

# Firearms Inquiries in Florida: “Medical Privacy” or Medical Neglect?

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A recent Florida law, Medical Privacy Concerning Firearms, potentially bars physicians from being able to ask patients about firearms ownership unless safety is an immediate concern. The ability of physicians to provide preventive medicine and perform risk assessments could be threatened. The ensuing debate has focused on a political and constitutional battleground between physicians and patients. In this article, we analyze the arguments from both perspectives and offer suggestions to physicians facing this unique clinical dilemma.

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On June 2, 2011, Florida Governor Rick Scott signed House Bill 155 (HB155) into law (Fla. Stat. 790.338), limiting the ability of physicians to ask patients about firearms ownership.<sup>1</sup> The law, entitled Medical Privacy Concerning Firearms, states that “a health care practitioner. . .or a health care facility. . .may not intentionally enter any disclosed information concerning firearms ownership into the patient’s medical record if the practitioner knows that such information is not relevant to the patient’s medical care or safety, or the safety of others” (Ref. 1, Section 1).

The law presents a unique clinical dilemma for physicians. Many will struggle with the ability to provide preventive care or perform risk assessments while respecting the rights of their patients. In this article, we first will explicate the clinical, legal, and ethical perspectives of the law. We will then provide a risk-benefit analysis to guide a physician’s decision of whether to inquire about a patient’s possession of firearms.

## Background

The Medical Privacy Concerning Firearms Law was prompted in part by an incident in which a Flor-

ida pediatrician allegedly told the mother of a minor patient to find a new physician after she refused to answer questions regarding gun ownership and storage.<sup>2</sup> Gun owners subsequently complained, and the National Rifle Association (NRA) sponsored legislation.<sup>3</sup> The law limits both written and verbal inquiries regarding patients’ firearms ownership. Exceptions to the law include provisions allowing such inquiries by emergency medical technicians and paramedics if this information is believed to be necessary to treat a patient or if the “presence or possession of a firearm would pose an imminent danger or threat to the patient or others” (Ref. 1, Section 3). Furthermore, patients may decline to provide information regarding the ownership or possession of firearms (Ref. 1, Section 4). The law dictates that a health care practitioner or facility may not “discriminate” (Ref. 1, Section 5) and “should refrain from unnecessarily harassing a patient about firearm ownership” (Ref. 1, Section 6).

The original version of HB155 would have made such infractions a third-degree felony punishable by a fine up to \$5 million and up to five years in prison.<sup>4</sup> The Florida legislature reached a compromise and amended the bill to remove language providing civil and criminal penalties against physicians. Now violators may face disciplinary action from the Florida Board of Medicine, which can include suspension, revocation of a clinician’s license, and a fine up to \$10,000.<sup>5</sup>

While the law intends to protect the privacy rights of Florida’s citizens, opponents argue that it limits

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the constitutional rights of physicians and have named this perceived infringement the Physician Gag Law.<sup>5</sup> Murtagh and Miller believe that the law is a “form of censorship that directly undermines the sanctity of the patient-physician relationship” (Ref. 6, p 1131). Other opponents have referred to this action as Docs versus Glocks<sup>7</sup> and have criticized the law as “irrational and irresponsible.”<sup>8</sup>

Legal action was taken against the law, with the first federal lawsuit filed on June 6, 2011.<sup>5</sup> Three Florida physicians, the Florida Chapter of the American Academy of Pediatrics, the Florida Chapter of the American Academy of Family Physicians, and the Florida Chapter of the American College of Physicians sought declaratory and injunctive relief prohibiting the enforcement of the provisions of the Florida statute sections that were amended or created by HB155.

Florida is the first state to enact a law that limits a physician’s ability to ask patients about firearms ownership, and it remains to be seen whether such laws will become a national trend. The North Carolina and Alabama legislatures considered but did not enact similar laws.<sup>9–12</sup> Virginia and West Virginia also failed to pass comparable legislation.<sup>13</sup>

In addition, there is a relevant provision within the recently enacted federal health care reform. The section in Title X of the Patient Protection and Affordable Care Act, entitled Protection of Second Amendment Gun Rights, prohibits wellness and prevention programs from requiring disclosure of gun ownership information.<sup>14</sup>

