The "Rules of the Road": Ethics, Firearms, and the Physician's "Lane"

Blake N. Shultz, Benjamin Tolchin, and Katherine L. Kraschel

Physicians play a critical role in preventing and treating firearm injury. From 2009-2014, there were an average of 74,319 annual encounters for firearm injury in US emergency departments (EDs) alone.[1] In 2017, firearms caused 39,773 deaths in the US – more than HIV, hypertension, automobiles, or alcohol.[2] A growing body of evidence strongly associates gun ownership with an increased risk of suicide.[3] As one emergency physician noted, "[gun violence] is an integral part of every residency program, and almost every hospital across the country sees victims of gun violence. It … affects [providers], both in terms of the number of resources that are needed to respond to [it] and in terms of the emotional aftermath."[4] Despite this undisputed treatment role, preventative clinical interventions and physician advocacy aimed at addressing firearm injury as a public health issue has been met with intense opposition from the National Rifle Association (NRA) and other firearm industry supporters. Although physicians regularly engage in advocacy to address public health matters — such as automobile and consumer products safety — when advocacy is related to guns, we are told by the NRA that "self-important anti-gun doctors [should] stay in their lane."[5]

Firearm violence, like other common causes of morbidity and mortality, is precisely within physicians' "lane." As long as guns are available, clinicians must address the injuries they create. The more relevant question is how broadly physicians' "lane" should be defined, and what rules of the road should guide their role in it. As clinicians have long acknowledged, "health is determined by a wide variety of influences beyond biology, including … social, … political, legal [and] cultural factors."[6] Because physicians have professional, ethical, and legal obligations to care for their patients' health, restricting their obligations to medical treatment of firearm injuries alone would be a "long-term waste of resources and lives" and represent less-than-adequate care.[7] Some legal frameworks guiding physicians' clinical engagement with firearm violence in are explored elsewhere in this volume.[8] This article focuses on how the obligations of medical ethics in particular should guide physician involvement in firearm violence. We argue, by unpacking fundamental principles of medical ethics, that physicians *ought* to engage in clinical screening and treatment and *may* engage in public advocacy to address gun violence.

Principles of Medical Ethics and the Patient-Physician Relationship

Physicians' ethical obligations to their patients arise from the agency they exercise when entrusted to utilize their expertise to assess the risks and benefits of treatment and/or act as medical decisionmakers on behalf of their patients.[9] Their agency relationship with patients creates ethical obligations grounded on three of four widely accepted ethical principles of mod-

Blake N. Shultz *is a sixth-year medical student at Yale School of Medicine and a third-year law student at Yale Law School in New Haven, CT. He is also a fellow at the Solomon Center for Health Law and Policy at Yale Law School. He received his B.A. from Cornell University (2015) in Ithaca, NY.* **Benjamin Tolchin, M.D., M.S.,** *is an Assistant Professor of Neurology at Yale School of Medicine and an Attending Physician at Yale New Haven Hospital and at the West Haven VA Medical Center.* **Katherine L. Kraschel, J.D.,** *is the Executive Director of the Solomon Center for Health Law and Policy as well as a Lecturer in Law, Clinical Lecturer in Law, and Research Scholar in Law at Yale Law School. She received her J.D. from Harvard Law School, and her B.A. from Mount Holyoke College.*

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ern medical ethics — patient autonomy, beneficence, and nonmaleficence.[10] Patient autonomy is the cornerstone of informed consent doctrines, while beneficence requires clinicians to promote their patients' welfare and health and nonmaleficence requires clinicians to avoid any harm to their patients. Balancing respect for patients' autonomy with concern for their welfare underlies a great deal of modern medical ethical discourse. Decisions about the ownership and use of firearms are one area where a patient's autonomous decisions might conflict with their medical wellbeing. Striking the right balance generally favors voluntary over coercive interventions in such situations.

