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The Gun Debate Extends to the Doctor's Office: Developing a Standard of Care for Firearm Screening and Counseling

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INTRODUCTION

For at least two decades, many medical organizations have openly supported stricter gun regulations, with some even stressing a complete ban on firearms.¹ More recently, at least eight professional health organizations (“Professional Health Organizations”) and the American Bar Association (“ABA”) have resolutely recognized firearm-related injuries and deaths as a major public health problem.² As such, these organizations have adopted official policy positions, which include the practice of physicians screening and counseling patients on firearms.³ Many doctors routinely ask their patients about potential dangers to their health, including drugs, swimming pools, household chemicals, and firearms.⁴ Additionally, some doctors educate certain patients on the risks of firearms in the home and firearm safety.⁵

In 2011, in reaction to patients’ complaints about firearm screening and counseling by doctors in Florida, Florida became the first state to pass a law curtailing physicians’ ability to inquire about whether patients own firearms and to counsel

¹ See, e.g., En Banc Brief of Amici Curiae Second Amendment Foundation & Citizens Committee for the Right to Keep & Bear Arms Supporting Appellants & Reversal at 21, *Wollschlaeger v. Governor of Fla.*, 649 Fed. App’x 647 (11th Cir. 2016) (No. 12-14009), 2016 WL 1642979, at *21 [hereinafter Second Amendment Foundation Amicus Brief].

² 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, 513 (2015).

³ *Id.* at 513–14.

⁴ See Brief Amicus Curiae of American Medical Ass’n et al. Submitted in Support of Plaintiffs/Appellees at the Rehearing En Banc & Urging Affirmance at 3, *Wollschlaeger v. Governor of Florida*, 649 Fed. App’x 647 (11th Cir. 2016) (No. 12-14009), 2016 WL 3011481, at *3 [hereinafter American Medical Ass’n Amicus Brief].

⁵ See *id.* at 3–4.

patients on firearm safety.⁶ Less than a month after Florida passed the Florida's Firearm Owners' Privacy Act ("FOPA"),⁷ physicians and physician interest groups challenged the law in court as violating the First Amendment.⁸ On February 16, 2017, after five years of litigation, the United States Court of Appeals for the Eleventh Circuit struck down major parts of the law as unconstitutional.⁹ In its en banc ruling, the Circuit found that FOPA's provisions were content-based restrictions on speech, and thus strict scrutiny should apply.¹⁰ The Circuit decided, however, it need not determine whether the provisions would withstand strict scrutiny, because three out of four of the provisions did not survive heightened scrutiny.¹¹ Applying heightened scrutiny, the Circuit held most provisions were unconstitutional because they did not advance a substantial government interest and were not narrowly drawn to achieve that interest.¹²

Wollschlaeger was a landmark ruling for health organizations, firearm interest groups, and many state legislatures. The Eleventh Circuit's decision essentially solidified a doctor's right to screen and counsel patients on firearms. Consequently, this precedent may lead to more aggressive policies and practices by physicians and healthcare providers regarding firearms.¹³ States may even create laws to encourage this practice based on the policy recommendations of many health organizations.¹⁴ On the other hand, some state legislatures may look for a way to

⁶ *Wollschlaeger v. Farmer*, 880 F. Supp. 2d 1251, 1255, 1258–59 (S.D. Fla. 2012), *rev'd in part, vacated in part sub nom.*, *Wollschlaeger v. Governor of Florida*, 760 F.3d 1195 (11th Cir. 2014), *opinion vacated and superseded on reh'g*, 797 F.3d 859 (11th Cir. 2015), *opinion vacated and superseded on reh'g*, 814 F.3d 1159 (11th Cir. 2015), *reh'g en banc granted, opinion vacated*, 649 Fed. App'x 647 (11th Cir. 2016), *on reh'g en banc*, 848 F.3d 1293 (11th Cir. 2017) [hereinafter *Wollschlaeger I*].

⁷ FLA. STAT. § 790.338 (2011).

⁸ *Wollschlaeger I*, 880 F. Supp. 2d at 1251.

⁹ See *Wollschlaeger v. Governor, Fla.*, 848 F.3d 1293, 1299 (11th Cir. 2017) [hereinafter *Wollschlaeger 2017*].

¹⁰ *Id.* at 1307.

¹¹ *Id.* at 1311 (finding the three provisions that could not survive the heightened scrutiny standard are the "record-keeping" provision, the "inquiry" restriction provision, and the "anti-harassment" provision); see also *infra* note 23 and accompanying text.

¹² *Wollschlaeger 2017*, 848 F.3d at 1311–12.

¹³ See Bethany L. Strong et al., *The American College of Preventive Medicine Policy Recommendations on Reducing and Preventing Firearm-Related Injuries and Deaths*, 51 AM. J. PREVENTIVE MED. 1084, 1084–86 (2016); see also M. Denise Dowd et al., *Firearm-Related Injuries Affecting the Pediatric Population*, 130 PEDIATRICS 1416, 1421 (2012).

¹⁴ See Wendy E. Parmet et al., *Wollschlaeger v. Governor of Florida—The First Amendment, Physician Speech, and Firearm Safety*, 374 NEW ENG. J. MED. 2304, 2306 (2016); see also Garen J. Wintemute, *Yes, You Can: Physicians, Patients, and Firearms*, 165 ANNALS OF INTERNAL MED. 205, 206–07 (2016).

constitutionally restrict physicians from asking questions and educating patients on firearms.¹⁵

Even if there is no immediate reaction by state legislatures to the Eleventh Circuit's ruling, doctors are arguably restrained in implementing this practice in other ways. Because many physicians have no formal firearm safety training or education, patients may be legitimately concerned about doctors' qualifications for providing firearm-related health advice.¹⁶ This dynamic creates a potential for inadequate or harmful medical advice, which in turn calls into question the physician standard of care for firearm screening and counseling.¹⁷

As a relatively innovative practice, at least for some healthcare providers, firearm screening and counseling does not have well established standards beyond the general policy recommending physician intervention to prevent firearm-related injuries and deaths in patients.¹⁸ This Note attempts to answer the following question: in light of the Eleventh Circuit's ruling that states cannot prohibit physicians from screening and counseling patients on firearms, how should physicians, the professional health community, and state legislatures proceed? Although the ruling struck down major parts of FOPA, the arguments for and against the law and the practice of firearm screening and counseling are still relevant to shaping the legislation and standards that should apply to the practice.

This Note proceeds in four parts. Part I briefly explains the background of FOPA, its litigation, and how the Eleventh Circuit addressed the main arguments for and against FOPA. Part II delves into the argument that storing firearms in the home is a threat to the health of household members. Relatedly, Part II shows why the professional health community considers firearm-related deaths and injuries to be a major public health problem. This part also presents data showing that out of all

¹⁵ See, e.g., Marla Spector Bowman, *Docs. v. Glocks: Speech, Guns, Discrimination, and Privacy—Is Anyone Winning?*, 67 FLA. L. REV. 1455, 1469–70 (2015).

¹⁶ *Id.*; see, e.g., Paul J. D. Roszko, et al., *Clinician Attitudes, Screening Practices, and Interventions to Reduce Firearm-Related Injury*, 38 EPIDEMIOLOGIC REV. 87, 104–06 (2016) (emphasizing the inconsistent education and training of physicians on firearm safety and the need for additional training to improve intervention by physicians).

¹⁷ See En Banc Brief of Amicus Curiae Unified Sportsmen of Florida, Inc., Supporting Appellants & Reversal at 13–16, *Wollschlaeger v. Governor of Fla.*, 649 Fed. App'x 647 (11th Cir. 2016) (No. 12-14009), 2016 WL 1642980, at *13–16 [hereinafter *Unified Sportsmen Amicus Brief*].

¹⁸ See Weinberger et al., *supra* note 2, at 513–16 (discussing physician gag laws and intervention and treatment of mental and substance use disorders, but not laying out specific standards for doing so); see also Roszko et al., *supra* note 16.

firearm related deaths, a high percentage takes place in the home, and that suicide or homicide by firearm is a leading cause of death for all ages. Finally, Part II includes data on firearm safety and shows the correlation between firearm access regulations and reduction in firearm-related deaths and injuries.

Part III delves into the strongest arguments for why physicians should not be encouraged, or even allowed, to screen and counsel patients on firearms. Proponents of FOPA fear that through the practice, doctors are promoting a political agenda posing as medical advice and that doctors may not be qualified to render advice on firearms to patients.¹⁹ For both contextual and argumentative purposes, Part III presents statistics on non-firearm-related dangers and leading causes of fatal and nonfatal unintentional injuries. Additionally, Part III discusses one legitimate motivation behind firearm ownership, namely self-defense, and the possible consequences of diminishing this purpose.

Part IV concludes that physicians, the professional health community, and state legislatures should take measures to reduce the risk of physicians using firearm screening and counseling as a way to promote a political agenda and of unqualified physicians giving advice on firearm safety. While this Note does not cover concerns of harassment and discrimination by physicians based on a patient's firearm ownership status, it explores the dynamics of firearm screening and counseling, the standard of care, and medical malpractice. Part IV proposes that the professional health community should establish strict standards of expert knowledge regarding firearms, and in turn, physicians should accurately communicate that knowledge to patients. Finally, Part IV calls for more extensive research on who should be questioned and advised on firearms, and explores the best practices for firearm screening and counseling.

I. FOPA AND ITS DOWNFALL

In 2011, Florida passed a law, known as FOPA, which created Florida Statute section 790.338, entitled "Medical privacy concerning firearms."²⁰ FOPA's legislative record includes several anecdotes involving complaints where doctors threatened to end the physician-patient relationship or to refuse treatment to patients based on the patient's answers to the doctor's questions

¹⁹ See *infra* Sections III(B) and III(D).