## The Clinical Perspective

### Psychiatric Evaluations and Treatment

The plaintiffs who filed the federal lawsuit against the law argued that it restricts the physician’s ability to perform safety counseling, which is a fundamental aspect of preventive medicine.<sup>5</sup> The lawsuit refers to the American Psychiatric Association’s (APA) recommendation that “health professionals and health systems should ask about firearm ownership whenever clinically appropriate in the judgment of the physician” (Ref. 5, Section 34). Although originally opposed to the bill, the Florida Medical Association (FMA) and Florida Psychiatric Society (FPS) have both expressed satisfaction with the revised language. In fact, Dr. Asher Gorelik, the Past President of the FPS, noted that language in the new bill “no longer

interferes with the ability of a psychiatrist to perform a risk assessment.”<sup>4</sup> Notably, neither the FMA or FPS nor individual Florida psychiatrists were involved in the federal action against HB155.

Arguments can be advanced as to whether because of the very nature of psychiatric evaluations and treatment, psychiatrists are automatically exempt from the law. In other words, does the mere fact that psychiatrists manage mental illness grant them an immediate safety-related exception to the Medical Privacy Concerning Firearms Law? Psychiatrists should be concerned about patients’ risk for suicide and violence to others, but there are many variables that influence the risk assessment, including the suspected diagnosis and setting of the evaluation. Certainly, a patient with a serious mental illness who is intoxicated and brought involuntarily to the emergency room for making threats of suicide must be asked about firearms ownership. However, an entirely different situation is presented when a patient without a history of mental illness, substance use, violence, or suicide attempts is evaluated in an outpatient clinic for anxiety related to public speaking. The argument for automatic screening of this patient for firearms ownership seems less clear. The presence of risk factors should influence whether a psychiatrist’s inquiries into firearms ownership is relevant to patient safety.

In addition, information about firearms ownership may provide clues as to a patient’s mental status and stability. A paranoid patient’s decision to move or hide his gun may indicate worsening psychosis. A depressed patient’s acquisition of a firearm may reflect suicidal ideation. These data would guide the diagnostic formulation and treatment plan.

Individuals with mental illness, especially those with major depressive disorder, substance abuse, and feelings of hopelessness, are at increased risk of suicide.<sup>15</sup> According to the American Psychiatric Association (APA), because of the increased risk, mental health providers should routinely ask patients about suicidal thoughts, intents, or plans, including the question, “Do you have any guns or weapons available to you?” (Ref. 15, p 20).

This type of direct questioning is crucial, because there is no specific symptom or element of a patient’s history that reliably determines the risk of future violence. Freedman *et al.* have noted, “[T]here is no single clinical picture associated with violent behavior” (Ref. 16, p 1315). Asking about firearms own-

ership, therefore, becomes an integral component of this assessment, even in the absence of other commonly recognized risk factors.

Evidence indicates that the presence of firearms in the home is a risk factor for suicide.<sup>17</sup> Miller and Hemmenway<sup>18</sup> suggested that the availability of firearms increases the risk of suicide for three reasons: many suicidal acts are impulsive, many suicidal crises are self-limiting, and guns are common in the United States and lethal. They contend, “[R]estriction of access to lethal means is one of the few suicide-prevention policies with proven effectiveness” (Ref. 18, p 991).

Florida citizens are not immune to the risks of suicide. The state’s average suicide rate between the years 2000 and 2006 was 11.83 to 14.18 per 100,000.<sup>19</sup> According to data from the National Institute of Mental Health, Florida’s rate is comparable with 12 other states, while only 12 other states have a higher rate (14.19–20.08 per 100,000).

In a situation in which a physician does not ask about firearms safety based on the Medical Privacy Concerning Firearms Law and there is a negative outcome, the physician may be found liable for failure to follow the appropriate standard of care. Historically, courts have used such guidelines and policies to set standards of care for the purpose of malpractice litigations.<sup>20</sup> For example, a psychiatrist who does not ask about gun ownership in a case in which the patient subsequently commits suicide after leaving the emergency room may fall below the standard of care if it can be demonstrated that a prudent psychiatrist would have chosen to hospitalize the patient instead of discharging him to his home after inquiring about access to firearms.

