicians' abilities to reduce firearm-related harms, this article suggests not only that physicians and other

healthcare providers require more nuanced education on this topic, but also that policymakers should consult with front-line healthcare providers — just as they consult with other stakeholders — when designing firearm policies.

The Law's Influence on Reducing Firearm Injury in Clinical Practice

Clinical encounters between physicians and their patients represent opportunities to screen for and identify firearm injury risk.⁵ Physicians can lawfully screen and ask patients about firearm ownership in all states.⁶ Next, a physician must decide how to appropriately manage that risk in order to reduce the likelihood of firearm injury by: (1) providing firearm safety counseling to patients and their families, such as encouraging voluntary transfer of an at-risk patient's firearm; (2) reporting high-risk individuals to law enforcement; (3) temporarily restricting an individual's access to firearms through a court order; and/or (4) involuntarily holding or committing an individual for further evaluation and care. The law may guide, and occasionally dictate, the appropriate course of

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action, but physicians often act based out of misperception or lack of awareness of what the law allows them to do. In almost all situations, counseling alone will be sufficient. In extremely high risk situations, the other three types of interventions — reporting, temporary restriction of access to firearms, and involuntary commitment — may be used, but bring risks and other implications for the patient-physician relationship.

Counseling

Like patient screening, counseling patients on firearm safety is legal in all states. For example, at a pediatric wellness visit, physicians can offer information about safe storage. Firearm safety and lethal means counseling may also be useful to mitigate suicide risk.⁷

State laws may limit the ways in which physicians counsel patients to reduce access to firearms. For example, physicians may wish to encourage particu-

cise their duty to warn.¹² Many physicians are aware of HIPAA's disclosure restrictions but are not familiar with disclosure permissions, so may hesitate to report firearm risk due to misunderstanding.

Court Orders and Involuntary Holding/Commitment

Some states allow physicians to trigger processes to temporarily and involuntarily remove firearms from extremely high-risk individuals. For example, extreme risk protection order (ERPO) laws allow certain groups of people to petition a court for the temporary removal of a person's access to firearms.

Additionally, when a patient poses an imminent risk to themselves or others, voluntary admission or involuntary commitment is an option in all states. Patients may voluntarily admit themselves for inpatient psychiatric care and are allowed to discharge themselves as long as they do not represent an imminent risk of

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larly high-risk patients to decrease access to lethal means by voluntarily and temporarily transferring their firearms to family members or friends. This strategy is strongly recommended for firearm suicide prevention.

Reporting

State law may govern whether physicians are legally mandated or permitted to report firearm injury, risk, or ownership to third parties. Most states' laws require physicians to report firearm-related injuries. Psychiatrists have a long-recognized "duty to warn," as articulated by the California Supreme Court in *Tarasoff v. Regents of the University of California*.⁸ Some states' legislatures have created a statutory "duty to warn" that typically arises only if a "patient has communicated ... an explicit threat to kill or inflict serious bodily harm ... upon a reasonably identified victim or victims and the patient has the apparent intent and ability to carry out the threat."⁹ Most states narrow the application of this duty to warn such that it applies only to "mental health professionals."¹⁰ Some states permit third-party warning without requiring it.¹¹

The Health Insurance Portability and Accountability Act (HIPAA) expressly allows physicians to exer-

harm to themselves or others. If extremely high-risk patients decline to voluntarily admit themselves, physicians may consider initiating an involuntary hold. An emergency hold is a temporary measure intended for observation and acute treatment purposes, usually lasting less than seventy-two hours. A minority of states require judicial approval prior to initiation.¹³ Most states require demonstration that the patient has a mental illness and represents a risk of danger to self or others.¹⁴ The use of involuntary commitment may carry significant ramifications for firearm owners, depending on their state of residence, because federal law prohibits firearm ownership by individuals who have been "adjudicated as a mental defective" or "committed to a mental institution."¹⁵ Civil commitment is rarely used.

Unintended Consequences of State Laws Designed to Reduce Firearm Injury

Some laws intended to reduce firearm injury may actually preclude or limit effective clinical interventions when a patient is in danger of hurting themselves or others. The case studies explore two such examples: universal background check (UBC) statutes and some

ERPO laws (see Tables 1a–d). UBCs may hamper voluntary firearm transfers by delaying what is ideally an immediate process. Almost all states exclude physicians from acting as petitioners for ERPOs. As legislatures revisit these laws they should include healthcare providers to design more effective processes, as they do for other key stakeholders.