²⁰ Wollschlaeger I, 880 F. Supp. 2d 1251, 1255 (S.D. Fla. 2012).

about the patient's firearm ownership.²¹ The Florida Legislature identified these anecdotes as a primary influence leading to the enactment of FOPA.²² The statute includes the following four provisions concerning the conduct of licensed health care practitioners or facilities:

- a) The "record-keeping provision" prohibits practitioners from recording any information regarding a patient's firearm ownership in the patient's medical record, if the practitioner knows the information is not relevant to the patient's medical care or safety, or the safety of others.
- b) The "inquiry restriction provision" prohibits practitioners from inquiring about a patient's firearm ownership status, unless the practitioner in good faith believes the information is relevant to the patient's medical care or safety, or the safety of others.
- c) The "antidiscrimination provision" prohibits practitioners from discriminating against a patient based solely on firearm ownership.
- d) The "anti-harassment provision" prohibits practitioners from unnecessarily harassing a patient about firearm ownership.²³

The Florida legislature originally passed FOPA to protect the Second Amendment and privacy rights of patients, and to regulate the doctor-patient relationship.²⁴ Less than a month after FOPA's enactment, physicians and physician interest groups challenged the law in the District Court for the Southern District of Florida, alleging FOPA violated the First and Fourteenth Amendments of the U.S. Constitution.²⁵ In 2012, the district court applied strict scrutiny and found FOPA's provisions were unconstitutional as violating free speech.²⁶

The case made its way to the United States Court of Appeals for the Eleventh Circuit, where a three-judge panel upheld the law in three different opinions, each vacating the one before it on

²¹ See *Wollschlaeger* 2017, 848 F.3d 1293, 1302 (11th Cir. 2017) ("A state representative said that his daughter's pediatrician inquired if he owned a firearm, and then asked him to remove the firearm from the home. An email described how a mother 'was separated from her children while medical personnel . . . interrogated' them about firearm ownership and put information about such ownership in their medical records. One doctor refused to treat a child because he wanted to know if there were firearms in the home.") (internal citations omitted).

²² *Id.*

²³ *Wollschlaeger I*, 880 F. Supp. 2d at 1255; FLA. STAT. § 790.338 (2011).

²⁴ See *Wollschlaeger I*, 880 F. Supp. 2d at 1256.

²⁵ *Id.* at 1259.

²⁶ *Id.* at 1261–62, 1267.

different grounds.²⁷ Upon the plaintiffs' motion, the Court of Appeals agreed to rehear the case en banc to determine the propriety of applying strict scrutiny to this case and whether the State "has a sufficiently compelling interest, such that the Act can withstand strict scrutiny."²⁸ On February 16, 2017, eight months after oral arguments, the Circuit issued its opinion that struck down the record-keeping, inquiry, and anti-harassment provisions of FOPA as violating the First Amendment, but upheld the anti-discrimination provision.²⁹

The Eleventh Circuit held that FOPA's provisions were content-based restrictions of speech by medical providers on firearm ownership, and "[c]ontent-based restrictions on speech normally trigger strict scrutiny."³⁰ However, the Circuit declined to decide whether strict scrutiny should apply, because the record-keeping, inquiry, and anti-harassment provisions could not survive the less stringent standard of heightened scrutiny.³¹ Under heightened scrutiny, state officials must show, at minimum, that the provisions directly advance a substantial government interest and are narrowly drawn to achieve that interest.³²

Substantial scholarly attention focuses on the constitutional issues of FOPA and its litigation.³³ An in-depth analysis of those issues is beyond the scope of this Note. The arguments for and against FOPA, however, are relevant to the public and social policy debate surrounding firearm screening and counseling by physicians, including its relation to medical malpractice. As such, this Note will next lay out Florida's arguments in defense of FOPA and how the Eleventh Circuit addressed them.

²⁷ See *Wollschlaeger v. Governor of Fla.*, 760 F.3d 1195 (11th Cir. 2014) [hereinafter *Wollschlaeger II*]; see also *Wollschlaeger v. Governor of Fla.*, 797 F.3d 859 (11th Cir. 2015) [hereinafter *Wollschlaeger III*]; *Wollschlaeger v. Governor of Fla.*, 814 F.3d 1159 (11th Cir. 2015) [hereinafter *Wollschlaeger IV*].

²⁸ *Maryanne Tomazic, Docs v. Glocks: Restricting Doctor's Professional Speech in the Name of Firearm Owner Privacy—Wollschlaeger v. Governor of Florida*, 41 AM. J.L. & MED. 680, 682 (2015).

²⁹ *Wollschlaeger* 2017, 848 F.3d 1293, 1311, 1314–15 (11th Cir. 2017).

³⁰ *Id.* at 1307–08.

³¹ *Id.* at 1311.

³² *Id.* at 1311–12.

³³ See generally, e.g., Michelle Foody, Comment, *Docs Versus Glocks: N.R.A. Takes Aim at Florida Physicians' Freedom of Speech: Leaving Patients' Health, Safety, and Welfare at Risk*, 2013 CARDOZO L. REV. DE NOVO 228 (2013); Tomazic, *supra* note 28; Harrison Blythe, *Physician-Patient Speech: An Analysis of the State of Patients' First Amendment Rights to Receive Accurate Medical Advice*, 65 CASE W. RES. L. REV. 795 (2015).

A. Protecting the Second Amendment

According to Florida, FOPA is necessary to protect “the Second Amendment right of Floridians to own and bear firearms” from “private encumbrances.”³⁴ Further, Florida argued “that doctors and medical professionals should not ask about, nor express views hostile to, firearm ownership.”³⁵ The Eleventh Circuit rejected this argument, saying that even if there were any “actual conflict between the First Amendment rights of doctors and medical professionals and the Second Amendment rights of patients,” it would not be significant enough to justify FOPA’s record-keeping, inquiry, and anti-harassment provisions.³⁶ First, there was no evidence that firearm screening and counseling of patients had infringed on patients’ Second Amendment rights, beyond the six anecdotes included in FOPA’s legislative record.³⁷ Further, heightened scrutiny does not allow Florida to “burden the speech of others in order to tilt public debate in a preferred direction,”³⁸ especially given the necessity of open and honest dialogue between doctors and patients about firearms and firearm safety.³⁹ The court conveyed that the “profound importance of the Second Amendment does not give the government license to violate the right to free speech under the First Amendment.”⁴⁰

B. Protecting Patient Privacy

The second interest Florida asserted in defense of FOPA was the need to protect a patient’s privacy from the public eye.⁴¹ Although the Eleventh Circuit conceded that “individual privacy is a substantial government interest,” it rejected this argument as a valid defense of FOPA’s record-keeping, inquiry, and anti-harassment provisions.⁴² The crux of the Circuit’s finding on this issue was based on an unchallenged provision of FOPA, section 790.338(4), which allows patients to refuse to answer doctors’ questions about guns.⁴³ Because Florida failed to give any reasons why this provision does not sufficiently protect patient privacy, this interest failed to satisfy heightened scrutiny.⁴⁴

³⁴ *Wollschlaeger 2017*, 848 F.3d at 1312 (internal marks omitted).

³⁵ *Id.* at 1313–14.

³⁶ *Id.* at 1313.

³⁷ *Id.* at 1312.

³⁸ *Id.* at 1314 (quoting *Sorrell v. IMS Health Inc.*, 564 U.S. 552, 578–79 (2011)).

³⁹ *Id.* at 1313.

⁴⁰ *Id.* at 1327 (Pryor, J., concurring).

⁴¹ *Id.* at 1314.

⁴² *Id.*

⁴³ *See id.*

⁴⁴ *See id.*

Florida also argued FOPA protects “the privacy of patients’ firearm ownership from the chilling effect of disclosure and record-keeping.”⁴⁵ According to the Eleventh Circuit, Florida’s current limits on disclosure of a patient’s medical information provides sufficient protection, and “there [was] no evidence that doctors or medical professionals [had] been improperly disclosing patients’ information about firearm ownership.”⁴⁶ Moreover, the Circuit explained it could not base its decision under heightened scrutiny on hypothetical dangers, such as hacking, theft, or some other intrusion of electronically stored information.⁴⁷ Consequently, Florida’s interest in protecting the privacy of patients could not carry FOPA’s record-keeping, inquiry, and anti-harassment provisions under heightened scrutiny.⁴⁸

C. Protecting Patients from Discrimination or Harassment

The Eleventh Circuit held that, besides FOPA’s anti-discrimination provision, the challenged provisions were not narrowly tailored to further Florida’s interest in “ensuring access to health care without discrimination or harassment.”⁴⁹ The Circuit noted that Florida law still allows a doctor to terminate his or her relationship with a patient as long as “the patient has reasonable notice and can secure the services of another health care provider.”⁵⁰ It also rejected Florida’s argument that the power imbalance between doctors and their patients was enough to warrant protection of a “vulnerable listener” from offensive speech, because “where adults are concerned the Supreme Court has never used [this] rationale to uphold speaker-focused and content-based restrictions on speech.”⁵¹ Again, Florida law gives patients the right to refuse to answer offensive questions, and there was no evidence to show that offended patients were “psychologically unable to choose another medical provider.”⁵²

D. Protecting the Public by Regulating the Medical Profession

As its final defense of FOPA, Florida asserted its interest in regulating “the medical profession in order to protect the public.”⁵³ Although the Eleventh Circuit agreed Florida has a general interest in regulating the medical profession, that

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ *See id.*

⁴⁸ *See id.* at 1319.

⁴⁹ *Id.* at 1314.

⁵⁰ *Id.* at 1315.

⁵¹ *Id.*

⁵² *Id.*

⁵³ *Id.* at 1316.

interest does not justify FOPA's record-keeping, inquiry, and anti-harassment provisions, "[g]iven that the applicable standard of care encourages doctors to ask questions about firearms" and the provisions were not narrowly tailored to address such interest.⁵⁴ The Circuit additionally stated:

There is no claim, much less any evidence, that routine questions to patients about the ownership of firearms are medically inappropriate, ethically problematic, or practically ineffective. Nor is there any contention (or, again, any evidence) that blanket questioning on the topic of firearm ownership is leading to bad, unsound, or dangerous medical advice.⁵⁵

Because there was no evidence to show firearm screening and counseling was negatively affecting the doctor-patient relationship or medical treatment for patients, this interest could not withstand heightened scrutiny.⁵⁶

In sum, FOPA's record-keeping, inquiry, and anti-harassment provisions could not pass heightened scrutiny for determining constitutionality, and thus would certainly fail strict scrutiny, which is normally applied to content-based restrictions.⁵⁷ Many of Florida's arguments in support of FOPA failed due to insufficient evidence to support Florida's contentions. For example, Florida presented no evidence that questions and counseling about firearms amounted to ineffective or dangerous medical advice.⁵⁸ However, that is not to say that these complaints should be forgotten or ignored by state legislatures and the professional health community because these concerns have the potential to become real detriments to adequate medical care. This idea will be explored further in Parts III and IV. Part II will lay out the professional health community's argument that guns are not only a danger to members of a household, but also a public health problem. This perception is what led to the policy encouraging doctors to ask questions about firearms, or what the Eleventh Circuit called "the applicable standard of care."⁵⁹

II. FIREARMS AS ADVERSE HEALTH RISKS

Joined by the ABA, the Professional Health Organizations collectively declared a policy to address firearm-related deaths and injuries based on their conclusion that the effects of firearm-related deaths and injuries pose a serious public health

⁵⁴ *Id.* at 1317.

⁵⁵ *Id.* at 1316.

⁵⁶ *See id.*

⁵⁷ *See id.* at 1311.