### **Medical Evaluations and Treatment**

As mentioned, the FMA was not involved in the federal lawsuit against the Medical Privacy Concerning Firearms Law. Although it was initially opposed to the bill, overwhelming support (including from NRA members) left the FMA in a position where it felt “forced to negotiate.”<sup>21</sup>

Just as all psychiatrists emphasize suicide and violence risk assessments, all physicians must share these concerns. In the United States, the 12-month prevalence of mental illness among adults is 26.2 to 32.4 percent.<sup>22,23</sup> The lifetime prevalence of any mental illness in adults is 57.4 percent and among 13- to

18-year-olds is 46.3 percent.<sup>24</sup> Most of those who are mentally ill are treated by nonpsychiatrists.<sup>25</sup>

In the United States in 2007, antidepressants were the third most frequently prescribed therapeutic category of drugs at ambulatory care visits, following analgesics and antihyperlipidemic agents.<sup>26</sup> From August 2006 to July 2007, 59 percent of psychotropic medications were prescribed by general practitioners compared with 23 percent by psychiatrists.<sup>27</sup> In 2007, suicide was the second-leading cause of death in the United States in the 25-to-34-year age group, the third-leading cause in the 15-to-24-year group, the fourth-leading cause in the 10-to-14- and 35-to-44-year groups, the fifth-leading cause in the 45-to-54-year group, and the eighth-leading cause in the 55-to-64-year group.<sup>28</sup>

These statistics suggest that general practitioners must be prepared to assess the mental stability and safety of their patients. Depression symptoms, for example, are often underreported by patients. Respondents with no depression history are more likely to believe that depression falls outside the purview of primary care.<sup>29</sup> In addition, many primary care physicians are unable to obtain outpatient mental health services for their patients,<sup>30</sup> again showing that this problem is relevant for all physicians.

Even seemingly straightforward patient care without any immediate suicide risk may become problematic for the general practitioner. Consider the following composite vignettes that demonstrate how nonpsychiatrists may use information about firearms ownership:

#### *Case Example 1*

An endocrinologist routinely treated a patient with type 2 diabetes mellitus and no significant psychiatric history. The patient’s glucose control worsened, and complications of his illness led to an amputation of a lower extremity. The patient became depressed, planned a suicide, and did not disclose his firearms ownership. He took a gun from his closet and fatally shot himself. Had the endocrinologist inquired about firearms ownership during the initial evaluation, he might have been aware of the increasing risk as the patient’s condition worsened.

#### *Case Example 2*

An internist referred her patient to a multitude of specialists to evaluate for hearing loss. The testing became more elaborate as each result returned within normal limits: blood work, neuroimaging, an EEG,

and genetic markers. An otolaryngologist learned that the patient enjoyed hunting and shooting at the gun range. After months of appointments and costly ancillary testing, the etiology was easily determined directly from the patient's history.

*Case Example 3*

A neurologist evaluated an elderly patient for a gradual worsening in cognition. The patient had been forgetful and inattentive and developed subtle changes in his personality. He had gotten lost while driving and had left the stovetop on after leaving the house. The patient routinely drank several glasses of wine every night with dinner. The neurologist assigned a diagnosis of dementia. The patient neglected to inform his physician that he owned a gun for protection. In a confused state one evening, the patient inadvertently mistook a neighbor for someone attempting to break into his house and shot the neighbor at the door.

Although many physicians routinely inquire about firearms ownership at the initial evaluation, it is unclear how often the question is revisited during subsequent visits. In the absence of events that raise safety concerns, many physicians will not update their files regarding a patient's firearms ownership. Therefore, an argument can be made that an initial inquiry as to firearms ownership will catch only a small percentage of future acts of violence. The standard of care may dictate how frequently physicians should revisit this question.

In U.S. district court, opponents to the Medical Privacy Concerning Firearms Law argued that this law "directly interferes with, and intrudes upon, health care practitioners' ability to engage fully in consultations by severely restricting inquiries about a significant and preventable risk to patients—the risk of injury or death posed by the presence of firearms in the home" (Ref. 5, p 2). The lawsuit argues that the "provisions are so vague, overbroad, and ambiguous, and its penalties so harsh, that prudent practitioners will be forced to curtail or forgo altogether counseling patients with regard to firearms" (Ref. 5, p 17).