Case Studies

Case One: Severe Depression — Legal Issue: Transfer of Firearm Away from At-Risk Patient

A patient presents to their long-time primary care physician in Maryland with the chief complaint of “worsening depression.” What can the provider do to help keep their patient safe?

Severe depression is associated with increased suicide risk,¹⁶ and access to lethal means like firearms increases that risk.¹⁷ Screening for suicidality and access to lethal means would be appropriate for this patient. If the physician’s assessment finds that the patient is at risk for suicide, possible interventions range from lethal means counseling to involuntary commitment. Physicians should also bear in mind the importance of trust in the ongoing patient relationship and the legal consequences of some clinical decisions.

If the patient discloses firearm possession, counseling may include discussing safe storage practices, such as storage of firearms in a locked location and separately storing ammunition from the firearm, or for those with severe depression a recommendation that possession of a firearm be temporarily transferred to a family member or friend. Federal law, which governs

only transfers and sales from federally-licensed dealers,¹⁸ does not prohibit transfer of possession, but state UBC and licensing laws may limit patients’ ability to legally, temporarily transfer possession. Twenty-two states and the District of Columbia have taken steps to close the “loophole” that allows for any private firearm transfer, with thirteen of these states and the District of Columbia requiring a background check at any point of transfer for all classes of firearms.¹⁹ Fourteen states and the District of Columbia, seven of which also have a UBC law, require a license to own or purchase a firearm. For the purposes of preventing access to firearms by prohibited persons, licensing and UBC laws may be useful, but without a workaround these well-intended laws create an unintended consequence: firearm owners in UBC and strict-licensure states who are in high-risk situations cannot easily or temporarily hand off their guns in a time of crisis.

Some states have tried to address this tension. In Maryland, although firearm transfers between parties who are not licensed dealers must be processed through a licensed dealer or law enforcement for a background check before transfer,²⁰ the state’s highest court held that “temporary gratuitous exchange or loan of a regulated firearm” does not constitute an illegal transfer.²¹ In Washington state, a work group that included representation from the National Rifle Association reached unanimous agreement to amend an existing UBC law, allowing temporary transfers intended to prevent suicide.²²

An ERPO is another legal mechanism, appropriate for only the highest-risk cases, by which a firearm can be temporarily removed from a patient. Most ERPO laws allow family members and law enforcement to petition the court for temporary restriction of a person’s access to firearms. Only the District of Columbia

Table 1a

Voluntary Transfers

	Voluntary Transfer	States
UBCs or licensing laws	Yes	CA, CO, DC, DE, HI, IA, IL, MA*, MD, MI*, NC*, NE, NV, NJ, NM, NY, OR, PA, VT, VA, WA
	No	CT, RI
NO UBCs or licensing laws	Yes	AL, AK, AZ, AR, FL, GA, ID, IN, KS, KY, LA, ME, MN, MS, MO, MT, NH, ND, OH, OK, SC, SD, TN, TX, UT, WV, WI, WY
	No	N/A

* Massachusetts has an exemption from the general prohibition for unlicensed persons who transfer “not more than four” firearms in any one calendar year. See Mass. Ann. Laws ch. 140 § 128A (2019). Iowa, Michigan, and North Carolina all have either licensing or permit to purchase laws for handguns. In Iowa, background checks are only required once every five years. In Michigan, a purchase license is void unless used within 30 days of issuance. In North Carolina, applicants must go through a background check to obtain a permit. All other types of firearms are not included in the licensing or permit to purchase laws in Iowa, Michigan, and North Carolina, and thus can be voluntarily transferred.

Table 1b

ERPOs

	Petitioner	States
ERPO	Mental health professionals*	DC, HI, MD
	Physicians	DC, HI, MD
	Medical professionals**	HI
	No medical or mental health professionals	CA, CO, CT, DE, FL, IL, IN, MA, NV, NJ, NM, NY, OR, RI, VT, WA
NO ERPO	–	AL, AK, AZ, AR, GA, IA, ID, MI, ME, MN, MS, MO, MT, NC, ND, NE, NH, OH, OK, PA, SC, SD, TN, TX, UT, VA, WV, WI, WY

*Mental health professionals includes physicians, psychologists, social workers, marriage, family, or child counselors, rape crisis or sexual abuse counselors, and professional psychiatric nurses.

