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# Yes, You Can: Physicians, Patients, and Firearms

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Physicians have unique opportunities to help prevent firearm violence. Concern has developed that federal and state laws or regulations prohibit physicians from asking or counseling patients about firearms and disclosing patient information about firearms to others, even when threats to health and safety may be involved. This is not the case. In this article, the authors explain the statutes in question, emphasizing that physicians may ask about firearms (with rare exceptions), may counsel about firearms as they do about other health matters, and may disclose information to third parties when necessary. The authors then review circumstances under which questions about firearms might be most appropriate if they are not asked routinely. Such circumstances include instances when the patient provides information or exhibits behavior suggesting an acutely increased risk for violence, whether to himself or others, or when the patient possesses other individual-level risk factors for violence, such as alcohol abuse. The article summarizes the literature on current physician practices in asking and counseling about firearms, which are done far less commonly than recommended. Barriers to engaging in those practices, the effectiveness of clinical efforts to prevent firearm-related injuries, and what patients think about such efforts and physicians who engage in them are discussed. Proceeding from the limited available evidence, the authors make specific recommendations on how physicians might counsel their patients to reduce their risk for firearm-related death or serious injury. Finally, the authors review the circumstances under which disclosure of patient information about firearms to third parties is supported by regulations implementing the Health Insurance Portability and Accountability Act.

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In 2014, a total of 33 599 Americans died of gunshot wounds (1). Although the risk for firearm-related homicide is highest among young African American men, most firearm-related deaths are suicides, for which older white men are at highest risk (2). Public mass shootings account for a small percentage of firearm-related deaths but are occurring more frequently and could affect the character of public life in the United States (3). In early 2013, more than 40% of Americans worried that they could fall victim to firearm-related homicide or assault (4).

Physicians seek to prevent important health problems at the individual and population levels. They inquire and counsel—routinely in some cases, selectively in others—about a wide range of health-related behaviors and conditions. In certain circumstances, they disclose otherwise confidential information to third parties to limit the risk an affected person poses to others.

Physicians generally do not do well at firearm-related injury prevention, however. They ask infrequently about firearms and counsel poorly, if at all, although they are aware that the high lethality of firearms makes prevention efforts particularly important.

In this article, we examine several commonly cited barriers to practicing preventive medicine for firearm-related injuries. Some physicians believe that it is against the law to discuss firearms; we show that this belief is unfounded. We then discuss the circumstances in which prevention efforts might be most appropriate. We briefly review other barriers to their more widespread adoption, patients' opinions about physicians addressing firearms, and the effectiveness of such prevention practices; more extensive information is available elsewhere (5, 6). We offer specific recommendations, based on the limited evidence available, for how physicians can incorporate firearm-related injury prevention into the care of their patients.

## You Can Ask

No federal or state statute prohibits physicians from asking about firearms when such information is relevant to the health of the patient or others.

### Federal Statute

The Patient Protection and Affordable Care Act (ACA) regulates the collection of firearm information, but the scope of these provisions is narrow (Table 1). Most important, the ACA prohibits *required* collection of firearm information by "wellness and health promotion" programs. The Obama administration's position was reflected in a January 2013 White House announcement that, to "protect the rights of health care providers to talk to their patients about gun safety," it would issue guidance clarifying that the ACA does not regulate communication between physicians and patients about firearms (7). The U.S. Department of Labor repeated this clarification (8); to our knowledge, this guidance has not been issued.

### State Statutes

#### *Florida*

The only existing gag law is Florida's medical privacy act concerning firearms (Table 1), enacted in 2011 after a series of inflammatory incidents occurred during clinician–patient interactions. In one widely publicized incident, a pediatrician in Ocala discharged from care 3 children whose mother declined to answer questions about firearms (9, 10).

Florida's law is seen as intruding on the patient–physician relationship (11). Its key provisions hold that health practitioners "should refrain" from asking about firearms and "may not intentionally enter" firearm infor-

**See also:**

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***Table 1.*** Language From Relevant Federal and State Statutes*

**Federal Statute: Patient Protection and Affordable Care Act.** Public L No. 111-148 (March 23, 2010). 124 Stat. 119. (H.R. 3590, 111th Cong. [2010]). Tit. X, subtitle A, §10101(e) (amending Public Health Service Act §2717).

PROTECTION OF SECOND AMENDMENT GUN RIGHTS.–

(1) WELLNESS AND PREVENTION PROGRAMS.–A wellness and health promotion activity implemented under subsection (a)(1)(D) may not require the disclosure or collection of any information relating to–

(A) the presence or storage of a lawfully-possessed firearm or ammunition in the residence or on the property of an individual; or

(B) the lawful use, possession, or storage of a firearm or ammunition by an individual.

(2) LIMITATION ON DATA COLLECTION.–None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used for the collection of any information relating to–

(A) the lawful ownership or possession of a firearm or ammunition;

(B) the lawful use of a firearm or ammunition; or

(C) the lawful storage of a firearm or ammunition.

(3) LIMITATION ON DATABASES OR DATA BANKS.–None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used to maintain records of individual ownership or possession of a firearm or ammunition.

. . .

(5) LIMITATION ON DATA COLLECTION REQUIREMENTS FOR INDIVIDUALS.–No individual shall be required to disclose any information under any data collection activity authorized under the Patient Protection and Affordable Care Act or an amendment made by that Act relating to–

(A) the lawful ownership or possession of a firearm or ammunition; or

(B) the lawful use, possession, or storage of a firearm or ammunition.

**State Statute: Florida, Medical Privacy Concerning Firearms.**

Florida statutes of 2015. Tit. 46, ch. 790, §338.

790.338 Medical privacy concerning firearms; prohibitions; penalties; exceptions.–

(1) A health care practitioner . . . may not intentionally enter any disclosed information concerning firearm 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.