This argument is troubling, because preventive care is central to the practice of physicians. Preventive care includes counseling safe practices in such areas as substance use, domestic violence, diet, exercise, swimming pools, and smoke detectors. Since 1992, the American Academy of Pediatrics (AAP) has issued several statements regarding firearms

safety that support office-based counseling on firearms safety and injury prevention.<sup>31</sup> Several other medical organizations, including the APA, American Academy of Family Physicians, American College of Physicians, and American College of Surgeons, have subsequently instituted guidelines regarding firearms injury prevention, with most of their policies emphasizing the importance of primary preventive counseling.<sup>32</sup> The AAP encourages pediatricians to educate patients on firearms safety starting at preschool age, along with counseling on traffic safety and prevention of burns, falls, poisoning, and drowning.<sup>33</sup> The AAP guidelines further urge that pediatricians routinely incorporate questions about firearms safety when taking the patient's history.<sup>34</sup>

Parental education by pediatricians plays a significant role in minimizing risk, preventing unintentional injury, and ensuring the safety of children. The leading cause of death in children less than one year of age is unintentional injury.<sup>33</sup> Albright and Burge<sup>35</sup> demonstrated that even brief counseling by primary care physicians has a positive influence on the firearms storage habits of patients and would thus have an impact on safety.

**Psychological Evaluations and Treatment**

The Medical Privacy Concerning Firearms Law also affects Florida psychologists and other mental health practitioners (e.g., licensed counselors and social workers). Not unlike psychiatrists, psychologists are ethically bound to "take care to do no harm" to their patients and to "seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons" (Ref. 36, p 1062). Psychologists are also ethically bound to respect all peoples' rights and dignity, and when conflicts between professional ethics and the law arise, psychologists must "clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict" (Ref. 36, p 1063).

The American Psychological Association Ethics Code promulgates standards for ethical psychological practice. A law that prohibits the routine inquiry about firearms in the home places psychologists in an ethics-based dilemma. Psychologists who serve alongside their physician colleagues in primary care settings have as one of their fundamental responsibilities the provision of primary prevention.

Psychologists working within the context of geriatrics frequently evaluate and treat individuals with acquired neurocognitive and neurobehavioral impairment. Cognitively impaired individuals who possessed and operated firearms before their brain trauma, stroke, or the onset of a neurodegenerative condition are in need of neuropsychological evaluation before resuming the independent possession or use of firearms. The cognitive and behavioral demands necessary to handle and operate firearms include attention and concentration, a working and short-term memory, spatial awareness, temporal sequencing, inhibitory control, visuospatial and spatial analysis, and fine motor control. Many neurological disorders impair these functions and, if impaired, individuals with brain dysfunction may need supervised use of or restricted access to firearms.

## Legal Analysis

### The First Amendment

The First Amendment provides that “Congress shall make no law abridging the freedom of speech.”<sup>37</sup> The plaintiffs in *Wollschlaeger v. Scott* alleged that the Physician Gag Law violates both physicians’ and patients’ First Amendment rights by placing limitations on physicians’ “open and free exchanges of information and advice with their patients about ways to reduce the safety risks posed by firearms” (Ref. 5, p 2); and patients’ ability “to receive such information and advice from their physicians” (Ref. 5, p 2). The plaintiffs also alleged that the law’s “content-based intrusion on speech” (Ref. 5, p 2) diminished the “the ability of physicians to practice such preventative medicine” (Ref. 5, p 2). By limiting what a physician may discuss with patients, the law’s capacity for censorship serves as an infringement on the physician’s First Amendment right to freedom of speech. The exemptions included in the Medical Privacy Concerning Firearms Law do not resolve this violation.

The law may also violate the First Amendment rights of patients. Censorship of the doctor-patient relationship limits open discourse. Patients may be disinclined to seek counseling regarding safe firearms ownership and storage practices, especially if their physicians take deliberate steps to avoid the matter. Of course, it seems that if the patient introduced questions regarding gun safety, then the physician would be permitted to participate in the discussion.

Despite this apparent invitation to discuss firearms safety, however, some physicians may remain apprehensive about having a frank discussion, given the potential repercussions for violating the law.

In September 2011, Judge Marcia Cooke of the U.S. District Court for the Southern District of Florida granted a preliminary injunction of the Florida law,<sup>38</sup> which became a permanent injunction in June 2012.<sup>39</sup> She ruled that the law violated the First Amendment of the Constitution and that permitting physicians to inquire about firearms does not infringe on the rights of gun owners. She also commented on the First Amendment as it pertains to the patient-physician relationship by stating that it was important not to limit “the free flow of truthful, non-misleading information within the doctor-patient relationship” (Ref. 38, p 3).