⁵⁸ *Id.*

⁵⁹ *Id.* at 1317; *see also* Weinberger et al., *supra* note 2, at 514.

problem.⁶⁰ To deal with this problem, these organizations recommend doctors do the following: counsel their patients about gun safety, intervene when patients may be at risk for initiating or becoming victim to gun violence, and document conversations and information regarding a patient's gun ownership status in the patient's medical record.⁶¹

Rather than reiterating the data relied upon by the Professional Health Organizations in support of their conclusion and polices, Part II will use data from the National Violent Death Reporting System ("NVDRS")⁶² and the Centers for Disease Control and Prevention's ("CDC") Web-Based Injury Statistics Query and Reporting System ("WISQARS"),⁶³ supplemented by studies from various literature on firearm safety and storage practices.

This Part will begin by attempting to rectify the varying claims coming from both sides of the gun debate on how significant firearm-related deaths are compared to other leading causes of death due to injury. For example, in their call to action, the ABA and Professional Health Organizations identify firearms as being the "second-leading cause of death due to injury after motor vehicle crashes for adults and adolescents."⁶⁴ One well-known anti-gun organization, Everytown for Gun Safety Support Fund ("Everytown"), suggests that federal data "substantially undercount[s]" the number of unintentional shootings in children.⁶⁵ According to Everytown, "[f]rom December 2012 to December 2013, at least 100 children were killed in unintentional shootings."⁶⁶ On the other side of the debate, the National Shooting Sports Foundation found that "[f]irearms are involved in less than 1.4 percent of unintentional fatalities among

⁶⁰ Weinberger et al., *supra* note 2, at 513.

⁶¹ *Id.* at 514; see En Banc Brief of Amicus Curiae the America Prof'l Soc'y on the Abuse of Children in Support of Plaintiffs-Appellees & Affirmance at 10, *Wollschlaeger v. Governor of Florida*, 649 Fed. App'x 647 (Fla. 2016) (No. 12-14009), 2016 WL 3011483, at *3 [hereinafter *America Prof'l Soc'y on the Abuse of Children Amicus Brief*].

⁶² NVDRS uses information from death certificates, medical examiner or coroner records, law enforcement records, and crime laboratory records from seventeen participating states to compile data on violent death, including the circumstances surrounding these deaths. Mary D. Fan, *Disarming the Dangerous: Preventing Extraordinary and Ordinary Violence*, 90 IND. L.J. 150, 163 (2015).

⁶³ WISQARS is an online database that provides fatal and nonfatal injury, violent death, and cost of injury data from a variety of sources, including NVDRS, the National Vital Statistics System, and CDC's National Center for Health Statistics. See *Welcome to WISQARS*, CTRES. FOR DISEASE CONTROL & PREVENTION (Jan. 12, 2017), <https://www.cdc.gov/injury/wisqars/index.html> [<http://perma.cc/FX3D-YQGWW>].

⁶⁴ Weinberger et al., *supra* note 59, at 513.

⁶⁵ *Innocents Lost: A Year of Unintentional Child Gun Deaths*, EVERYTOWN FOR GUN SAFETY SUPPORT FUND 3 (June 2014), <http://everytownresearch.org/documents/2015/04/innocents-lost.pdf> [<http://perma.cc/3DMP-ZG2M>].

⁶⁶ *Id.*

children 14 years of age and under and are among the least likely causes of unintentional fatality.”⁶⁷

A. Leading Causes of Death Due to Injury

According to the CDC data on the leading causes of death due to injury in 2015 for all ages, suicide by firearm was the fourth leading cause of death due to injury, making up 10.2% (22,018 deaths of the 216,694 total injury deaths).⁶⁸ Homicide by firearm was the fifth leading cause at 6% (12,979 deaths).⁶⁹ The number one leading cause was unintentional poisoning at 21.9% (47,478 deaths), followed by motor vehicle traffic at 16.7% (36,161 deaths).⁷⁰ Homicide by cut/pierce made up 0.7% (1622 deaths) as the fifteenth leading cause of death due to injury.⁷¹

For ages 10 to 44, the number of firearm-related deaths due to injury was slightly more significant than for all age groups.⁷² There were 86,235 total injury deaths. Homicide by firearm was the third leading cause at 12.1% with 10,454 deaths, and suicide by firearm was the fourth leading cause at 10.1% with 8670 deaths.⁷³ Again, unintentional poisoning was the number one leading cause at 29.9% with 25,767 deaths, and motor vehicle traffic was the second leading cause at 21.1% with 18,212 deaths for this age group.⁷⁴ The data from the state of Florida on the leading causes of death due to injury virtually mirrors the national data.⁷⁵

⁶⁷ *Firearms-Related Injury Statistics*, NAT'L SHOOTING SPORTS FOUND. 1 (2013), http://www.projectchildsafe.org/sites/default/files/2014_InjuryIIR_2015.pdf.

⁶⁸ *Leading Causes of Death Reports, 1981 – 2016*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://webappa.cdc.gov/sasweb/ncipc/leadcause.html> (last updated Feb. 19, 2017) (To generate the statistics for leading causes of death due to injury, select “2015” to “2015” for “Year(s) of Report”; select “Top 20” for “Number of Causes”; select “All Injuries” for “Categories of Causes”; leave all other report options unchanged; then follow “Submit Request.” To view the statistics for all ages, follow the link for “All Ages” in the last column of the generated table.).

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² *Id.* (To generate the statistics for leading causes of death due to injury for ages 10 to 44, select “2015” to “2015” for “Year(s) of Report”; select “Top 20” for “Number of Causes”; select “All Injuries” for “Categories of Causes”; select “Custom Age Range” for “Age Group Formatting” and input “10” to “44”; leave all other report options unchanged; then follow “Submit Request.” To view the statistics for ages 10 to 44, follow the link for “10–44” at the top of the generated table.).

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ *Id.* Out of 15,225 total injury deaths for all age groups in Florida, suicide by firearm was the fourth leading cause (11% or 1630 deaths). *Id.* Homicide by firearm was the fifth leading cause (6% or 880 deaths). *Id.* Unintentional poisoning was the number one leading cause (19.3% or 2938 deaths), followed by motor vehicle traffic (19% or 2896 deaths). *Id.*

Based on these numbers, the ABA and the Professional Health Organizations' claim that firearms were the "second-leading cause of death due to injury after motor vehicle crashes for adults and adolescents" needs clarifying. If the number of firearm-related suicides and homicides are combined into one category of firearm-related deaths by injury, they would amount to 34,997 deaths, which still falls below the number of both poisoning and motor vehicle traffic deaths. However, for ages 10 to 44, the combined firearm-related deaths by injury would amount to 19,124 deaths, surpassing motor vehicle traffic as the second leading cause. It is unclear what the ABA and the Professional Health Organizations meant by "adults and adolescents" and whether it was their intention to combine firearm-related suicides and homicides into one category.

With that being said, multiple injury-causing mechanisms or forces consistently lead to more deaths per year than firearm-related deaths due to injury. For example, unintentional poisoning and motor vehicle traffic-related injuries are deadlier than firearms for all age groups. Despite this fact, we must recognize while injuries and deaths from poisoning and motor vehicle crashes pose a greater risk overall than firearm-related deaths due to injury, motor vehicle and poisoning deaths cannot be alleviated in the same way injuries and deaths from firearms can be alleviated. First, nine out of ten American households have access to a motor vehicle, while less than a third contain a gun.⁷⁶ Second, poisoning deaths—the leading cause of injury death in the United States—primarily involve both pharmaceutical and illicit drugs and occur when a person accidentally takes or gives too much of a substance.⁷⁷ While there are certainly ways to prevent and reduce motor vehicle crashes and drug overdoses, motor vehicles and prescription drugs are essential in homes. Guns, while constitutionally protected, are arguably not necessary in a household and are certainly not ubiquitous to households.

B. Violent Firearm Deaths in the Home

The percentage of violent firearm-related deaths that take place in the home, as reported in the NVDRS, is particularly

⁷⁶ *Gun Deaths Compared to Motor Vehicle Deaths*, VIOLENCE POL'Y CTR., <http://www.vpc.org/regulating-the-gun-industry/gun-deaths-compared-to-motor-vehicle-deaths/> [<http://perma.cc/HAC3-UUTD>] (last visited Dec. 27, 2017).

⁷⁷ See *NCHS Data on Drug-poisoning Deaths*, NAT'L CNTR. FOR HEALTH STATISTICS (Aug. 24, 2017), https://www.cdc.gov/nchs/data/factsheets/factsheet_drug_poisoning.pdf [<http://perma.cc/L7FD-JPGF>]; see also *Poisoning*, CTRS. FOR DISEASE CONTROL & PREVENTION (Nov. 24, 2015), <https://www.cdc.gov/homeandrecreationalafety/poisoning/index.html> [<http://perma.cc/6N3P-AHTR>].

relevant to the discussion on firearm screening and counseling of patients by physicians. The NVDRS defines a violent death “as a death resulting either from the unintentional use of physical force or power against oneself, another person, or a group or community.”⁷⁸ Manners of violent death include suicide, homicide, unintentional firearm, undetermined intent, and legal intervention.⁷⁹ An unintentional firearm death is a death from a gunshot where “the shooting was not directed intentionally at the decedent” or “the person causing the injury did not intend to discharge the firearm.”⁸⁰

According to the NVDRS, out of 4486 total homicides in 2013, 67% (3021 deaths) were firearm-related homicides.⁸¹ Out of all firearm-related homicides, 48% (1443 deaths) took place in the home.⁸² The percentage of unintentional violent-firearm related deaths that take place in the home is also significant. Out of 125 total unintentional violent firearm deaths in 2013, 70% (87 deaths) took place in the home.⁸³ There are certainly many

⁷⁸ Sharyn E. Parks et al., *Surveillance for Violent Deaths — National Violent Death Reporting System, 16 States, 2010*, CTRS. FOR DISEASE CONTROL & PREVENTION 3 (Jan. 17, 2014), <https://www.cdc.gov/mmwr/pdf/ss/ss6301.pdf> [<http://perma.cc/Q932-4JQX>].

⁷⁹ *Id.*

⁸⁰ *Id.* at 3–4.