(2) A health care practitioner . . . shall respect a patient's right to privacy and should refrain from making a written inquiry or asking questions concerning the ownership of a firearm or ammunition by the patient or by a family member of the patient, or the presence of a firearm in a private home or other domicile of the patient or a family member of the patient. Notwithstanding this provision, a health care practitioner or health care facility that in good faith believes that this information is relevant to the patient's medical care or safety, or the safety of others, may make such a verbal or written inquiry

. . .

(4) 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, or the presence of a firearm in the domicile of the patient or a family member of the patient. A patient's decision not to answer a question relating to the presence or ownership of a firearm does not alter existing law regarding a physician's authorization to choose his or her patients.

(5) A health care practitioner . . . may not discriminate against a patient based solely upon the patient's exercise of the constitutional right to own and possess firearms or ammunition.

(6) A health care practitioner . . . shall respect a patient's legal right to own or possess a firearm and should refrain from unnecessarily harassing a patient about firearm ownership during an examination.

* Boldface, underlined formatting was added by the authors to highlight key text.

mation into medical records. There are broad exceptions, however. A practitioner who "in good faith believes that this information is relevant to the patient's medical care or safety, or the safety of others" may ask about firearms, and only information that "is not relevant to the patient's medical care or safety, or the safety of others" is excluded from medical records (12).

Physicians and medical professional organizations challenged the law in U.S. District Court, contending that it unduly restricted their First Amendment rights. They were successful (9), but that decision was overturned by a divided 3-judge panel in the U.S. Court of Appeals for the Eleventh Circuit (10, 13). In February 2016, the full court vacated its panel's decision and agreed to rehear the case (14). The District Court decision remains in effect.

### *Other States*

Three states–Montana, Missouri, and Minnesota–have statutes addressing firearm information acquired by health practitioners or agencies. None includes a gag provision. Montana prohibits requiring patients to provide firearm information as a condition of receiving health care (15). 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" (16). Minnesota prohibits collection of firearm information by its state health commissioner and MNsure, the agency administering its health insurance exchange (17, 18).

More restrictive proposals have been considered elsewhere. In 2015, North Carolina's legislature debated prohibiting the collection of firearm information in any written form and the disclosure of responses to firearm-related questions "unless the patient has been adjudicated incompetent due to mental illness" (19). A true gag law proposal was introduced in Ohio in June 2015: "A physician shall not ask a patient or prospective patient . . . [any] question related to the ownership or possession of a firearm" (20). As of April 2016, no action had been taken on this bill.

## WHEN TO ASK

Firearm information would be directly relevant to the health of an individual patient and that patient's close contacts under 3 general conditions (Table 2). Where physician preference or simple lack of time precludes routine screening for firearm access, physicians could identify patients for whom these conditions apply and proceed selectively.

The first arises when a patient provides information or exhibits behavior suggesting an acutely increased risk for violence, such as explicit or implicit endorsement of suicidal or homicidal intent or ideation. This is an emergency; the need to determine access to lethal means for such patients is self-evident.

The second involves patients who possess other individual-level risk factors for future violence. A history of violence perpetration is a strong predictor of future violence in the general population (21) and among firearm owners (22). Similarly, patients hospitalized or treated in emergency departments for violent victimization are at high risk for committing violence (23, 24). Alcohol abuse is common in the general population and among firearm owners (25) and is a well-established risk factor for interpersonal and self-directed firearm violence (26). Drug abuse is another risk factor, but the magnitude of the risk may be drug-specific (27).

Serious mental illness is a relatively minor risk factor for violence to others, and risk depends on the nature of the illness (28, 29). Alcohol and drug abuse, prior violence, and violent victimization account for much of the risk popularly ascribed to mental illness (30, 31). Self-directed violence is very strongly linked to mental illness, however. Suicide risk is increased by a factor of at least 10 across a range of psychiatric diagnoses, and an estimated 47% to 74% of suicides are directly attributable to mental disorders (30). Violence risk is particularly high among patients seen for mental illness in emergency departments, recently discharged psychiatric inpatients, and persons experiencing a first psychotic episode (30). Brain disorders associated with impaired cognition and judgment, such as Alzheimer disease, are associated with an increased risk for aggression and violence (32).

Third, questions about firearms would be relevant for patients in demographic groups that are at increased risk for firearm-related injury. Middle-aged and older white men are at high risk for firearm-related suicide (up to 5 times higher than black men of the same age), and young African American men are 20 times as likely as young white men to die of firearm-related homicide (1). Children and adolescents may engage in risk behaviors with firearms because their judgment and cognitive skills are not fully developed (33).

Persons with risk factors, including substance abuse disorders, diagnosed mental illness, impulsive anger, suicidal ideation, and dementia, report access to firearms at levels similar to those in the general population (34–39). Persons with multiple risk factors are a high-priority group, because risk is likely more than additive in such cases (22, 40).

Questions about firearms may be appropriate when the patient is not a firearm owner, given that risk for victimization may extend to all household members if one is at risk for violence and firearms are present. For example, firearm-related questions would be appropriate if a patient's intimate partner exhibited violence and abused alcohol.

## BARRIERS

High proportions of physicians (66% to 84%) believe they have the right to counsel patients about firearms (41) and a responsibility to engage in efforts to prevent firearm-related injuries (42, 43). The American Academy of Pediatrics has long recommended that physicians provide counseling (44); since the passage of the Florida law, many other medical specialty societies have made similar recommendations (45).

Actual practice is another matter. Screening and counseling about firearms is uncommon, whether as anticipatory guidance (46) or a selective intervention (47–49). For example, in a study of veterans who screened positive for suicidal thoughts, only 15% of providers documented whether patients had access to firearms (50).