**Medical professionals includes licensed physicians, advanced practice registered nurses, psychologists, and psychiatrists.

Table 1c

CAP Laws

Criminal Liability	Variation	States
Negligent Storage	“May” or “Is Likely To” Gain Access	CA, DC, MA, MN, NV, NY
	Allowing a Child to Gain Access, Regardless of Whether Child Uses Firearm	CA, DC, HI, MA, MD, MN, NV, NJ, TX
	Allowing a Child to Gain Access, and Child Uses or Carries Firearm	CT, FL, IA, IL, NC, NH, RI, WA
Intentionally, Knowingly, and/or Recklessly Providing Firearms to Minors	All Firearms	IN*, MO, NV, OK*, UT*
	All Loaded Firearms	DE, VA, WI
	Handguns Only	CO, GA*, KY*, MS, TN*

* Georgia, Indiana, Kentucky, Oklahoma, Tennessee, and Utah have a weaker standard for parents and guardians, such that parents may be guilty only if they know of a substantial risk that the child will use the firearm to commit a felony.

Table 1d

Mandatory Reporting of Intimate Partner Violence

	Variation	States
Mandatory Reporting of Non-Accidental Injury	Yes – Gun	LA, MD, ME, MO, SC, SD, TX, VT
	Yes – Gun or Other Weapon	CT, DC, DE, IN, KS, MS, MT, VA, WA, WV
	Yes – Gun, Other Weapon, or Burn	AR, MN, NJ, NV, NY, RI
	Yes – Gun, Other Weapon, Burn, or Injury from Other Means of Violence	AK, AZ, CA, CO, FL, GA, HI, IA, ID, IL, KY, MA, MI, NC, ND, NE, NH, OH, OK, OR, PA, TN, UT, WI
	No	AL, NM, WY

and Maryland allow physicians and “mental health professionals” to petition, and Hawaii allows all “medical professionals” to petition for an ERPO.²³ For an ERPO to be granted, petitioners must typically show either “probable cause” or “reasonable cause” that the firearm owner poses “an imminent risk” of “significant danger” to themselves or others. Most statutes allow for orders directing the individual to surrender their firearms for a period of up to fourteen days.

In this Maryland case, if other interventions are unsuccessful and the patient is felt to be at imminent risk, the physician may petition directly for an ERPO. HIPAA permits unconsented disclosure about a patient’s imminent threat to self to “a person ... reasonably able to prevent or lessen the threat,”²⁴ so a physician may disclose the patient’s risk to petition for the ERPO directly or disclose the risk to a family member or law enforcement officer who can then initiate an ERPO. As always, this decision requires the physician to balance potential violation of patient-provider trust with assessment of the degree of patient risk.

Case Two: Intoxication and Threats — Legal Issue: Emergency Holds

A patient presents to a hospital in New York threatening to “shoot up the whole ER.” He is intoxicated. What can the physician do to keep the patient and others safe?

In this case, the physician’s “duty to warn” is unclear. While his threat to “the whole ER” may satisfy the particularity requirement common in “duty to warn” statutes, it is debatable whether the patient has presented a serious and imminent danger to themselves or others. In New York, the Secure Ammunition and Firearms Enforcement Act of 2013 (SAFE Act) requires “mental health professionals” (including “a physician”) to report persons “likely to engage in conduct that would result in serious harm to self or others.”²⁵ Office of Mental Health guidance indicated that “harm” means “threats of ... homicidal/violent behavior towards others.”²⁶ The requirement includes a discretionary safety valve to exclude “any action which, in the exercise of reasonable professional judgment, would endanger [a] mental health professional or increase the danger to a potential victim.”²⁷

Here, the most appropriate action would be to hold the patient for observation with a sitter. Refusing to discharge an intoxicated patient is common practice and is subject to fewer formal procedures and requirements than involuntary commitment.²⁸ Generally, whether to hold an intoxicated patient against their

will turns on a determination that the patient lacks decision-making capacity, and/or a determination that the patient poses a risk to self or others should they be released in an intoxicated state.

Once the patient is no longer intoxicated, they should be reassessed for violent intentions. If the patient continues to make threats, particularly if the patient indicated possession of a firearm, the physician should consider involving law enforcement and recommending an ERPO, voluntary admission, or an emergency hold.