⁸¹ *National Violent Death Reporting System (NVDRS)*, CTRS. FOR DISEASE CONTROL & PREVENTION (Jan. 24, 2017), <https://wisqars.cdc.gov:8443/nvdrs/nvdrsDisplay.jsp> (To generate the statistics for total number of homicides, select “Homicide” for “What was the intent or manner of the injury based on the abstractor-assigned manner of death?”; select “2013” as “Year(s) of Report”; leave all other report options unchanged; then follow “Submit Request.” To generate the statistics for total number of firearm related-related homicides, select “Homicide” for “What was the intent or manner of the injury based on the abstractor-assigned manner of death?”; select “Firearm” as “What was the cause or mechanism of the injury based on the abstractor-assigned manner of death?”; select “2013” as “Year(s) of Report”; leave all other report options unchanged; then follow “Submit Request.” The percentage of firearm-related homicides was calculated by dividing 3021 (total firearm-related homicides) by 4486 (total deaths).).

⁸² *Id.* (To generate the statistics for total number of firearm-related homicides that took place in the home, select “Violent Death Counts and Percentages by KNOWN CIRCUMSTANCES of DEATH, Place of Injury . . .” as the “Victims of Violence” report type (the first report input option); select “Homicide” for “What was the intent or manner of the injury based on the abstractor-assigned manner of death?”; select “Firearm” as “What was the cause or mechanism of the injury based on the abstractor-assigned manner of death?”; select “2013” as “Year(s) of Report”; leave all other report options unchanged; then follow “Submit Request.” The percentage of firearm-related homicides that took place in the home was calculated by dividing 1443 (total firearm-related homicides that took place in the house, apartment, including driveway, porch, and yard) by 3021 (total firearm-related homicides).).

⁸³ *Id.* (To generate the statistics for total number of unintentional violent-firearm related deaths that took place in the home, select “Violent Death Counts and Percentages by KNOWN CIRCUMSTANCES of DEATH, Place of Injury . . .” as the “Victims of Violence” report type (the first report input option); select “Unintentional firearm” for “What was the intent or manner of the injury based on the abstractor-assigned manner of death?”; select “Firearm” as “What was the cause or mechanism of the injury based on the abstractor-assigned manner of death?”; select “2013” as “Year(s) of Report”; leave all other report options unchanged; then follow “Submit Request.” The percentage of unintentional

explanations for why almost half of all firearm-related homicides and more than half of unintentional violent firearm deaths take place in the home, but that analysis is beyond the scope of this Note.⁸⁴ Whatever the reasons may be, these rates have led medical organizations to believe that the best way to prevent gun violence is by removing guns from the home.⁸⁵

Based on this data, the ABA and the Professional Health Organizations' recommendation for physicians to ask patients about firearms and counsel patients on firearm safety is not unreasonable. Because most violent firearm-related deaths occur in the home, it is logical to highlight the firearm-related health problem by targeting those firearm-related deaths and injuries that occur in the home. After all, doctors talk to patients about many other potential household health risks as part of the practice of preventive medicine.⁸⁶ Furthermore, there are statistics suggesting that the presence of firearms in the home increases the likelihood of firearm-related deaths or injuries,⁸⁷ and safe storage practices have shown to be effective at reducing these incidents.⁸⁸

C. Prevalence and Effect of Firearm Safety and Storage Measures

The American College of Preventive Medicine is one health organization that has encouraged counseling of patients on firearm safety, as well as stricter laws regulating child access to firearms.⁸⁹ Child Access Protection ("CAP") laws, which hold the adult gun owner criminally responsible if a minor uses a gun that has been stored insecurely, are one such form of regulation.⁹⁰ CAP laws are relevant to the discussion of firearm screening and

violent-firearm related deaths that took place in the home was calculated by dividing 87 (total unintentional firearm deaths that took place in the house, apartment, including driveway, porch, and yard) by 125 (total unintentional firearm deaths).

⁸⁴ For further discussion on this point, see America Professional Society on the Abuse of Children Amicus Brief, *supra* note 61, at 6–10, *Wollschlaeger v. Governor of Fla.*, 649 Fed. App'x 647 (Fla. 2016) (No. 12-14009), 2016 WL 3011483, at *3. *See generally* Arthur L. Kellermann et al., *Gun Ownership as a Risk Factor for Homicide in the Home*, 329 NEW ENG. J. MED. 1084 (1993); Eric J. Crossen et al., *Preventing Gun Injuries in Children*, 36 PEDIATRICS REV. 43 (2015).

⁸⁵ *See* Dowd et al., *supra* note 13, at 1416 ("The absence of guns from children's homes and communities is the most reliable and effective measure to prevent firearm-related injuries and children and adolescents.").

⁸⁶ *See* America Professional Society on the Abuse of Children Amicus Brief, *supra* note 61, at 3.

⁸⁷ *See, e.g.*, Dowd et al., *supra* note 13, at 1419 ("Research in several US urban areas indicates that a gun stored in the home is associated with a three-fold increase in the risk of homicide and a fivefold increase in the risk of suicide.").

⁸⁸ *See infra* notes 95, 104 and accompanying text.

⁸⁹ *See* Strong et al., *supra* note 13, at 1086.

⁹⁰ *Id.*

counseling of patients due to the overlapping goals of CAP laws and firearm screening and counseling. The purpose of CAP laws is to make guns inaccessible to children while still providing accessibility to adults.⁹¹ Similarly, the public health community's policy promoting firearm screening and counseling is aimed at maximizing firearm safety regulations, while staying consistent with the Second Amendment.⁹² Therefore, members of the public health community and legislatures concerned with doctors talking to patients about firearms should consider the effect CAP laws may have on reducing nonfatal firearm-related injuries.

Twenty-eight states have child access prevention laws as of 2014.⁹³ These laws range from statutes imposing criminal liability when a child gains access to a firearm as a result of negligent firearm storage (strictest CAP regulation) to laws preventing people from providing firearms to minors (least strict CAP regulation).⁹⁴ A recently published study, based on annual hospital discharge data from 1998 to 2003, suggests CAP laws are associated with a decrease in nonfatal gun injuries.⁹⁵ The study found that the existence of any type of CAP law is associated with a total average annual 26% reduction in self-inflicted gun injuries among youth.⁹⁶ For the strictest type of CAP regulation, negligent storage laws, the average annual reduction was 30%.⁹⁷ For non-self-inflicted injuries—encompassing assaults, unintentional injuries, and injuries of undetermined intent—CAP laws are associated with a 5% reduction.⁹⁸

Why do CAP laws matter to the discussion of FOIA and the general practice of firearm screening and counseling by doctors? Doctors who ask patients about firearm ownership are arguably effectuating the purpose of CAP laws and other access protection regulations.⁹⁹ Take a Florida CAP law, for example. Florida's Title XLVI section 790.174(1) provides that a person who

⁹¹ See Jeffrey DeSimone et al., *Child Access Prevention Laws and Nonfatal Injuries*, 80 S. ECON. J. 5, 6 (2013).

⁹² Weinberger et al., *supra* note 2, at 514.

⁹³ *States with Firearm Laws Designed to Protect Children*, THE HENRY J. KAISER FAMILY FOUND., <http://kff.org/other/state-indicator/firearms-and-children-legislation/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%D> [<http://perma.cc/2KN3-RDUV>] (last visited Dec. 21, 2017).

⁹⁴ *Summary of State Child Access Prevention Laws*, WASHINGTON STATE LEGISLATURE (Dec. 2012), <http://leg.wa.gov/Senate/Committees/LAW/Documents/SummaryOfStateChildAccessPreventionLaws.pdf> [<http://perma.cc/R9B9-MJ96>]. State definitions of minor vary from children under age fourteen to those under age eighteen. *Id.*

⁹⁵ DeSimone et al., *supra* note 91, at 5, 22.

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ See Bowman, *supra* note 15, at 1459.

reasonably knows a minor may gain access to a firearm “shall keep the firearm in a securely locked box or container or in a location which a reasonable person would believe to be secure.”¹⁰⁰ This statute is based on access by a minor to a negligently stored firearm, which is the strongest type of CAP law.¹⁰¹ While state legislatures are in a better position to regulate firearms, doctors still play an important role in promoting safe storage practices.

The number of households that store unlocked and/or unloaded guns in the house lends further support for why preventive measures and CAP laws are needed. A 2002 study estimated that 248,430 children and youths in Florida were being raised in a household with at least one loaded gun.¹⁰² Approximately half of those households contained a firearm that was both unlocked and loaded.¹⁰³ There are reliable studies to show that keeping a gun locked and unloaded have significant protective effects with regard to risk of both unintentional injury and suicide for children and teenagers.¹⁰⁴ Therefore, primary care physicians should, at the very least, ask whether patients keep firearms in the home and provide them reliable safety advice accordingly.

III. THE DANGERS OF DOCTORS DISCUSSING FIREARMS WITH PATIENTS

This Part lays out the strongest arguments for FOPA and against the practice of firearm screening and counseling, including those made in support of FOPA in its litigation. It will first attempt to put firearm related injuries and deaths into perspective by introducing data on fatal and nonfatal unintentional injuries. Next, it will discuss the argument that doctors use this practice to promote their politics and that most doctors are not qualified to give advice on firearms. Lastly, this Part evaluates the self-defense motivation behind keeping a

¹⁰⁰ FLA. STAT. § 790.174(1) (2017).

¹⁰¹ *Summary of State Child Access Prevention Laws*, WASH. STATE LEGISLATURE 3 (Dec. 2012), <http://leg.wa.gov/Senate/Committees/LAW/Documents/SummaryOfStateChildAccessPreventionLaws.pdf> [<http://perma.cc/R9B9-MJ96>].

¹⁰² Catherine A. Okoro et al., *Prevalence of Household Firearms and Firearm-Storage Practices in the 50 States and the District of Columbia: Findings From the Behavioral Risk Factor Surveillance System, 2002*, 116 PEDIATRICS 370, 373 (2005). This study was compiled from the 2002 cross-sectional Behavioral Risk Factor Surveillance System survey of 240,735 adults from randomly selected households with telephones in the fifty states and the District of Columbia. *Id.*

¹⁰³ *Id.*

¹⁰⁴ See Dowd et al., *supra* note 13, at 1420 (“A multisite study found that keeping a gun locked and keeping a gun unloaded have protective effects of 73% and 70% respectively, with regard to risk for both unintentional injury and suicide for children and teenagers.”).

firearm in the home and presents statistics on the incidence of gun use for self-defense. All of these arguments tie into the overarching idea behind FOPA that firearms are not an appropriate conversation topic in the doctor's office.

A. Firearms and Unintentional Injuries

Perhaps surprisingly, the briefs in support of FOPA and the State of Florida do not appear to challenge the conclusion that firearms pose a public health problem, but they do argue that firearm screening and counseling is not as crucial to protecting the public health as the Professional Health Organizations portray it to be.¹⁰⁵ Although not mentioned in the briefs, a possible factor contributing to this belief is the WISQARS data on the leading causes of both fatal and nonfatal unintentional injuries.