***Table 2.*** Conditions When Firearm Information Might Be Particularly Relevant to the Health of a Patient and Potentially to Others

| Condition | Examples | How to Respond When Patients Have Firearm Access |
|---|---|---|
| Acute risk for violence to self or others (based on information or behavior) | Suicidal ideation or intent<br>Homicidal ideation or intent | This is an emergency<br>Act promptly to ensure safe storage, in cooperation with patient if possible<br>If necessary, disclose to others who are able to reduce risk (family, caregivers, psychiatric services, law enforcement) |
| Individual-level risk factors for violence to self or others or unintentional firearm injury | History of violence<br>Alcohol or drug abuse<br>Serious mental illness, especially:<br>In combination with substance abuse or violence<br>During acute exacerbations<br>After violent victimization<br>Conditions impairing cognition and judgment | Counsel on safe storage (5 Ls* or similar)<br>Counsel on risk reduction<br>When capacity is diminished, consider disclosure to others who are able to reduce risk |
| Member of demographic group at increased risk for violence to self or others or unintentional firearm injury | Middle-aged and older white men<br>Young African American men<br>Children and adolescents | Counsel on safe storage (5 Ls* or similar)<br>Counsel on risk reduction<br>For minors, involve parents |

* Locked, Loaded, Little children, feeling Low, Learned owner. If the patient indicates that a firearm is in the home, questions on the following topics should be asked: "Is it loaded?" "Is it locked?" "Are there little children present?" "Is the operator feeling low?" "Is the operator learned about firearm safety?" and "Is the operator experiencing any type of cognitive impairment?" (77, 78).

*Table 3.* Materials for Distribution to Patients

| Source | Description | Location |
|---|---|---|
| *JAMA Pediatrics* | Handout focused on children | Moreno MA. JAMA Pediatrics patient page. Keeping children and adolescents safe from firearms. JAMA Pediatr. 2015;169:412. [PMID: 25844989] doi:10.1001/jamapediatrics.2014.2122 |
| University of Michigan Injury Center | Handout focused on children | www.injurycenter.umich.edu/sites/default/files/documents/firearm_safety_flyer_final_6-3-15.pdf |
| New Hampshire Firearm Safety Coalition | Handout focused on suicide | www.theconnectprogram.org/sites/default/files/site-content/firearm_storage_options.pdf |
| King County Department of Public Health | Information and model patient materials on firearm violence prevention and safe storage | http://kingcounty.gov/healthservices/health/injury.aspx |
| American Academy of Pediatrics | A series of handouts focused on children, along with policy statements and a detailed review of the evidence | www.healthychildren.org/English/safety-prevention/all-around/Pages/Where-We-Stand-Gun-Safety.aspx |

Many barriers exist. Perhaps the most important is clinician unfamiliarity with the benefits and risks of firearm ownership, with what to say during firearm safety counseling and how to say it, and with firearms themselves (41, 43, 48, 51–53). It is prudent to avoid areas of practice when one is unfamiliar with the evidence, and in fairness, too little solid evidence exists. These barriers can be addressed through training (54) and through development of information about referral resources (55, 56).

Physicians may worry about damaging the patient relationship (48) by asking questions that seem intrusive or invite discord (57). They may feel uncomfortable asking about firearms, even when they are well-informed (48, 51), or worry that patients will not be truthful (48). Some may believe that firearm counseling is outside their scope of practice (51, 57) or that discussing firearms could infringe on patients' Second Amendment rights (43, 58). Fortunately, studies of patient perspectives on firearm counseling have found that most—although certainly not all—patients seem to be open to nonjudgmental education, especially for members of high-risk groups (48, 57, 59). The American Bar Association has stated that Second Amendment rights are not affected by asking and counseling about firearms (45). Finally, clinicians may doubt the effectiveness of firearm counseling, especially given time limitations and competing clinical priorities (43, 51, 60).

## BENEFITS

Research on practices to prevent firearm-related injury is in its infancy; too few studies have been done. For example, a recent systematic review identified no studies of the accuracy or predictive value of screening for firearm access among high-risk patients (5). Such absence of evidence is common. Except for a few behavioral screens endorsed by the U.S. Preventive Services Task Force (61), there are few clinically based studies of valid screening tools for other frequently encountered risk behaviors. Nonetheless, the Joint Commission has, for example, mandated screening for suicide among high-risk inpatient and emergency department populations (62). Because firearms are the most common means of violent death in the United States, the lack of rigorously validated tools should not, in itself, deter screening.

Many, but not all, studies of clinical interventions to prevent firearm-related injuries have shown increased firearm safety behaviors among populations at high risk for injury. No interventions have resulted in harm (5, 6).

Most studies have assessed interventions in primary care settings. In one randomized, controlled trial, a screening, brief intervention, and referral to treatment (SBIRT) intervention involving specially trained pediatricians led to increased safe firearm storage in households with children (63). Other observational and intervention studies have had positive results, including decreased firearm access among suicidal teens and adults (64, 65) and increased safe firearm storage in households with children (66–69). After brief counseling by a psychiatrist, for example, almost one third of suicidal adolescents' families removed a firearm from the home (68). Because there was no control population, we do not know how many families would have removed a firearm without intervention. Firearm counseling may be less effective when combined with other interventions or delivered universally (70–72).

Hospital- and emergency department–based interventions using SBIRT methods or comprehensive case management have shown promise in reducing the risk for repeated violence (73, 74). A randomized trial of a collaborative care program, including brief interventions, comprehensive case management, and as-needed mental health treatment, showed decreased weapon carrying among adolescents hospitalized after an injury (75). Many studies have relied on surrogate outcomes or had shortcomings in design or execution, such as frequent loss to follow-up. Controlled trials and a systematic review now in progress (74) will hopefully clarify the role of these interventions.

## HOW TO ASK AND COUNSEL

The provider's attitude is critical (76). Patients are more open to firearm safety counseling when providers are not prescriptive but focus on well-being and safety—especially where children are concerned—and involve the family in respectful discussions (48, 57). Conversations should acknowledge local cultural norms (57); be individualized (48); and, when possible, occur within

a well-established clinician–patient relationship (57). Acute care physicians, such as hospitalists and emergency physicians, should intervene when risk is increased or they encounter a teachable moment. We suggest, "Don't just ask, inform"; emphasize education, not just information gathering (48, 57).