### The Second Amendment

The law seeks to protect the Florida gun owner’s “Constitutional right to own and possess firearms or ammunition” (Ref. 1, p 7). In an extension of this Second Amendment protection, it also prevents “an insurer from considering the fair market value of firearms or ammunition in the setting of premiums for scheduled personal property coverage” (Ref. 1, p 4) and disallows an insurer from denying coverage or increasing premiums based on gun ownership or possession status. Notably, the NRA unsuccessfully tried to intervene in *Wollschlaeger v. Scott*, as they viewed the right to bear arms at stake, as opposed to the freedom of speech.

Physicians do not intend to disarm Florida’s gun owners by inquiring about firearms safety, just as their goal is not to alter the sexual orientation of adolescents when discussing safe sex practices. The U.S. district court supported this position stating, “A practitioner who counsels a patient on firearm safety, even when entirely irrelevant to medical care or safety, does not affect nor interfere with the patient’s right to continue to own, possess, or use firearms” (Ref. 38, p 3). The argument is similar for physicians’ inquiries into contraception usage: physicians ask the question to promote safe practices, not to promote a patient’s practice of abstinence.

### The Fifth Amendment and Right to Privacy

The Medical Privacy Concerning Firearms Law reminds patients of their Fifth Amendment rights and echoes the Constitution’s penumbral right to

privacy. It states, "A patient may decline to answer or provide any information regarding ownership of a firearm by the patient or a family member of the patient" (Ref. 1, p 4). Although the law intends to protect the privacy of patients, they have the right to decline to answer any question posed by a physician at any time. This right may be followed by a physician's discretion on how to proceed. For example, the physician who does not want to treat an uncooperative patient has the right to terminate the relationship if and only if care is appropriately transferred to another provider. Therefore, the law does not appear to offer any additional protections for patient privacy.

### **The Health Insurance Portability and Accountability Act**

Patient privacy is currently covered under the Health Insurance Portability and Accountability Act (HIPAA), a national law. HIPAA protects all information regardless of its immediate relevance to the clinician. Medical documentation regarding a gun owner's privacy is already protected by this national law, just as any other patient information is protected. The Medical Privacy Concerning Firearms Law, therefore, is a redundant and unnecessary intrusion into the physician-patient relationship, because it singles out one aspect of patient privacy that is already covered.

Judge Cooke's permanent injunction of the law echoes this argument stating:

The State [of Florida] . . . fails to provide any evidence that the confidentiality of this information is at risk. If a patient does not want to provide this information, she may simply refuse to do so. If a patient discloses whether she owns or possesses a firearm and the practitioner includes that information in her file, state and federal laws pertaining to the confidentiality of medical records will protect that information [Ref. 39, p 19].

### **The Potential Effect of Granting More Rights to Individuals**

Repealing state safety laws in the name of individuals' rights has resulted in sharp increases in trauma-related deaths. For example, repeal or modifications to the motorcycle helmet laws of Texas,<sup>40</sup> Louisiana,<sup>41</sup> and Florida<sup>42</sup> have resulted in reduced helmet use and increased motorcycle-related deaths. In addition, many studies have shown that when the minimum legal drinking age has been lowered, motor vehicle crashes, injuries, and deaths have increased. The inverse has also been seen to be true: raising the

minimum legal drinking age decreases these negative outcomes (for a review, see Ref. 43).

Similar observations have been made regarding gun ownership. As noted by Wintermute, "Permissive policies regarding carrying guns have not reduced crime rates, and permissive states generally have higher rates of gun-related deaths than others do" (Ref. 44, p 1423). The Medical Privacy Concerning Firearms Law affects a health care practitioner's ability to inquire routinely about the patient's possession of firearms at home and consequently decreases the potential effectiveness of primary prevention efforts. The repeal of effective state safety laws may be followed with worse outcomes.

### **Ethics Analysis**

The American Medical Association (AMA) has developed and published a Code of Medical Ethics that serves as a reference for physicians of all specialties. In it, the AMA defined the patient-physician relationship and established opinions on various topics including social policy, professional rights and responsibilities, and confidentiality.<sup>45</sup> Opinion 10.01 of the code, entitled the "Fundamental Elements of the Patient-Physician Relationship," acknowledges the relationship to be a "collaborative effort" and one that exists in a "mutually respectful alliance" (Ref. 45, p 1). The Code, in its effort to define the relationship, describes specific rights that patients may expect when entering into the patient-physician relationship. These rights include the following: the "right to receive information from physicians," "the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs," and "the right to confidentiality" (Ref. 45, p 1).