For all ages, unintentional injury was the fourth leading cause of death in the United States in 2015, accounting for 5.4% of all deaths.¹⁰⁶ Out of the 146,571 total unintentional injury deaths, firearm-related injury was only the sixteenth leading cause at 489 deaths (0.3% of fatal unintentional injuries).¹⁰⁷ Poisoning-related injury was the number one leading cause at 32.4% (47,478 injuries), followed by motor vehicle traffic at 24.7% (36,161 injuries).¹⁰⁸ Unintentional drowning-related deaths caused 3602 deaths, which is over seven times more deaths than unintentional firearm-related injuries.¹⁰⁹ Falls, suffocation, drowning, fire/burn, and machinery all caused more unintentional injury deaths than firearms.¹¹⁰

For ages 10 to 44, unintentional injury was the number one leading cause of death.¹¹¹ Out of the 50,890 total unintentional injury deaths for this age group, firearm-related injury was the thirteenth leading cause at 274 deaths (0.5% of fatal unintentional injuries).¹¹² Again, poisoning-related and motor vehicle traffic injuries were the first and second leading causes of unintentional injury deaths.¹¹³ For this age group, unintentional drowning-related injuries caused approximately five times more

¹⁰⁵ See, e.g., Unified Sportsmen Amicus Brief, *supra* note 17.

¹⁰⁶ Nat'l Ctr. for Injury Prevention & Control, *Leading Causes of Death Reports, 1981–2016*, CTRS. FOR DISEASE CONTROL & PREVENTION (June 24, 2015), <https://webappa.cdc.gov/sasweb/ncipc/leadcause.html> [<http://perma.cc/DH57-8XG6>].

¹⁰⁷ *Id.* (choose “Unintentional Injuries Only” for “Categories of Causes”).

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² *Id.* (choose 10–44 as the “Custom Age Range” and choose “Unintentional Injuries Only” for “Categories of Causes”).

¹¹³ *Id.*

deaths than firearms. Falls, suffocation, drowning, and fire/burn all caused more fatal unintentional injuries than firearms.¹¹⁴

Based on this data, firearms are not a top-ten leading cause of fatal unintentional injuries, nor are they a top-ten leading cause of nonfatal unintentional injuries.¹¹⁵ Nonfatal unintentional injury data includes “injuries and poisonings described as unintended or ‘accidental,’ regardless of whether the injury was inflicted by . . . another person.”¹¹⁶ WISQARS compiles nonfatal injury data from hospital emergency departments.¹¹⁷ In 2015, there were 29,608,581 nonfatal unintentional injuries, with firearm-gunshots causing only 0.1%, (17,311 injuries) making firearm-gunshots the twentieth leading cause of nonfatal unintentional injury.¹¹⁸ Other causes, such as falls, cut/pierce, poisoning, bite/sting, fire/burn, machinery, and suffocation, all preceded unintentional firearm gunshot injuries on the list.¹¹⁹

Does the data on unintentional injuries suggest that firearm related deaths and injuries are not, in fact, a public health problem? Not necessarily. Remember that both suicide and homicide by firearm were in the top-five leading causes of death due to injury.¹²⁰ Furthermore, homicide by firearm accounts for over 60% of all violent deaths.¹²¹ Even though firearms only account for 0.5% of unintentional injury deaths for ages 10 to 44, that is still 274 children and adults who lost their lives to the unintentional use of a firearm by or against them.¹²² Firearm-related injuries may appear insignificant compared to other causes of fatal and nonfatal unintentional injuries, but that does not mean the professional health community is wrong in focusing its policies on preventing firearm violence.

While poisonings and motor vehicle accidents are obviously a public health concern, we cannot completely eradicate these forces due to the ubiquity of medicines, toxic products, and motor vehicles. Among the CDC’s “Key Prevention Tips” for preventing

¹¹⁴ *Id.*

¹¹⁵ *See id.*; *infra* note 118; *see also* *Definitions for WISQARS Nonfatal*, CTRS. FOR DISEASE CONTROL & PREVENTION (Mar. 21, 2007), <https://www.cdc.gov/ncipc/wisqars/nonfatal/definitions.htm> [<http://perma.cc/A39M-2HFG>] (defining a nonfatal unintentional injury as “bodily harm resulting from severe exposure to an external force or substance” not inflicted by deliberate means).

¹¹⁶ *Definitions for WISQARS Nonfatal*, *supra* note 115.

¹¹⁷ *Id.*

¹¹⁸ *20 Leading Causes of Nonfatal Unintentional Injuries, United States*, CTRS. FOR DISEASE CONTROL & PREVENTION (Feb. 19, 2017) [<http://perma.cc/2WGK-3G85>].

¹¹⁹ *Id.*

¹²⁰ *See supra* notes 68–75 and accompanying text.

¹²¹ *See supra* note 81 and accompanying text.

¹²² *See supra* notes 111–114 and accompanying text.

poisonings in the home are to “[s]afely dispose of unused, unneeded, or expired prescription drugs and over the counter drugs, vitamins, and supplements,” and “[k]eep medicines and toxic products, such [as] cleaning solutions and detergent pods, in their original packaging where children can’t see or get them.”¹²³ With regard to motor vehicle safety, the CDC recommends health professionals “[e]ncourage patients to make wearing a seat belt a habit”¹²⁴ and parents “[i]nstall and use car seats and booster seats according to the seat’s owner’s manual or get help installing them from a certified Child Passenger Safety Technician.”¹²⁵

These tips embrace the reality that potentially poisonous products and motor vehicles, while dangerous, are necessary to most households and families. That is why doctors often ask patients with children whether they have toxic chemicals in the home and whether they implement seatbelts and/or car seats, and counsel them on safe storage and use of these products. On the other hand, firearms are not ubiquitous to most homes and, according to some health organizations, are not necessary either.¹²⁶ It does not make sense that doctors should continue to counsel parents on the safety benefits of using car seats and securing chemicals, while simultaneously remaining silent on firearm safety.

However, as will be discussed in the rest of this Note, firearms are a complicated issue, and thus the standard for firearm screening and counseling must submit to special considerations. Firearms are constitutionally protected and have strong political connotations. There are also many legitimate motivations behind owning firearms, such as self-defense. Additionally, many physicians lack knowledge of or training on firearm safety, which opens the door to liability for harmful medical advice.

B. Hidden Political Agendas

Despite the Supreme Court’s ruling in *District of Columbia v. Heller* (where the Court struck down a statute banning handgun possession in the home)¹²⁷ and the more recent case of *McDonald v. City of Chicago* (where the Court struck down

¹²³ *Poisoning Prevention*, CTRS. FOR DISEASE CONTROL & PREVENTION (Apr. 28, 2016), <https://www.cdc.gov/safechild/poisoning/index.html> [<http://perma.cc/5RVF-8EHU>].

¹²⁴ *Adult Seat Belt Use*, CTRS. FOR DISEASE CONTROL & PREVENTION (Jan. 4, 2011), <https://www.cdc.gov/vitalsigns/seatbeltuse/index.html> [<http://perma.cc/FN3k-Q9HX>].

¹²⁵ *Child Passenger Safety*, CTRS. FOR DISEASE CONTROL & PREVENTION (Sept. 18, 2017), <https://www.cdc.gov/features/passengersafety/index.html> [<http://perma.cc/5H2V-BX7M>].

¹²⁶ See Dowd et al., *supra* note 13, at 1416.

¹²⁷ *District of Columbia v. Heller*, 554 U.S. 570, 635 (2008).

comprehensive local and statewide firearm bans),¹²⁸ certain medical organizations advocate for the strongest possible legislative and regulatory approaches to prevent firearm injuries and deaths.¹²⁹ For this reason, supporters of FOPA believe the policies of these organizations demonstrate “an institutional motivation in unrestrained political advocacy for gun control, up to and including firearm bans.”¹³⁰ For example, the American Academy of Pediatrics (“AAP”) openly advocates for the removal of guns from homes and communities as “the most reliable and effective measure to prevent firearm-related injuries in children and adolescents.”¹³¹

In fact, each amicus curiae brief supporting the State of Florida in *Wollschlaeger* contains a similar argument regarding the political motivations behind physicians questioning and advising patients on firearms.¹³² The Unified Sportsmen of Florida underscored the importance of protecting patients and regulating the medical profession because “[p]atients see physicians for medical advice and treatment, not to be harangued about politics[.]”¹³³ Supporters of FOPA contend FOPA actually protects the public health by “(1) strengthen[ing] the integrity of the doctor-patient relationship by taking politics out of the examination room and (2) stym[ying] politicized efforts to deter people who wish to own arms for public-safety reasons.”¹³⁴

While the “politicization of medical care” is theoretically concerning,¹³⁵ this should not be a basis for prohibiting firearm screening and counseling for several reasons. First, these briefs present little to no data to bolster their argument that physicians who engage in firearm screening and counseling “desire to push an anti-gun message” and “are clearly placing their own interests above their patients.”¹³⁶ According to the Eleventh Circuit, “the Florida Legislature, in enacting FOPA, relied on six anecdotes and nothing more. There was no other evidence, empirical or otherwise, presented to or cited by the Florida Legislature.”¹³⁷ Florida may have been preemptively attempting to prevent the

¹²⁸ *McDonald v. City of Chicago*, 561 U.S. 742, 780 (2010).

¹²⁹ *See* Dowd et al., *supra* note 13, at 1416, 1421.

¹³⁰ Second Amendment Foundation Amicus Brief, *supra* note 1, at 21.

¹³¹ Dowd et al., *supra* note 13, at 1416.

¹³² *See id.* at 1421; *see also* Unified Sportsmen Amicus Brief, *supra* note 17, at 20–22; En Banc Brief of Amicus Curiae Nat'l Rifle Ass'n of America, Inc. in Support of Appellants and Reversal at 21, *Wollschlaeger v. Governor of Fla.*, 649 Fed. App'x 647 (11th Cir. 2016) (No. 12–14009), 2016 WL 1642981, at *11–12 [hereinafter Nat'l Rifle Ass'n Amicus Brief].

¹³³ Unified Sportsmen Amicus Brief, *supra* note 17, at 22.

¹³⁴ Nat'l Rifle Ass'n Amicus Brief, *supra* note 132.

¹³⁵ Unified Sportsmen Amicus Brief, *supra* note 17, at 6.

¹³⁶ Second Amendment Foundation Amicus Brief, *supra* note 1, at 24, 25.

¹³⁷ *Wollschlaeger* 2017, 848 F.3d 1293, 1312 (11th Cir. 2017).

politicization of medical care by enacting FOPA, but in reality, Florida effectively “pick[ed] ideological winners and losers” without any meaningful facts to support its conclusions.¹³⁸ Thus, Florida clearly overstepped its boundaries.