Giving a context for firearm-related questions can enhance the interaction. For anticipatory guidance, a firearm-related question can be included in routine screening for household hazards or risk behaviors (57). For selective screening in patients with other risk factors, we recommend that clinicians briefly explain why firearms might be relevant to the patient's well-being and safety.

The first question might simply be, "Are any firearms kept in or around your home?" When the answer is "yes," 2 follow-up questions are important: "Do any of these firearms belong to you personally?" and "Are any of these firearms stored loaded and not locked away?"

What to do with the answers depends on the circumstances (Table 2). Questions and advice about safe storage might make use of the "5 Ls" mnemonic (Locked, Loaded, Little children, feeling Low, Learned owner [77, 78]), accompanied by a nonjudgmental educational handout (Table 3) and information on firearm storage devices (Table 4). The desired outcome is that firearms are stored unloaded and locked, with ammunition stored separately. Safe storage is less common when other risk factors are present.

For patients at risk for violence, counseling to reduce access to lethal means of harm ("lethal means counseling") (69, 79) is indicated; mental health, social service, and substance abuse referrals may be appropriate. It may become important for the patient to temporarily relinquish custody of firearms to family members, gun shops, or law enforcement, as allowed by state law. California's new Gun Violence Restraining Order statute allows family members or law enforcement officers to petition for a court order that firearms be recovered for safekeeping in such cases (80). Connecticut, Indiana, and Texas also allow for mandated firearm recovery. Other states may soon follow.

The advisability of having firearms at home may come up for discussion. Clinicians can point to a large body of evidence establishing that, on balance, firearms in the home (81) and purchasing a handgun (82) are associated with a substantial and long-lasting increased risk for violent death.

## YOU CAN DISCLOSE

The Code of Federal Regulations, in provisions governing the Health Insurance Portability and Ac-

***Table 4.*** Firearm Safe Storage Options*

| Option | Features | Notes |
|---|---|---|
| Retaining possession of firearm | Choice of storage method will likely depend on cost and acceptability | For example, a person who owns a firearm mostly for self-protection may not be interested in a cable or trigger lock (which preclude instant use) but may be open to a rapid-access, PIN-operated bedside lock box |
| Cable lock | Uses key or combination; usable on most firearms<br>Cost: $10–$50 | Must install according to directions (not around trigger); must keep key or combination away from at-risk persons; can be cut |
| Trigger lock | Uses key or combination; blocks trigger but does not prevent loading<br>Cost: $10–$50 | Never use on a loaded gun (could still fire); not usable on lever-action guns; must keep key or combination away from at-risk persons |
| Lock box | Uses key, combination, keypad, or biometrics; smaller than safe<br>Cost: $25–$350 | Firearm can be stored loaded or unloaded; lock box could be stolen; in electronic version, batteries must be replaced; must keep key or combination away from at-risk persons |
| Safe | Uses key, combination, or biometrics<br>Cost: $200–$2500 | Most secure option for multiple guns (especially long guns) |
| Disassembly of gun | Requires gun knowledge but ensures gun cannot be fired | Not always practical; may lose parts; may not be appealing to some patients |
| Personalized "smart" guns | Various technologies proposed; helps ensure that only authorized users can fire gun | Does not protect against misuse by authorized user; cannot be retrofitted |
| Transferring possession to others | | |
| To a family member or friend | State laws vary widely; discuss with your practice's legal advisor or local law enforcement | May be the most feasible option for out-of-home storage (especially if stored with family), if allowed by state law |
| To law enforcement | Allowed in many states; discuss with your practice's legal advisor or local law enforcement | May not be appealing to some patients |
| To a gun range or store | Allowed in many states; discuss with your practice's legal advisor or local law enforcement | Not all stores or ranges store firearms |

PIN = personal identification number.
* Expanded and adapted from materials from Project ChildSafe (www.projectchildsafe.org/safety/safety-resources), Means Matter (www.hsph.harvard.edu/means-matter/lethal-means-counseling), the New Hampshire Firearm Safety Coalition (www.theconnectprogram.org/sites/default/files/site-content/firearm_storage_options.pdf), the Law Center to Prevent Gun Violence (http://smartgunlaws.org/safe-storage-gun-locks-policy-summary), and the National Rifle Association (www.nrafamily.org/articles/2016/4/14/6-ways-to-safely-store-your-firearms).

***Table 5.*** Additional Resources

| Source | Description | Location |
|---|---|---|
| Information for clinicians | | |
| American College of Physicians | Detailed review of the epidemiology and prevention of firearm violence, recommended policy interventions, and actions for clinicians | Butkus R, Doherty R, Daniel H; Health and Public Policy Committee of the American College of Physicians. Reducing firearm-related injuries and deaths in the United States: executive summary of a policy position paper from the American College of Physicians. Ann Intern Med. 2014;160:858-60. [PMID: 24722815] doi:10.7326/M14-0216 |
| Center for Gun Policy and Research, The Johns Hopkins Bloomberg School of Public Health | Comprehensive resource on the epidemiology and prevention of firearm violence | www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-gun-policy-and-research |
| Means Matter, Harvard School of Public Health | Basic information, answers to frequently asked questions, and other resources | www.hsph.harvard.edu/means-matter |
| National Network of Hospital-based Violence Intervention Programs | Information and materials | http://nnhvip.org |
| National Shooting Sports Foundation: Project ChildSafe | Industry-sponsored campaign to promote firearm safety | www.projectchildsafe.org |
| Suicide Prevention Resource Center | Online training for counseling on access to legal means | http://training.sprc.org |
| Recent collections of research and review articles on firearm violence and its prevention | | |
| *Annual Review of Public Health* | Articles on epidemiology, effective interventions, and deterrence | Symposium: Strategies to Prevent Gun Violence. Annual Review of Public Health. 2015;36:1-68. |
| *Preventive Medicine* | Articles on epidemiology, alcohol, defensive gun use, effective policies, and public opinion | Special Issue on the Epidemiology and Prevention of Gun Violence. Prev Med. 2015;79:1-58. |
| *Behavioral Sciences & the Law* | Articles on firearms and mental illness, firearm recovery interventions, and related policies | Special Issue: Guns, Mental Illness and the Law. Behav Sci Law. 2015;33:167-365. |
| *Epidemiologic Reviews* | Articles on clinician attitudes and practices, firearm storage, effective policies, alcohol, substance use, intimate partner violence, and social networks | Special Issue: Gun Violence, Risk, Consequences, and Prevention. Epidemiol Rev. 2016;38:1-157. |
| *RSF: Russell Sage Foundation Journal of the Social Sciences* | Articles on underground gun markets, firearm trafficking, gun carrying, and high-risk firearm retailers | Forthcoming |