These patient rights comport with the major principles of medical ethics: autonomy, nonmaleficence, beneficence, and justice.<sup>46</sup> When these rights and principles are considered along with the AMA's Declaration of Professional Responsibility: Medicine's Contract with Humanity, the result is a set of ideals and standards that articulate the physician's commitment to "respect human life and the dignity of every individual. . .[and to] treat the sick and injured with competence and compassion and without prejudice."<sup>47</sup> Harassment and discrimination of gun owners, two concerns mentioned in the Medical Privacy Concerning Firearms Law, are abuses that the law attempts to address by restricting discussions about gun possession in doctor-patient conversations. Ha-

rassment and discrimination by a practitioner, however, are acts that would contravene a physician's directive to respect human life and dignity, do no harm, and act with courtesy. Physicians must show patients the same respect when inquiring about firearms ownership as they do for other sensitive questions relevant to patient care. Therefore, the Medical Privacy Concerning Firearms Law does not provide any additional safeguards that are not already articulated in the key ethics and professional guidelines governing the practice of medicine.

## Risk-Benefit Analysis

### **The Argument for Physicians to Inquire About Firearms Ownership**

The primary reason for inquiring about firearms ownership is that physicians have an obligation to provide preventive counseling, which is consistent with adhering to the standard of care. This obligation is general, holistic, and applies to all patient behavior.

Psychiatrists have a specific obligation to screen patients for suicidal and homicidal thoughts and behavior. As mentioned, however, we argue that this obligation extends to all physicians.

Physicians concerned about liability and litigation from negative patient outcomes may find reason to inquire about firearms. This is a cautious and defensive posture similar to the practice of ordering additional laboratory studies or the prophylactic prescription of antibiotics.

As illustrated in Case Example 2, asking about firearms ownership may assist in determining a patient's diagnosis.

Justification of firearms inquiries is similar to that for reporting threats of harm to self or others to third parties in the absence of relevant *Tarasoff* statutes. Florida is not a *Tarasoff* state, and yet the standard for physicians is to disclose threats of violence to third-party individuals under certain circumstances.

The final reason for inquiring about firearms ownership is that the physician believes that the law is vague, that the reason for asking is relevant or the inquiry is made in good faith, and there is a low likelihood that legal action would be pursued by the patient. In addition, the physician may decide that even if sued, his or her defense is sound and the chance of fines or disciplinary action by the board of medicine is low.

### **The Argument for Physicians Not to Inquire About Firearms Ownership**

A compelling reason not to inquire about firearms ownership is the fear of disciplinary action. This risk alone is a major deterrent to physicians' asking patients about owning firearms and may have a "chilling effect" (Ref. 6, p 1131) on discussion.

The physician who agrees with the rationale for the Medical Privacy Concerning Firearms Law (namely, that such inquiries violate patients' Second Amendment rights) will not feel any obligation to obtain this information from patients.

The law may decrease the responsibility of those physicians who choose not to ask about firearms ownership and automatically refer suicidal or homicidal patients to the emergency room or obtain a psychiatric consultation when questions of safety arise.

There are many other proven methods for improving patients' mortality and morbidity rates, which do not potentially conflict with statutory restrictions (e.g. promoting healthy nutrition and exercise, counseling in smoking cessation, and providing prenatal care). Time may be better served by focusing on areas of prevention other than firearms safety.

The final argument for not asking about firearms ownership initially is similar to the final argument for asking: the apparent vagueness of the law. The relevance to the patient's safety may be uncertain, and so the physician decides not to ask about firearms ownership.

## Discussion

Weighing the risks and benefits of whether to inquire about firearms ownership is not a simple task. At the heart of the argument is a precarious balance of a patient's right to privacy versus a physician's need to deliver appropriate patient care. A physician cannot abrogate that right, however, without justification. Reliance on professional standards and ethics will suggest that there are times when a patient's right to privacy can be a secondary priority. The conclusion might be described as a belief that more harm than good will come to the patient by not asking about firearms ownership. Judge Cooke was persuaded that "the balance of interests tip significantly in favor of safeguarding practitioners' ability to speak freely to their patients" (Ref. 39, p 20).