Another reason political-agenda prevention is not a valid basis for prohibiting physicians from questioning and advising patients on firearms is that patients can refuse to answer these questions or they can find a new doctor.¹³⁹ The topic is not so sensitive as to require a statutory ban, especially when a doctor may terminate his or her relationship with a patient in most circumstances.¹⁴⁰ Given these conditions, restricting the “potentially unpopular speech” on firearms is far less necessary than Florida and FOPA’s supporters allege.¹⁴¹

However, one argument in support of FOPA deserves further consideration and ultimately forms the basis of the overall proposal of this Note. Namely, there is a legitimate concern that a physician’s advice on firearms “is given with complete disregard for personal or family decisions about home defense, matters that physicians are dangerously unqualified to advise on.”¹⁴² To effectively evaluate this proposition, it is important to understand the patterns of gun ownership and usage for self-defense purposes, which this Note will discuss next.

C. Second Amendment and Self-Defense

In 2008, the Supreme Court in *District of Columbia v. Heller* solidified an individual’s Second Amendment right to keep a handgun in the home for self-defense.¹⁴³ A pre-*Heller* study determined that approximately one-third of America’s privately held firearms were handguns.¹⁴⁴ About three-fourths of handgun owners reported owning a handgun for self-protection purposes.¹⁴⁵ While a clear majority of handgun owners say their primary motivation for having a gun is self-protection, the actual incidence of gun use for self-defense against crime is unclear.¹⁴⁶ One very commonly cited report on the use of guns in self-defense asserts there are 2.2 to 2.5 million episodes of defensive gun

¹³⁸ *Id.* at 1328 (Pryor, J., concurring).

¹³⁹ *See supra* note 43 and accompanying text.

¹⁴⁰ *See supra* note 50 and accompanying text.

¹⁴¹ *Wollschlaeger 2017*, 848 F.3d at 1328 (Pryor, J., concurring).

¹⁴² Second Amendment Foundation Amicus Brief, *supra* note 1, at 23.

¹⁴³ *District of Columbia v. Heller*, 554 U.S. 570, 628–29 (2008).

¹⁴⁴ Philip J. Cook et al., *Gun Control After Heller: Threats and Sideshows From a Social Welfare Perspective*, 56 UCLA L. REV. 1041, 1046 (2009).

¹⁴⁵ *Id.* at 1046 n.21.

¹⁴⁶ Philip J. Cook & Jens Ludwig, *Aiming for Evidence-Based Gun Policy*, 25 J. POL’Y ANALYSIS & MGMT. 691, 702 (2006).

use per year.¹⁴⁷ Briefs in both *Heller* and *Wollschlaeger* cite these results.¹⁴⁸

However, these estimates differ significantly from estimates of the National Crime Victimization Survey (“NCVS”), a “large government-sponsored in-person survey that is generally considered the most reliable source of information on predatory crime[.]”¹⁴⁹ Based on the NCVS data from 2007 to 2011, there were 235,700 incidents of a victim using a firearm to threaten or attack an offender.¹⁵⁰ Based on this estimate, victims used firearms in about 1% of all nonfatal violent victimizations in the five-year period.¹⁵¹ This is compared to 44% of nonfatal violent crimes where the victim offered no resistance, 26% where the victim used non-confrontational tactics (e.g., yelling, running, or arguing), 22% where the victim attacked or threatened without a weapon, and 1% where the victim used another type of weapon.¹⁵² The 235,700 estimate means that an average of 47,140 incidents of defensive gun use occurred each year from 2007 to 2011, which is about four or five orders of magnitude smaller than Kleck and Gertz’s figure.

Before considering the significance of the NCVS data, it is important to understand why the various estimates for episodes of defensive gun use are grossly inconsistent. Kleck and Gertz have challenged the NCVS data as underestimating the true count of defensive gun use.¹⁵³ Kleck and Gertz based their study on one-time telephone surveys, while NCVS involves in-person interviews.¹⁵⁴ The Kleck and Gertz telephone method likely includes many false positives due to the use of open-ended questions, which allow “telescoping, confusion, a desire to impress the interviewer, and other causes.”¹⁵⁵ The NCVS data

¹⁴⁷ Gary Kleck & Marc Gertz, *Armed Resistance to Crime: The Prevalence and Nature of Self-Defense with a Gun*, 86 J. CRIM. L. & CRIMINOLOGY 150, 164 (1995).

¹⁴⁸ Unified Sportsmen Amicus Brief, *supra* note 17, at 21; Brief for the Nat’l Rifle Ass’n and the NRA Civil Rights Defense Fund as Amici Curiae in Support of Respondent at 32, *District of Columbia v. Heller*, 554 U.S. 570, 635 (2008) (No. 07-290), 2008 WL354081, at *32.

¹⁴⁹ Cook & Ludwig, *supra* note 146.

¹⁵⁰ Michael Planty & Jennifer L. Truman, *Firearm Violence, 1993–2011*, U.S. DEPT OF JUSTICE 12 (2013), <https://www.bjs.gov/content/pub/pdf/fv9311.pdf> [<http://perma.cc/H7HG-2FAN>]. The estimates of nonfatal violent victimizations in the NCVS data are based on “information on nonfatal crimes against persons age 12 or older reported and not reported to the police from a nationally representative sample of U.S. households.” *Id.* at 2.

¹⁵¹ *Id.* at 12.

¹⁵² *Id.*

¹⁵³ See PHILIP J. COOK & JENS LUDWIG, GUNS IN AMERICA: RESULTS OF A COMPREHENSIVE NATIONAL SURVEY ON FIREARMS OWNERSHIP AND USE 73 (1996).

¹⁵⁴ See Philip J. Cook, *The Great American Gun War: Notes from Four Decades in the Trenches*, 42 CRIME & JUST. 19, 42 (2013).

¹⁵⁵ *Id.*; COOK & LUDWIG, *supra* note 153, at 85–86.

attempts to deal with the potential for false-positives by only asking respondents about defensive gun use if they first say they were the victim of a crime.¹⁵⁶ This means some NCVS respondents “fail to report a defensive gun use,” because they are never asked about it, leading to some false-negatives in the NCVS figure.¹⁵⁷

Philip J. Cook and Jens Ludwig undertook to resolve the discrepancies in the numbers by organizing a comparable telephone survey to the one used by Kleck and Gertz in terms of instrument, sampling procedure, and interviewing method.¹⁵⁸ Cook and Ludwig’s study suggests there are about 1.5 million defensive gun users per year.¹⁵⁹ If we accept the 1.5 million figure, we would be “led to conclude that . . . guns are used far more often to defend against crime than to perpetrate crime.”¹⁶⁰ However, “if we reject these estimates in favor of those based on NCVS data, the reverse is true.”¹⁶¹ Cook and Ludwig ultimately concluded their 1.5 million figure, and Kleck and Gertz’s 2.5 million figure, include a significant amount of false-positives and that the “NCVS is closer to a truly representative sample of U.S. adults than are telephone surveys.”¹⁶² What this means is that while the NCVS data might be lower than the true number of defensive gun uses per year, “[t]he 2.5 million figure [that] has been picked up by the press and now appears regularly in newspaper articles, letters to editorials, and even in Congressional Research Services briefs for public policymakers” is greatly exaggerated.¹⁶³

D. Risks of a Doctor’s Advice on Firearm Removal

With the self-defense data as background, this Section briefly presents the argument that if a patient follows a physician’s advice on firearms, the advice “could lead to adverse personal consequences” for patients.¹⁶⁴ In its amicus curiae brief in *Wollschlaeger*, the Unified Sportsmen of Florida posits that the practice of firearm screening and counseling is usually devoid of informed consent.¹⁶⁵ The brief argues that informed consent requires a physician “to render objective advice about the

¹⁵⁶ COOK & LUDWIG, *supra* note 153, at 86.

¹⁵⁷ Cook, *supra* note 154, at 42.

¹⁵⁸ See COOK & LUDWIG, *supra* note 153, at 61.

¹⁵⁹ See *id.* at 62.

¹⁶⁰ *Id.* at 68.

¹⁶¹ *Id.*

¹⁶² *Id.* at 73.

¹⁶³ *Id.* at 57, 70.

¹⁶⁴ Unified Sportsmen Amicus Brief, *supra* note 17, at 17.

¹⁶⁵ *Id.* at 13–15.

alternatives in order to obtain an informed consent.”¹⁶⁶ It poses the questions:

Of the physicians who pursue an anti-Second Amendment agenda under the pretension of rendering medical advice, how many advise patients that not having a firearm in the home could render the patient defenseless in the event of a burglary, home invasion, or attempted rape? And how many obtain a written consent with objective warnings to patients to undergo the “treatment” of removing firearms from their homes and becoming defenseless?¹⁶⁷

Thus, informed consent will not exist where doctors merely discuss one viewpoint on firearms and reject another. According to this amicus curiae, physicians must evaluate the claim that a gun “would be an effective protection against violent intrusion or deadly force in the home” and must relay this information to a patient in order for the patient to “weigh[] the risks and benefits of gun ownership.”¹⁶⁸

Consider a situation where a physician advises a patient to remove a gun from her household, but omits any information about the use of guns for self-protection. If that patient follows her doctor’s advice, gives up her gun, and subsequently becomes the victim of robbery or rape in her home without her gun for protection, she may have a claim against her doctor for medical negligence. She could argue that “but for the physician’s advice, she would have been armed at the time of the attack, and her being armed would have prevented the injury.”¹⁶⁹ The validity of this claim would depend on proximate cause and the foreseeability of the attack on the patient, but it is possible that a court would find that “the physician’s negligent counseling created a foreseeable risk that the patient would be the victim of a crime by impairing her ability to defend herself.”¹⁷⁰

The potential harm to patients and the expansion of liability for physicians are very legitimate concerns. As such, the professional health community must soon develop a standard of care for firearm screening and counseling if they are to continue to encourage the practice in their official policies and recommendations. Next, Part IV discusses generally how a standard of care is developed, the current standard of care for firearm screening and counseling, and possible ways to improve this practice.

¹⁶⁶ *Id.* at 14–15.

¹⁶⁷ *Id.* at 15.

¹⁶⁸ *Id.* at 21–22.

¹⁶⁹ *Id.* at 21.