countability Act, lists specific situations in which protected health information may be disclosed (83). These include occasions when disclosure "is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and . . . is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat."

The Obama administration has emphasized that disclosure is permissible: "No federal law prevents health care providers from warning law enforcement authorities about threats of violence" (7). A letter from the U.S. Department of Health and Human Services added that "a health care provider may disclose patient information, including information from mental health records, if necessary, to law enforcement, family members of the patient, or any other persons who may reasonably be able to prevent or lessen the risk of harm" (84).

There is no agreed-on definition of the key term "imminent"; in research on violence prediction, it describes time frames ranging from a few days to months (85). Elsewhere in the Code of Federal Regulations, an imminent hazard is defined as one that may cause harm before it can be alleviated by a formal regulatory action.

There is also no clear guidance on informing patients of such disclosures. The American College of Physicians (ACP) Ethics Manual states, "In general, individuals have the right to full and detailed [information]" (86). Timing and other specifics will vary because "upsetting news and information should be presented . . . in a way that minimizes distress." Citing the American Medical Association (AMA) Code of Medical Ethics (87), ACP's manual adds that decisions not to inform patients (once referred to as therapeutic privilege) should be rare. However, the AMA Code stresses that "therapeutic privilege does not refer to withholding medical information in emergency situations" and allows for delayed disclosure even in nonemergency situations (87). As in domestic violence and child abuse cases, providers should proceed from a right-to-know position, determining when and whether a patient is informed on the basis of the provider's assessment of the patient's cognitive status and "the balance of ben-

efits and harms" (87) expected to result from providing the information.

## CONCLUSIONS

Medical specialty societies recommend asking and counseling about firearms during routine patient care or as an element of risk assessment (45). Neither the law nor the Second Amendment prohibits such activities, and the First Amendment may protect them. The limited evidence on effectiveness is encouraging, and the need for additional research should not impede efforts to provide patient care consistent with the best information available (Table 5).

More training and better resource are needed. A systematic review identified only 4 reports on the development and assessment of training for clinicians (88). Input from clinician and nonclinician firearm owners is important (51). Collaborations with firearm retailers to prevent suicide are being tested in New England, the Rocky Mountain states, and Washington and may become important (89).

We recommend that, at a minimum, clinicians determine access to firearms for patients who fall into any of the risk categories discussed previously. Depending on the circumstances, interventions may include education; counseling in support of behavior change; or more direct efforts, such as disclosure to others, to prevent death or serious injury.

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## References

1. **Centers for Disease Control and Prevention.** Injury Prevention & Control: Data & Statistics (WISQARS). Atlanta, GA: Centers for Disease Control and Prevention; 2014. Accessed at www.cdc.gov/injury/wisqars/index.html on 11 April 2016.

2. **Wintemute GJ.** The epidemiology of firearm violence in the twenty-first century United States. Annu Rev Public Health. 2015;36:5-19. [PMID: 25533263] doi:10.1146/annurev-publhealth-031914-122535

3. **Krouse WJ, Richardson DJ.** Mass Murder with Firearms: Incidents and Victims, 1999–2013. Report no. R44126. Washington, DC: Congressional Research Service; 2015.

4. **The Henry J. Kaiser Family Foundation.** Kaiser Health Tracking Poll. Menlo Park, CA: The Henry J. Kaiser Family Foundation; 2013. Accessed at https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8418-t1.pdf on 24 August 2015.

5. **Roszko PJ, Ameli J, Carter PM, Cunningham RM, Ranney ML.** Clinician attitudes, screening practices, and interventions to reduce firearm-related injury. Epidemiol Rev. 2016;38:87-110. [PMID: 26905894] doi:10.1093/epirev/mxv005

6. **Rowhani-Rahbar A, Simonetti JA, Rivara FP.** Effectiveness of interventions to promote safe firearm storage. Epidemiol Rev. 2016;38:111-24. [PMID: 26769724] doi:10.1093/epirev/mxv006

7. **The White House.** Now Is the Time: The President's Plan to Protect Our Children and Our Communities by Reducing Gun Violence. Washington, DC: The White House; 2013. Accessed at www.whitehouse.gov/sites/default/files/docs/wh_now_is_the_time_full.pdf on 21 January 2013.

8. **U.S. Department of Labor.** FAQs about Affordable Care Act Implementation Part XI. Washington, DC: U.S. Department of Labor; 2013. Accessed at www.dol.gov/ebsa/faqs/faq-aca11.html on 1 September 2015.