If the physician identifies that the patient requires emergent psychiatric care, they may offer voluntary admission. If the patient does not agree to voluntary admission, the physician may opt to initiate an emergency hold in some states. Every state and the District of Columbia have emergency hold laws, but who can initiate an emergency hold varies, as does the duration of emergency holds, patients’ rights during the hold, and whether judicial approval is required.²⁹ Twenty-six states and the District of Columbia allow physicians to initiate emergency holds. Five states, including New York, allow physicians to initiate emergency holds of up to seventy-two hours, even if the danger that the individual poses is unrelated to an underlying mental illness.³⁰ Across all states, the most common maximum duration for an emergency hold is seventy-two hours, but ranges from twenty-three hours to ten days.³¹ Importantly, in some states, a history of voluntary admission to a mental hospital or involuntary commitment may prohibit the patient from legally possessing a firearm in the future.³²

Case Three: Childhood Aggression — Legal Issues: Child Access Prevention Laws

A parent brings their child into their pediatrician’s office in Missouri due to concern about the child’s involvement in numerous fights. The family has firearms in the home. What should a physician do?

Studies suggest that a pattern of childhood aggression places the child at serious risk of future harm to others.³³ In addition, firearms in the home are an independent risk factor for future violent offenses and violent victimization,³⁴ particularly with respect to adolescent suicide.³⁵ For this at-risk patient, a conversation about firearms in the home should include counseling regarding these risks and strategies for mitigating them, including safe storage.

Both the National Rifle Association and the American Academy of Pediatrics recommend that firearms be stored in ways that are inaccessible to unauthor-

ized users; evidence-based recommendations indicate the safest form of firearm storage in a locked safe, unloaded, and separate from ammunition.³⁶ If followed diligently by even half of households with children, this storage practice could prevent up to one third of youth suicides.³⁷ As the majority of school shootings involve weapons obtained from the home, safe storage plays a significant role in preventing homicide. In some states, counseling on safe storage can be bolstered by reference to safe storage and child access prevention (CAP) laws.

not in the owner's possession or control to be stored with a safety lock in place.⁴²

Despite the variety of laws related to safe storage — or perhaps because of their patchwork and state variation — more than half of owners store at least one firearm in a less safe manner,⁴³ and over 4.6 million minors live in homes with loaded, unlocked firearms.⁴⁴ Physicians can play a role in reducing children's access to firearms, particularly for patients with significant risk factors such as the child in this case. Physicians responsible for the care of children should be aware of

Each of these case studies illustrates important aspects of the physician-patient relationship. Most saliently, a number of laws discussed above require or permit a physician to intervene without or against a patient's permission. In such a scenario, special care must be taken to preserve trust in the patient-physician relationship by pursuing other interventions first, by seeking assent where consent is not possible, and by ensuring that patients are informed about the goals and evidence in support of a particular intervention.

There are no federal CAP laws or standards for locking devices used to store firearms. However, federal law prohibits licensed dealers from selling or transferring any handgun without a secure storage or safety device.³⁸ The prohibition does not apply to private sales, and there is no requirement that the buyer use the device. Twenty-nine states and the District of Columbia have CAP laws. Missouri's CAP law prohibits a person from knowingly or recklessly selling, leasing, loaning, giving away, or delivering a firearm to a minor without the consent of the child's custodial parent or guardian.³⁹ In comparison, states with stronger CAP laws such as California impose criminal liability when a minor is *likely* to gain access to a negligently stored firearm, regardless of whether they do.⁴⁰ In California, physicians could reference these strong CAP laws as a way to encourage compliance with safe storage counseling, similar to counseling regarding mandatory car seat use. Regardless, physicians must keep patient trust at the forefront of such discussions, and avoid creating any perception of threatening patients regarding their compliance with state laws.

States may also regulate methods of firearm storage. Eleven states require safety locks for firearms in the home, although Massachusetts is the only state that requires all firearms to be stored with a lock.⁴¹ Some municipalities have local laws regulating firearm storage. For example, New York City requires all weapons

applicable CAP laws, risk factors for firearm-related injury, and evidence-based strategies for mitigating these risks.

Here, a physician could recommend that firearms be temporarily removed from the home in the case of acute child aggression or, at the least, that the firearms be stored in a locked safe, unloaded, and separate from ammunition.