¹⁷⁰ *Id.*

IV. REDUCING NEGATIVE EFFECTS OF FIREARM SCREENING AND COUNSELING BY DEVELOPING AN APPROPRIATE STANDARD OF CARE

Before the Eleventh Circuit struck down FOPA, opponents of the law and Florida judges were concerned about doctors “self-censoring themselves out of fear of disciplinary actions”¹⁷¹ (e.g., suspension or permanent revocation of medical licenses, restriction of practices, fines of up to \$10,000, and refunds of fees billed¹⁷²). Indeed, physicians and physician interest groups presented evidence that “[a]gainst their professional judgement, [practitioners] are no longer asking patients questions related to firearm ownership, no longer using questionnaires with such questions, and/or no longer maintaining written records of consultations with patients about firearms.”¹⁷³ Under FOPA, doctors could only engage in firearm screening and counseling and recording information on firearms in the patient’s medical record if such acts were “necessary” or “relevant” to the patient’s medical care.¹⁷⁴ Consequently, doctors were second-guessing whether they could legally question and advise patients on firearms, with some ultimately deciding to avoid the topic altogether, out of fear of disciplinary consequences for violating FOPA’s provisions.¹⁷⁵

Now that FOPA is no longer in effect, doctors need not fear liability for breaching its provisions. The hypothetical malpractice lawsuit presented above, however, demonstrates there is still a likelihood of expanded liability for doctors who question and advise patients on owning and storing firearms.¹⁷⁶ Whether such lawsuits would be successful may not matter, because the mere possibility of medical malpractice liability prevents doctors from engaging in the practice in the first place.¹⁷⁷ This expanded liability stems from at least two causes: lack of informed consent from patients¹⁷⁸ and lack of

171 *E.g.*, *Wollschlaeger v. Farmer*, 814 F. Supp. 2d 1367, 1383 (S.D. Fla. 2011).

172 FLA. STAT. § 456.072(2)(b)–(d), (f), (i)–(j) (2016).

173 *Wollschlaeger 2017*, 848 F.3d 1293, 1304 (11th Cir. 2014).

174 *Id.* at 1319 (Marcus, J., concurring).

175 *See American Medical Ass’n Amicus Brief*, *supra* note 4, at 8–9.

176 *See supra* Section III(D).

177 *See supra* notes 171–175 and accompanying text.

178 *See supra* notes 164–170 and accompanying text; *see also* Rodney A. Smolla, *Professional Speech and the First Amendment*, 119 W. VA. L. REV. 67, 106 (2016) (“Doctors, for example, are required by tort law to obtain a patient’s informed consent before performing a medical procedure, out of solicitude for preserving the dignity and autonomy of patients.”); RICHARD A. EPSTEIN, TORTS § 6.3 (1999) (indicating that in every state, violation of a patient’s right to informed consent is actionable in tort).

training of healthcare providers on firearm intervention.¹⁷⁹ Thus, for professional health organizations to see their policies through, there must be an accepted standard of medical practice for firearm screening and counseling. Otherwise, physicians, lawyers, and judges “may genuinely not know the degree of malpractice liability risk that is associated with adopting [this relatively] new clinical” practice.¹⁸⁰

This Part proceeds by explaining medical malpractice liability in general and the development of a particular standard of care. Next, it discusses the current standard of care for firearm screening and counseling and suggests ways to improve it.

A. Medical Malpractice and Developing a Standard of Care

Medical malpractice liability allows individuals harmed by a healthcare provider's negligence to bring suit against the provider to recover damages. Generally, a claim for medical malpractice requires the plaintiff to establish the following: (1) the defendant owed a duty of care to the plaintiff; (2) that duty was breached by the defendant; (3) the plaintiff was harmed and suffered damages; and (4) the plaintiff's harm was caused by the defendant's actions.¹⁸¹ In essence, a healthcare provider can be held liable if the care that he or she provides deviates from the standard of care of a reasonable physician as dictated by the profession.¹⁸² The medical practitioner's duty is specific to the specialty involved and is based on a national standard of care, rather than a specific standard for the particular locality.¹⁸³

In a medical malpractice suit, “courts require only that physicians and surgeons exercise in diagnosis and treatment that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of the medical profession under similar circumstances.”¹⁸⁴ To determine whether a

¹⁷⁹ See, e.g., Second Amendment Amicus Brief, *supra* note 1, at 23 (“The advice is given with complete disregard for personal or family decisions about home defense, matters that physicians are dangerously unqualified to advise on.”); Bowman, *supra* note 15, at 1459 (“At the same time, many patients may certainly wonder what qualifies a medical doctor as an appropriate person to give advice on firearm safety.”); see also *infra* Section IV(C).

¹⁸⁰ Michael D. Greenberg, *Medical Malpractice and New Devices: Defining an Elusive Standard of Care*, 19 HEALTH MATRIX 423, 425 (2009).

¹⁸¹ W. PAGE KEETON ET AL., PROSSER AND KEETON ON TORTS 164–65 (5th ed. 1984).

¹⁸² Greenberg, *supra* note 180, at 423.

¹⁸³ Telephone Interview with Dr. Richard Redding, Vice Chancellor for Graduate Education, Chapman Univ. (Apr. 13, 2017). Dr. Redding specializes in forensic issues in criminal law and juvenile justice and the use of social science research in law and public policy, among other areas. Dr. Richard Redding, CHAP. UNIV., <https://www.chapman.edu/our-faculty/richard-redding> [<http://perma.cc/8GF2-6Z9F>] (last visited Apr. 26, 2017).

¹⁸⁴ Mann v. Cracchiola, 694 P.2d 1134, 1143 (Cal. 1985).

healthcare provider failed to adhere to accepted standards within the profession, courts will rely on expert opinion testimony, unless the medical procedure or treatment is a matter of common knowledge.¹⁸⁵ Thus, experts will testify about what a doctor should have done in the circumstances based on their education, their medical experience, and results of scientific or medical research.¹⁸⁶ As these basics of medical malpractice law demonstrate, the medical profession itself develops certain standards of practice for medical treatment, such as how a surgery should be performed and what kinds of tests should be run for patients showing certain symptoms.¹⁸⁷

The data presented above in Parts II and III is conflicting and inconclusive in many respects, such as the significance of firearm-related injuries and the frequency of self-defense uses of guns. However, the Professional Health Organizations have come to the conclusion that clinician intervention to reduce firearm-related deaths and injuries is necessary to the public health. Therefore, it would appear that in a medical malpractice lawsuit involving a doctor's advice on firearms, expert testimony would favor the physician's intervention, yet it is unclear what standards would apply beyond this basic starting point.

B. Current Standard of Care for Firearm Screening and Counseling

In 2015, the ABA and the Professional Health Organizations released a "Call to Action" with recommendations and policies for "a public health approach to firearm-related violence and prevention of firearm injuries and deaths."¹⁸⁸ In addition to opposing laws that "forbid physicians to discuss a patient's gun ownership," the Call to Action recommended the following:

When appropriate, physicians can intervene with patients who are at risk for injuring themselves or others due to firearm access. To do so, physicians must be allowed to speak freely to their patients in a nonjudgmental manner about firearms, provide patients with factual information about firearms relevant to their health and the health of those around them, fully answer their patients' questions, and advise them on the course of behaviors that promote health and safety without fear of liability or penalty. Physicians must also be able to document these conversations in the medical record as they are

¹⁸⁵ See *Kelley v. Trunk*, 78 Cal. Rptr. 2d 122, 124 (App. 1998); *Curtis v. Santa Clara Valley Med. Ctr.*, 2 Cal. Rptr. 3d 73, 76–77 (Ct. App. 2003).

¹⁸⁶ Telephone Interview with Dr. Richard Redding, *supra* note 183.

¹⁸⁷ *Id.*

¹⁸⁸ Weinberger et al., *supra* note 2, at 513.

able and required to do with discussion of other behaviors that can affect health.¹⁸⁹

In turn, specific medical organizations released their own policies to mirror this recommendation.¹⁹⁰

Based on these broad recommendations, the Eleventh Circuit concluded “that the applicable standard of care encourages doctors to ask questions about firearms (and other potential safety hazards).”¹⁹¹ To the contrary, the Unified Sportsmen of Florida posited that it is merely a “charade” to say that firearm screening and counseling by physicians is “an accepted standard of medical practice among members of the medical profession with similar training and experience.”¹⁹² They argued “such viewpoints are not part of medical training and experience and there is no such accepted standards of medical practice.”¹⁹³ These conflicting conclusions demonstrate that the standard of care for this practice is ill-defined, which may lead to adverse consequences for patients, healthcare providers, and the public health.

C. Education and Training on Firearms and Intervention

Since many physicians are not knowledgeable when it comes to firearms, there is a legitimate concern over physicians’ qualifications for giving advice on firearm safety. This potential lack of training and expertise on firearms could result in inadequate or harmful medical advice, which in turn could lead to adverse consequences for patients who heed such advice. While medical malpractice suits provide a way to redress injuries caused by a healthcare provider’s negligence, an appropriate standard of care, including consistent training of physicians on firearm safety and intervention, could prevent many injuries from ever occurring.

A 2016 report (“Interventions Report”) “systematically identifi[ed] and summarize[d] existing literature on clinical

¹⁸⁹ *Id.* at 514.

¹⁹⁰ *See, e.g.*, Dowd et al., *supra* note 13, at 1421 (“Pediatricians and other child health care professionals are urged to counsel parents about the dangers of allowing children and adolescents to have access to guns inside and outside the home. The AAP recommends that pediatricians incorporate questions about the presence and availability of firearms into their patient history taking and urge parents who possess guns to prevent access to these guns by children.”); Strong et al., *supra* note 13, at 1086 (“ACPM supports . . . Physicians’ ability to speak openly to their patients about firearms, fully answering questions, and advising them on the course of behaviors that promote health and safety.”).

¹⁹¹ *Wollschlaeger* 2017, 848 F.3d 1293, 1317 (11th Cir. 2017).

¹⁹² Unified Sportsmen Amicus Brief, *supra* note 17, at 14 (internal quotations omitted).

¹⁹³ *Id.*

firearm injury prevention screening and interventions” and assessed each study based on its methodological quality and bias.¹⁹⁴ The Interventions Report found fifty-three studies examining clinician attitudes/practice patterns, prior training, experience, and expectations correlated with clinicians’ regularity of firearm screening.¹⁹⁵ Most of these assessed the frequency of clinicians asking parents about firearm ownership and recommending safe storage or firearm removal.¹⁹⁶

The studies showed that clinicians who lacked formal training or who felt that patients were unlikely to follow their advice were unlikely to screen and counsel on firearm safety.¹⁹⁷ In turn, clinicians who believed that screening and counseling made a difference in injury prevention, who had prior training, and who had high self-efficacy reported higher screening and counseling rates.¹⁹⁸ Further, the Interventions Report found that pediatric, psychiatric, and family medicine residencies, as well as program directors for preventive medicine, psychiatric nursing, and physician assistant training programs, reported infrequently offering firearm injury prevention or safety training to their residents and students.¹⁹⁹ One cross-sectional study of high methodological quality found only 16% of family practitioners sometimes or usually counsel patients regarding firearm safety, with over 75% reporting they lacked formal training.²⁰⁰

These studies indicate that there are inconsistent attitudes among physicians toward screening and counseling to increase firearm safety. Furthermore, there is a disparity between the attitudes and the actual practice, which is likely caused by “the lack of screening and intervention guidelines, as well as the absence of clinician education about why and how to reduce high-risk patients’ firearm injury rates.”²⁰¹ The results of the Interventions Report suggest the existing standard of care for firearm screening and counseling, if there is such a standard at all, is severely deficient. Healthcare providers cannot be expected to provide consistent and effective treatment to prevent firearm-related deaths and injuries when there is insufficient clinician awareness and training regarding firearm injury prevention. Therefore, the professional health community—and

¹⁹⁴ Roszko et al., *supra* note 16, at 87–88.