9. Wollschlaeger et al v. Farmer et al. 880 F Supp 2d 1251 (SD Fla 2012).

10. Wollschlaeger et al v Governor of Florida et al. 760 F3d 1195 (11th Cir 2014).

11. **Weinberger SE, Lawrence HC 3rd, Henley DE, Alden ER, Hoyt DB.** Legislative interference with the patient-physician relationship. N Engl J Med. 2012;367:1557-9. [PMID: 23075183] doi:10.1056/NEJMsb1209858

12. Fla. Stat. Ann. §790.338 (2015).

13. Wollschlaeger et al v Governor of Florida et al: On Petition for Rehearing. 797 F3d 859 (11th Cir 2015).

14. Wollschlaeger et al v Governor of Florida et al: Order for Rehearing. 797 F3d 859 (11th Cir 2016).

15. Mont. Code Ann. §50-16-108 (2014).

16. Mo. Rev. Stat. §571.012 (2015).

17. Minn. Stat. §144.05 (2015).

18. Minn. Stat. §62V.06 (2015).

19. HR 562, Sess 2015 (N.C. 2015).

20. S 177, 131st Sess (Ohio 2015).

21. **Cook PJ, Ludwig J, Braga AA.** Criminal records of homicide offenders. JAMA. 2005;294:598-601. [PMID: 16077054]

22. **Wintemute GJ, Drake CM, Beaumont JJ, Wright MA, Parham CA.** Prior misdemeanor convictions as a risk factor for later violent and firearm-related criminal activity among authorized purchasers of handguns. JAMA. 1998;280:2083-7. [PMID: 9875875]

23. **Rowhani-Rahbar A, Zatzick D, Wang J, Mills BM, Simonetti JA, Fan MD, et al.** Firearm-related hospitalization and risk for subsequent violent injury, death, or crime perpetration: a cohort study. Ann Intern Med. 2015;162:492-500. [PMID: 25706337] doi:10.7326/M14-2362

24. **Cunningham RM, Carter PM, Ranney M, Zimmerman MA, Blow FC, Booth BM, et al.** Violent reinjury and mortality among youth seeking emergency department care for assault-related injury: a 2-year prospective cohort study. JAMA Pediatr. 2015;169:63-70. [PMID: 25365147] doi:10.1001/jamapediatrics.2014.1900

25. **Wintemute GJ.** Association between firearm ownership, firearm-related risk and risk reduction behaviours and alcohol-related risk behaviours. Inj Prev. 2011;17:422-7. [PMID: 21670071] doi:10.1136/ip.2010.031443

26. **Wintemute GJ.** Alcohol misuse, firearm violence perpetration, and public policy in the United States. Prev Med. 2015;79:15-21. [PMID: 25937594] doi:10.1016/j.ypmed.2015.04.015