Case Four: Intimate Partner Violence — Legal Issues: Mandatory Reporting

As part of the recommended intimate partner violence screening of all women of reproductive age,⁴⁵ a patient discloses to her primary care physician in Oklahoma that her partner threatens her with physical violence. She reports that he owns multiple firearms and frequently gets drunk. What can the provider do?

Intimate partner violence (IPV) is prevalent — 36.4% of women are raped, stalked, or assaulted by a partner at some point in their lives.⁴⁵ Many instances of intimate partner violence involve a firearm; nearly one million women report being shot or shot at by an intimate partner, and about 4.5 million report that an intimate partner threatened them with a firearm.⁴⁷ Physicians have a significant role to play in both iden-

tifying and preventing firearm-related IPV.⁴⁸ Prior to engaging in conversations about risk of future harm, safety planning, and legal resources and options, physicians should take care to notify the patient if they are mandated reporters for any category of information.

Most states have a mandatory reporting law for physicians related to IPV.⁴⁹ Many states require reporting wounds from firearms, certain burns, and knives or sharp and pointed instruments.⁵⁰ Some states, including Oklahoma, require reporting wounds involving a criminal act, including IPV.⁵¹ Physician compliance with mandatory IPV reporting laws is variable and controversial,⁵² and some studies suggest that mandatory reporting laws may decrease patient disclosure of IPV.

In this case, after informing the patient about the possibility of mandatory reporting, the physician can counsel the patient about her risk factors for harm. For example, her partner's access to a firearm places her at a five times higher likelihood of IPV death.⁵³ Alcohol and controlled substance use are independently significant predictors of future violence, placing this patient at high risk of harm given her partner's frequent drinking.⁵⁴ Particular care must be taken to build trust in the physician-patient relationship prior to counseling, and the patient's safety must be carefully balanced with her own goals.

Patients may seek legal protections such as a temporary restraining order, or a related IPV order, but these are complicated legal processes subject to a number of loopholes. There is a substantial risk of homicide when patients report IPV to law enforcement and when patients seek restraining orders.⁵⁵ Therefore, physicians are well-advised to rely on trained experts in IPV advocacy, particularly when designing exit plans or intervention strategies, and refer patients to programs such as the National Domestic Violence Hotline rather than give their own advice regarding legal courses of action. Additionally, although some states have firearm relinquishment statutes covering cases of IPV, physicians have no ability to activate them beyond mandated reporting to law enforcement. The victim of IPV may not remove the firearm from the perpetrator's possession as this could constitute theft.

In this case, the role of law enforcement may be limited even if they are notified via reporting. Oklahoma's IPV-related firearm relinquishment laws allow seizure of the firearm only if the law enforcement officer has probable cause to believe that the firearm was used "to commit an act of domestic abuse."⁵⁶ Therefore, physician responsibilities in cases of suspected IPV involving firearms are generally limited to screening, identification, mandatory reporting, counseling regarding risk factors, safety planning where appro-

priate, and engaging expert advocates when desired by the patient.

* * *

Each of these case studies illustrates important aspects of the physician-patient relationship. Most saliently, a number of laws discussed above require or permit a physician to intervene without or against a patient's permission. In such a scenario, special care must be taken to preserve trust in the patient-physician relationship by pursuing other interventions first, by seeking assent where consent is not possible, and by ensuring that patients are informed about the goals and evidence in support of a particular intervention. Each of these scenarios highlight the complexity of managing the risks to the individual and the community.

Conclusion

When a physician identifies that a patient is at risk of firearm injury, they have an opportunity to mitigate potential harm to the patient and others. Physicians may not fully understand or be aware of the firearm laws that impact their clinical decision-making and the way they interact with one another and other legal requirements such as HIPAA. States should develop guides that physicians can reference when they are unsure what they are legally permitted or mandated to do when their patient is at risk of firearm injury. As legislators consider amending and enacting firearm laws, they also should include healthcare providers in these discussions to better understand how laws interact with clinical practice. Consideration of firearm laws should focus on the complete package of statutory protections and requirements in a state, so that interactions between laws and their influence on clinical practice can be more fully considered.

Note

Megan Ranney reports grants from NIH and CDC outside the submitted work; she is also serving as the Chief Research Officer (volunteer) for the American Foundation for Firearm Injury Reduction in Medicine. The other authors do not have conflicts of interest to disclose.

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