¹⁹⁵ *Id.* at 87.

¹⁹⁶ *Id.* at 103.

¹⁹⁷ *Id.*

¹⁹⁸ *Id.*

¹⁹⁹ *Id.*

²⁰⁰ *Id.* (referring to Sherry A. Everett et al., *Family Practice Physicians’ Firearm Safety Counseling Beliefs and Behaviors*, 22 J. COMMUNITY HEALTH 313, 320–21 (1997)).

²⁰¹ Roszko et al., *supra* note 16, at 105.

state legislatures, if necessary—must improve clinician training on firearm safety counseling. Such training should include the identification of who should be screened for firearms and the execution of effective injury prevention practices.²⁰²

D. Affirmative Duty to Advise and Counsel or Something Else

Other crucial considerations in developing an appropriate standard of care for firearm intervention by physicians is determining when intervention is necessary and the extent of the intervention that is required. The Professional Health Organizations' recommendation applies to "patients who are at risk for injuring themselves or others due to firearm access," but this provides little guidance for physicians on recognizing persons at risk.²⁰³ Further, there is insufficient literature identifying "who should be screened for firearms and in what health-care setting such screening should occur."²⁰⁴

Although the medical profession itself typically develops the standard of care for a particular practice or procedure, states often enact statutes that define the boundaries of a standard of care. In the last decade, over a dozen states have introduced legislation that would either completely bar doctors from asking patients about firearm ownership (known as "gag laws") or would somehow regulate the discussion between a doctor and patient on firearms.²⁰⁵ Other than FOIPA, only three laws have passed; none of them are true gag laws, as they only limit the collection of gun ownership information by medical professionals or agencies.²⁰⁶ Therefore, the existing statutes regulating the doctor-patient relationship with respect to firearms do not fill the void in the current standard of care regarding when and in what setting firearm screening and counseling is appropriate.

Some states have certain statutes or judicially-created laws imposing an affirmative duty on individuals to prevent harm to

²⁰² For a discussion of possible interventions, see *id.* at 105–06, and Ali Rowhani-Rahbar et al., *Firearm-Related Hospitalization and Risk for Subsequent Violent Injury, Death, or Crime Perpetration*, 162 ANNALS OF INTERNAL MED. 492 (2015).

²⁰³ Weinberger et al., *supra* note 2, at 514.

²⁰⁴ Roszko et al., *supra* note 16, at 105.

²⁰⁵ *Doctor Gag Order Laws*, EVERYTOWN FOR GUN SAFETY SUPPORT FUND (July 7, 2015), <https://everytownresearch.org/wp-content/uploads/2015/07/0715DoctorGagOrderLaws.pdf> [<http://perma.cc/5344-J2FJ>].

²⁰⁶ Wintemute, *supra* note 14, at 205–06 ("Montana prohibits requiring patients to provide firearm information as a condition of receiving health care. Missouri prohibits requiring that health professionals collect or record firearm information, but with an exception 'if such inquiry or documentation is necessitated or medically indicated by the health care professional's judgment'. Minnesota prohibits collection of firearm information by its state health commissioner and MNSure, the agency administering its health insurance exchange.") (footnotes omitted).

another. These laws may provide some guidance on developing when a physician's duty to advise and counsel a patient on firearms and record information about firearms in the patient's medical record applies. For example, under Florida Statute section 456.059, "a psychiatrist may 'disclose patient communications to the extent necessary to warn any potential victim or to communicate the threat to a law enforcement agency' after a 'patient has made an actual threat to physically harm an identifiable victim' and the psychiatrist has made a clinical judgment that the patient is capable of committing the threatened action."²⁰⁷

Similar to Florida's statute, a California Supreme Court ruling provides:

When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or take whatever other steps are reasonably necessary under the circumstances.²⁰⁸

This duty of a psychotherapist "to use reasonable care to protect the intended victim of a patient who presents a serious danger of violence" has come to be known as the *Tarasoff* duty, a violation of which can give rise to a negligence claim against the psychotherapist.²⁰⁹ However, not all jurisdictions that follow *Tarasoff* have extended the affirmative duty to warn to primary care doctors.²¹⁰

The above examples raise the question of whether an affirmative *Tarasoff*-like duty should apply to all healthcare providers in all situations where a patient appears to be a danger to himself or others. This is an important question, considering that many primary care doctors are unaware of the *Tarasoff* duty.²¹¹ Even more expansive would be the duty for physicians to question and counsel *all* patients on firearm safety, regardless of whether something triggers the physician to believe that such intervention is necessary to the patient's health or the health of others. One factor to support this expansive duty is that patients

²⁰⁷ See Bowman, *supra* note 15, at 1478–79.

²⁰⁸ *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 340 (Cal. 1976).

²⁰⁹ MIGUEL A. MENDEZ, EVIDENCE: THE CALIFORNIA CODE AND THE FEDERAL RULES 910 (5th ed. 2012).

²¹⁰ See Damor Muir Walcott et al., *Current Analysis of the Tarasoff Duty: an Evolution towards the Limitation of the Duty to Protect*, 19 BEHAV. SCI. L. 325, 336 (2001).

²¹¹ See Telephone Interview with Dr. Richard Redding, *supra* note 183.

are protected by the right to refuse to answer their physician's questions. On the other hand, the breadth of this obligation may be unrealistic, given that doctors do not engage in the same methods of preventive care for all patients.²¹²

One possible alternative to the universal duty to verbally question and counsel patients on firearms is the dissemination of pamphlets or brochures on firearm safety to patients.²¹³ The pamphlets could provide information and resources on firearm safety and invite patients to discuss these issues further with their doctor. This alternative could make it less likely that patients will perceive their doctors as promoting an anti-Second Amendment political agenda.²¹⁴ Furthermore, a healthcare provider can provide this information without the usual hesitation that may come with advising patients on an area that is unfamiliar to the healthcare provider. The downside to this option is that patients may not actually read the information in the pamphlets and it would be difficult to tailor the intervention to different populations.²¹⁵ There is also a chance that advocates of the Second Amendment will be just as offended, if not more, by such literature. Thus, disseminating pamphlets or brochures may protect physicians from liability, but it realistically does little for the public health and may not reduce the likelihood of offending some patients.

Another possible alternative would be for the professional health community to explicitly define specific conditions that would trigger a doctor's duty to intervene to prevent firearm-related injuries.²¹⁶ These conditions should include: when a patient has directly or indirectly expressed suicidal or homicidal thoughts; when a patient exhibits other personal risk factors for violence (i.e., history of violence perpetration, history of violence victimization, substance abuse, mental disorders, etc.); and when a patient is part of a particular demographic that is known to be at increased risk for firearm violence (i.e., middle-aged white men, young African American men, etc.).²¹⁷ The limitations to this option relate to the lack of high-quality studies and conclusive evidence on who is at risk and best practices for

²¹² *See id.*

²¹³ Interview with Kimberly D. Snow, Shareholder, LaFollette, Johnson, DeHaas, Fesler & Ames (Apr. 20, 2017). Ms. Snow specializes in civil litigation defense, primarily representing physicians and hospitals in medical malpractice claims. *Attorneys List*, LAFOLLETTE JOHNSON (2016), <http://www.ljdfa.com/attorneys.php?attorney=snow> [<http://perma.cc/QY9L-UMMZ>].

²¹⁴ *See* Interview with Kimberly D. Snow, *supra* note 213.

²¹⁵ *Id.*; *see also* Roszko et al., *supra* note 16, at 106.

²¹⁶ *See* Wintemute et al., *supra* note 14, at 210.

²¹⁷ *See id.*

firearm safety screening and counseling.²¹⁸ Consequently, this lack of consensus causes physicians to hesitate to intervene at all.

Thus, the most persistent barrier to rounding out the standard of care for firearm screening and counseling is a lack of consistent guidance and reliable evidence on determining exactly when and in what setting the duty to screen and counsel on firearms should apply. The proposals in this Section should serve as a starting point for the professional health community in developing an appropriate standard of care; but first and foremost, there is a need for a stricter focus on studying effective injury prevention practices and identifying who is at risk.

CONCLUSION

In light of the Eleventh Circuit's recent ruling that states cannot prohibit physicians from screening and counseling patients on firearms, the professional health community must develop an applicable standard of care for this practice to safeguard patients against unadvised counseling. The standard of care should be evidence-based, focusing on data about the following: firearm-related deaths and injuries; firearm safety and storage practices and their effects; defensive uses of firearms; and qualifications and training of healthcare providers on firearms. Further, although FOIPA is no longer in effect, the arguments for and against the law and the practice of firearm screening and counseling can provide guidance to the professional health community in developing the standard.

The data presented in Part I showed that firearm-related injuries are a leading cause of death for all age groups. Additionally, firearm-related homicides account for 67% of all violent deaths, a large majority of which take place in the home. Even though the data presented in Part II showed that firearm-related injuries are not a top-ten leading cause of fatal and nonfatal unintentional injuries, the data presented in Parts I and II, taken as a whole, supports the conclusion that firearm violence is a public health problem. Although a public health approach to prevention of firearm injuries and deaths is advisable, the standard applicable to this sort of preventive treatment must take into account the legitimate use of guns for self-defense and the risks of doctors advising patients without having adequate education or training on firearm safety and counseling.

²¹⁸ *Id.* at 106; *see also* Roszko et al., *supra* note 16, at 106.

As it currently stands, the standard of care for firearm screening and counseling is ill-defined, and most healthcare providers lack the minimum training necessary to effectively identify at risk patients and implement intervention practices. This causes reluctance in health care providers to engage in the practice because they fear malpractice liability as well as overstepping into an unfamiliar area of practice. At this juncture, the crucial next step for the professional health community is to implement more uniform and formal training on firearm screening and counseling and research on clinical interventions to prevent firearm-related injuries, focusing on best practices and recognition of persons at risk.