27. McGinty EE, Choksy S, Wintemute GJ. The relationship between controlled substances and violence. Epidemiol Rev. 2016;38:5-31. [PMID: 26905893] doi:10.1093/epirev/mxv008
28. Pulay AJ, Dawson DA, Hasin DS, Goldstein RB, Ruan WJ, Pickering RP, et al. Violent behavior and DSM-IV psychiatric disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions. J Clin Psychiatry. 2008;69:12-22. [PMID: 18312033]
29. Van Dorn R, Volavka J, Johnson N. Mental disorder and violence: is there a relationship beyond substance use? Soc Psychiatry Psychiatr Epidemiol. 2012;47:487-503. [PMID: 21359532] doi:10.1007/s00127-011-0356-x
30. Swanson JW, McGinty EE, Fazel S, Mays VM. Mental illness and reduction of gun violence and suicide: bringing epidemiologic research to policy. Ann Epidemiol. 2015;25:366-76. [PMID: 24861430] doi:10.1016/j.annepidem.2014.03.004
31. Johnson KL, Desmarais SL, Grimm KJ, Tueller SJ, Swartz MS, Van Dorn RA. Proximal risk factors for short-term community violence among adults with mental illnesses. Psychiatr Serv. 2016: appips201500259. [PMID: 26927580]
32. Liljegren M, Naasan G, Temlett J, Perry DC, Rankin KP, Merrilees J, et al. Criminal behavior in frontotemporal dementia and Alzheimer disease. JAMA Neurol. 2015;72:295-300. [PMID: 25559744] doi:10.1001/jamaneurol.2014.3781
33. Dowd MD, Sege RD; Council on Injury, Violence, and Poison Prevention Executive Committee. Firearm-related injuries affecting the pediatric population. Pediatrics. 2012;130:e1416-23. [PMID: 23080412] doi:10.1542/peds.2012-2481
34. Swanson JW, Sampson NA, Petukhova MV, Zaslavsky AM, Appelbaum PS, Swartz MS, et al. Guns, impulsive angry behavior, and mental disorders: results from the National Comorbidity Survey Replication (NCS-R). Behav Sci Law. 2015;33:199-212. [PMID: 25850688] doi:10.1002/bsl.2172
35. Ilgen MA, Zivin K, McCammon RJ, Valenstein M. Mental illness, previous suicidality, and access to guns in the United States. Psychiatr Serv. 2008;59:198-200. [PMID: 18245165] doi:10.1176/appi.ps.59.2.198
36. Miller M, Barber C, Azrael D, Hemenway D, Molnar BE. Recent psychopathology, suicidal thoughts and suicide attempts in households with and without firearms: findings from the National Comorbidity Study Replication. Inj Prev. 2009;15:183-7. [PMID: 19494098] doi:10.1136/ip.2008.021352
37. Sorenson SB, Vittes KA. Mental health and firearms in community-based surveys: implications for suicide prevention. Eval Rev. 2008;32:239-56. [PMID: 18456876] doi:10.1177/0193841X08315871
38. Hsieh JK, Arias JJ, Sarmey N, Rose JA, Tousi B. Firearms among cognitively impaired persons: a cross-sectional study [Letter]. Ann Intern Med. 2015;163:485-7. [PMID: 26370021] doi:10.7326/L15-5138
39. Spangenberg KB, Wagner MT, Hendrix S, Bachman DL. Firearm presence in households of patients with Alzheimer's disease and related dementias. J Am Geriatr Soc. 1999;47:1183-6. [PMID: 10522950]
40. Elbogen EB, Johnson SC. The intricate link between violence and mental disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions. Arch Gen Psychiatry. 2009;66:152-61. [PMID: 19188537] doi:10.1001/archgenpsychiatry.2008.537
41. Butkus R, Weissman A. Internists' attitudes toward prevention of firearm injury. Ann Intern Med. 2014;160:821-7. [PMID: 24722784] doi:10.7326/M13-1960
42. Cassel CK, Nelson EA, Smith TW, Schwab CW, Barlow B, Gary NE. Internists' and surgeons' attitudes toward guns and firearm injury prevention. Ann Intern Med. 1998;128:224-30. [PMID: 9454531] doi:10.7326/0003-4819-128-3-199802010-00009
43. Price JH, Thompson A, Khubchandani J, Wiblishauser M, Dowling J, Teeple K. Perceived roles of emergency department physicians regarding anticipatory guidance on firearm safety. J Emerg Med. 2013;44:1007-16. [PMID: 23352862] doi:10.1016/j.jemermed.2012.11.010
44. Dowd MD, Sege RD; Council on Injury, Violence, and Poison Prevention Executive Committee. Firearm-related injuries affecting the pediatric population. Pediatrics. 2012;130:e1416-23. [PMID: 23080412] doi:10.1542/peds.2012-2481
45. Weinberger SE, Hoyt DB, Lawrence HC 3rd, Levin S, Henley DE, Alden ER, 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. Ann Intern Med. 2015;162:513-6. [PMID: 25706470] doi:10.7326/M15-0337
46. Price JH, Kinnison A, Dake JA, Thompson AJ, Price JA. Psychiatrists' practices and perceptions regarding anticipatory guidance on firearms. Am J Prev Med. 2007;33:370-3. [PMID: 17950401]
47. Betz ME, Miller M, Barber C, Miller I, Sullivan AF, Camargo CA Jr, et al; ED-SAFE Investigators. Lethal means restriction for suicide prevention: beliefs and behaviors of emergency department providers. Depress Anxiety. 2013;30:1013-20. [PMID: 23495002] doi:10.1002/da.22075
48. Walters H, Kulkarni M, Forman J, Roeder K, Travis J, Valenstein M. Feasibility and acceptability of interventions to delay gun access in VA mental health settings. Gen Hosp Psychiatry. 2012;34:692-8. [PMID: 22959420] doi:10.1016/j.genhosppsych.2012.07.012
49. Betz ME, Miller M, Barber C, Beaty B, Miller I, Camargo CA Jr, et al. Lethal means access and assessment among suicidal emergency department patients. Depress Anxiety. 2016. [PMID: 26989850] doi:10.1002/da.22486
50. Dobscha SK, Denneson LM, Kovas AE, Corson K, Helmer DA, Bair MJ. Primary care clinician responses to positive suicidal ideation risk assessments in veterans of Iraq and Afghanistan. Gen Hosp Psychiatry. 2014;36:310-7. [PMID: 24650585] doi:10.1016/j.genhosppsych.2013.11.007
51. Slovak K, Brewer TW, Carlson K. Client firearm assessment and safety counseling: the role of social workers. Soc Work. 2008;53:358-66. [PMID: 18853672]
52. Pierson J, Viera AJ, Barnhouse KK, Tulsky JA, Richman BD, Goldstein AO. Physician attitudes and experience with permit applications for concealed weapons [Letter]. N Engl J Med. 2014;370:2453-4. [PMID: 24941197] doi:10.1056/NEJMc1401815
53. Traylor A, Price JH, Telljohann SK, King K, Thompson A. Clinical psychologists' firearm risk management perceptions and practices. J Community Health. 2010;35:60-7. [PMID: 20094905] doi:10.1007/s10900-009-9200-6
54. Slovak K, Brewer TW. Suicide and firearm means restriction: can training make a difference? Suicide Life Threat Behav. 2010;40:63-73. [PMID: 20170262] doi:10.1521/suli.2010.40.1.63
55. Betz ME, Wintemute GJ. Physician counseling on firearm safety: a new kind of cultural competence. JAMA. 2015;314:449-50. [PMID: 26241594] doi:10.1001/jama.2015.7055
56. McGee KS, Coyne-Beasley T, Johnson RM. Review of evaluations of educational approaches to promote safe storage of firearms. Inj Prev. 2003;9:108-11. [PMID: 12810734]
57. Sege RD, Hatmaker-Flanigan E, De Vos E, Levin-Goodman R, Spivak H. Anticipatory guidance and violence prevention: results from family and pediatrician focus groups. Pediatrics. 2006;117:455-63. [PMID: 16452366]
58. Paola FA. Firearm injury prevention [Letter]. Ann Intern Med. 1998;129:336-7. [PMID: 9729194] doi:10.7326/0003-4819-129-4-199808150-00020
59. Betz ME, Flaten HK, Miller M. Older adult openness to physician questioning about firearms [Letter]. J Am Geriatr Soc. 2015;63:2214-5. [PMID: 26480997] doi:10.1111/jgs.13695
60. Everett SA, Price JH, Bedell AW, Telljohann SK. Family practice physicians' firearm safety counseling beliefs and behaviors. J Community Health. 1997;22:313-24. [PMID: 9353680]
61. U.S. Preventive Services Task Force. Guide to Clinical Preventive Services, 2014. Recommendations of the U.S. Preventive Services Task Force. Rockville, MD: Agency for Healthcare Research and Quality; 2014. Accessed at www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/index.html on 12 April 2016.

62. **The Joint Commission.** National Patient Safety Goals Effective January 1, 2015. Oakbrook Terrace, IL: The Joint Commission; 2014. Accessed at www.jointcommission.org/assets/1/6/2015_NPSG_HAP.pdf on 12 April 2016.