Despite this analysis, many physicians are likely to rely on personal and professional experiences to de-

cide how to handle this dilemma. Many follow the doctrine of better to be safe than sorry, making clinical decisions in lieu of adhering to evidence-based medicine or practice guidelines (e.g. ordering ancillary testing or imaging studies or hospitalizing patients who could be managed as outpatients). Other physicians become biased after patients have a negative outcome: for example, a physician may hesitate to prescribe a particular antipsychotic drug after one patient develops neuroleptic malignant syndrome when taking that medication.

These patterns of behavior are also relevant to the risk-benefit analysis of inquiring about firearms. If a patient's suicide follows a physician's failure to screen for firearms, then that physician may subsequently ask all patients about firearms ownership despite prohibition and possible disciplinary action. Alternately, a complaint arising from a patient who was asked about gun ownership might subsequently bias a physician to perform this screening less frequently. Both of these conclusions, however, are flawed, because they have been reached by overgeneralization, by extrapolating a single experience to broad generalizations.

The Medical Privacy Concerning Firearms Law is an example of how politics and legislation influence the doctor-patient relationship. If firearms ownership becomes an illegal line of questioning, other areas of preventive medicine might also become targets for legislation. Would physicians respond by self-censoring as a form of defensive practice, a variant of preventive medicine? With perceived infringement on their First Amendment rights, might physicians feel that the doctor-patient relationship is tainted and be reluctant to engage fully in a mutually respectful manner? The effects may be seen if there is a successful appeal of the U.S. district court's injunction.

Alternately, there are several potential implications of an unsuccessful appeal to the U.S. district court decision. If physicians continue preventive inquiries related to firearms, patients may fear harassment and discrimination by physicians for their gun-ownership status. This debated law has received national attention and may elevate awareness about gun owners' rights. Consequently, patients may be more confident in not disclosing ownership to their physicians.

The Medical Privacy Concerning Firearms Law, while clearly prohibiting physicians under certain

circumstances from asking about firearms ownership, does not provide sanctions against educating parents and patients. A physician concerned about violating the law can still provide routine anticipatory guidance to patients on firearms safety without specifically asking about ownership. Because this approach may be burdensome, physicians may choose to distribute handouts to patients with information regarding proper firearms safety and injury prevention. Opponents, however, will argue that written material may not be as effective as an open discourse.

It is important to remember that this recent legislation was passed in the context of a greater political and social debate regarding gun ownership. In Jill Lepore's article, "Battleground America: One Nation, Under the Gun," she highlights both the origins and recent developments.<sup>48</sup> National statistics continue to uphold the dangers of firearms, especially in the United States, where they are associated with higher rates of suicide, accidental injury, homicide, and domestic violence.<sup>49-51</sup> The NRA continues vigorously to oppose gun control. While gun control legislation was viewed as "essentially a law enforcement matter. . .only secondarily a psychiatric concern" (Ref. 52, p 129), it is now considered a psychiatric matter because it affects psychiatrists, patients, and their practices. Federal and state laws restrict those who have been adjudicated as mentally ill from accessing firearms.<sup>53</sup> Furthermore, mental health professionals are commonly involved in assessing fitness to possess firearms as part of dangerousness assessments.<sup>54</sup>

This legislation also pertains in a greater context to an individual's right to privacy. The debate has included Internet privacy and consumer online tracking, the privacy of job applicants not to be required to share their social network passwords with potential employers, and the extent to which individual privacy must yield to needs for national security (especially following the terrorist attacks of September 11, 2001).

The context of the Medical Privacy Concerning Firearms Law is also particular to Florida, which has been described as "a haven for Second Amendment enthusiasts."<sup>55</sup> For example, Florida's Justifiable Use of Force law<sup>56</sup> has received national attention in the recent case of George Zimmerman charged for the fatal shooting of Trayvon Martin. Although approximately 24 to 30 other states have similar stand-your-ground laws,<sup>57,58</sup> this tragic case reminds us that

Florida was the first state to explicate this right. When practicing medicine in this context, one's personal political position and professional ethics can be challenged, especially in cases with high liability and risk.

It is clear that the U.S. district court's ruling of the unconstitutionality of the Medical Privacy Concerning Firearms Law has granted Florida physicians only a temporary reprieve. All physicians must prepare to face this matter in their respective jurisdictions. The question is not moot and may resurface through other legislation or through the federal health care reform act. Physicians should seek counsel from their professional organizations, risk management offices, and attorneys general to decide how best to practice preventive medicine while adhering to applicable statutes. Mindful of this advice, physicians must weigh personal and professional ethics considerations to continue to serve the needs of their patients.

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