63. **Barkin SL, Finch SA, Ip EH, Scheindlin B, Craig JA, Steffes J, et al.** Is office-based counseling about media use, timeouts, and firearm storage effective? Results from a cluster-randomized, controlled trial. Pediatrics. 2008;122:e15-25. [PMID: 18595960] doi:10.1542/peds.2007-2611

64. **Kruesi MJ, Grossman J, Pennington JM, Woodward PJ, Duda D, Hirsch JG.** Suicide and violence prevention: parent education in the emergency department. J Am Acad Child Adolesc Psychiatry. 1999; 38:250-5. [PMID: 10087685]

65. **Sherman ME, Burns K, Ignelzi J, Raia J, Lofton V, Toland D, et al.** Firearms risk management in psychiatric care. Psychiatr Serv. 2001; 52:1057-61. [PMID: 11474051]

66. **Albright TL, Burge SK.** Improving firearm storage habits: impact of brief office counseling by family physicians. J Am Board Fam Pract. 2003;16:40-6. [PMID: 12583649]

67. **Carbone PS, Clemens CJ, Ball TM.** Effectiveness of gun-safety counseling and a gun lock giveaway in a Hispanic community. Arch Pediatr Adolesc Med. 2005;159:1049-54. [PMID: 16275796]

68. **Brent DA, Baugher M, Birmaher B, Kolko DJ, Bridge J.** Compliance with recommendations to remove firearms in families participating in a clinical trial for adolescent depression. J Am Acad Child Adolesc Psychiatry. 2000;39:1220-6. [PMID: 11026174]

69. **Runyan CW, Becker A, Brandspigel S, Barber C, Trudeau A, Novins D.** Lethal means counseling for parents of youth seeking emergency care for suicidality. West J Emerg Med. 2016;17:8-14. [PMID: 26823923] doi:10.5811/westjem.2015.11.28590

70. **Stevens MM, Olson AL, Gaffney CA, Tosteson TD, Mott LA, Starr P.** A pediatric, practice-based, randomized trial of drinking and smoking prevention and bicycle helmet, gun, and seatbelt safety promotion. Pediatrics. 2002;109:490-7. [PMID: 11875146]

71. **Johnston BD, Rivara FP, Droesch RM, Dunn C, Copass MK.** Behavior change counseling in the emergency department to reduce injury risk: a randomized, controlled trial. Pediatrics. 2002;110:267-74. [PMID: 12165577]

72. **Grossman DC, Cummings P, Koepsell TD, Marshall J, D'Ambrosio L, Thompson RS, et al.** Firearm safety counseling in primary care pediatrics: a randomized, controlled trial. Pediatrics. 2000; 106:22-6. [PMID: 10878144]

73. **Purtle J, Dicker R, Cooper C, Corbin T, Greene MB, Marks A, et al.** Hospital-based violence intervention programs save lives and money. J Trauma Acute Care Surg. 2013;75:331-3. [PMID: 23887566] doi:10.1097/TA.0b013e318294f518

74. **Purtle J, Rich JA, Fein JA, James T, Corbin TJ.** Hospital-based violence prevention: progress and opportunities. Ann Intern Med. 2015;163:715-7. [PMID: 26301734] doi:10.7326/M15-0586

75. **Zatzick D, Russo J, Lord SP, Varley C, Wang J, Berliner L, et al.** Collaborative care intervention targeting violence risk behaviors, substance use, and posttraumatic stress and depressive symptoms in injured adolescents: a randomized clinical trial. JAMA Pediatr. 2014; 168:532-9. [PMID: 24733515] doi:10.1001/jamapediatrics.2013.4784

76. **Shaughnessy AF, Cincotta JA, Adelman A.** Family practice patients' attitudes toward firearm safety as a preventive medicine issue: a HARNET Study. Harrisburg Area Research Network. J Am Board Fam Pract. 1999;12:354-9. [PMID: 10534083]

77. **Pinholt EM, Mitchell JD, Butler JH, Kumar H.** "Is there a gun in the home?" Assessing the risks of gun ownership in older adults. J Am Geriatr Soc. 2014;62:1142-6. [PMID: 24898055] doi:10.1111/jgs.12836

78. **Lum HD, Flaten HK, Betz ME.** Gun access and safety practices among older adults. Curr Gerontol Geriatr Res. 2016;2016:2980416. [PMID: 26949391] doi:10.1155/2016/2980416

79. **Yip PS, Caine E, Yousuf S, Chang SS, Wu KC, Chen YY.** Means restriction for suicide prevention. Lancet. 2012;379:2393-9. [PMID: 22726520] doi:10.1016/S0140-6736(12)60521-2

80. Cal. Penal Code §18100 (2014).

81. **Anglemyer A, Horvath T, Rutherford G.** The accessibility of firearms and risk for suicide and homicide victimization among household members: a systematic review and meta-analysis. Ann Intern Med. 2014;160:101-10. [PMID: 24592495] doi:10.7326/M13-1301

82. **Wintemute GJ, Parham CA, Beaumont JJ, Wright M, Drake C.** Mortality among recent purchasers of handguns. N Engl J Med. 1999;341:1583-9. [PMID: 10564689]

83. 45 C.F.R. §164.512 (1996).

84. **Rodriguez L.** Letter to U.S. Health Care Providers on HIPAA Privacy Rule. 15 July 2013.

85. **Simon RI.** The myth of "imminent" violence in psychiatry and the law. Univ Cincinnati Law Rev. 2006;75:631-44.

86. **Snyder L; American College of Physicians Ethics, Professionalism, and Human Rights Committee.** American College of Physicians Ethics Manual: sixth edition. Ann Intern Med. 2012;156:73-104. [PMID: 22213573] doi:10.7326/0003-4819-156-1-201201031-00001

87. **American Medical Association.** Opinion 8.082 - Withholding Information from Patients. AMA Code of Medical Ethics. Chicago: American Medical Association; 2006. Accessed at www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8082.page on 12 February 2016.

88. **Puttagunta R, Coverdale TR, Coverdale J.** What is taught on firearm safety in undergraduate, graduate, and continuing medical education? A review of educational programs. Acad Psychiatry. 2016. [PMID: 26911492]

89. **Vriniotis M, Barber C, Frank E, Demicco R; New Hampshire Firearm Safety Coalition.** A suicide prevention campaign for firearm dealers in New Hampshire. Suicide Life Threat Behav. 2015;45:157-63. [PMID: 25348506] doi:10.1111/sltb.12123

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