The principle of beneficence applies most strongly to relations between physicians and their patients — what Beauchamps and Childress refer to as "obligations of specific beneficence."[11] But the principle of beneficence also applies more generally but more weakly to relations between physicians and all members of society. General beneficence does not generate *obligations* but rather *nonobligatory* moral ideals. Promoting the health and welfare of other members of society is praiseworthy, even if it is not required. Such ideals are secondary to and less binding than physicians' obligations to their patients, but are important nonetheless.

A fourth foundational ethical principle — justice — requires that clinicians attempt to ensure that the benefits and burdens of healthcare are distributed fairly.

Ethical Engagement in Firearm Injury

The requirements to minimize patients' risks of harm and promote patients' welfare impels physician interventions that minimize the risks and mitigate harms caused by firearms. Respect for patients' self-determination dictates that such clinical interventions should be voluntary whenever possible and include interventions such as patient counseling and education. Coercive measures may be justified when severe harms such as loss of life are foreseeable and when voluntary interventions are likely to be ineffective. Finally, as discussed above, the principle of beneficence encourages physicians to engage in public education or political advocacy to reduce firearm injuries, though it does not create an obligation to do so.

Clinical Interventions

Respect for autonomy counsels that non-coercive clinical interventions should be the obligatory first-line approach to address firearm injury in appropriate patients. Of these, educating and counseling patients regarding risk of harm and risk mitigation strategies — known as "anticipatory guidance" — is a regular component of clinical practice that is applicable to firearms.[12] Patient education and counseling are widely used by physicians to mitigate risks to their patients presented by drugs, alcohol, tobacco, unhealthy foods, a sedentary lifestyle, motor vehicles, and many other risk factors.[13] Clinicians are obliged to inform patients of relevant risk factors and mitigation strategies in order for them to make informed decisions about their health, including information regarding firearm risks. The American Medical Association's Code of Medical Ethics instructs that physicians should, consistent with their professional commitment, "[e]ducate patients about modifiable risk factors."[14] For example, studies have shown that parents are likely to voluntarily remove guns from the home when educated by a physician about the increased risk for suicidal children.[15] Counseling must be grounded in rigorous scientific data, individually tailored, and presented without judgment and with cultural sensitivity. The focus of education should be on well-being and safety and should involve family-members whenever possible.

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The paucity of appropriate data regarding firearm ownership, injury risk, and risk mitigation strategies represents a significant barrier to presenting evidence-based recommendations to patients.[16] Other perceived barriers are less substantial. Although physicians have a First Amendment right to discuss gun ownership and injury risk with patients, many physicians incorrectly believe such discussions are against the law.[17] Many physicians fear that these discussions conducted to promote the welfare and autonomy of their patients could be interpreted as a criticism of gun ownership and might therefore violate Second

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Amendment prohibitions on the infringement of the right to bear arms. In part because of this misconception, physicians counsel patients about firearm injury infrequently — in just 15% of encounters with veterans screening positive for suicidal thoughts, for example.[18] The ethical principles of beneficence and nonmaleficence suggest that education should occur far more frequently. Studies find that the majority of the general public believe that conversations about gun safety with physicians are sometimes or usually appropriate.[19]

When voluntary measures are insufficient to avert foreseeable severe harm for high-risk patients, coercive measures are generally ethically mandated and may be legally required in certain situations. Outside of the firearm injury context, physicians can and do trigger a number of measures that severely restrict individual autonomy, albeit with extreme care and selectivity. For example, in the case of acute suicidality when patients represent a risk of harm to themselves or others, physicians may involuntarily commit a patient for inpatient treatment and monitoring. The risk of future harm must be real and substantial, and nearly all state laws reflect this requirement — some include *ex ante* due process protections.[20] In other cases, physicians are required to play a role in restricting access to drivers' licenses for patients with Alzheimer's disease and seizure disorders, and in accessing worker's compensation benefits.[21] In many states, certain physicians are also statutorily required under "duty to protect" (or warn) statutes to notify third parties of real and imminent threats made by patients.[22]

State and federal laws often include a significant degree of discretion allowing physicians' ethical obligations and professional judgment to dictate a course of action.[23] When approaching a coercive measure, the principle of autonomy dictates that physicians should be informed and guided by a "soft" approach to paternalism, through which the physician attempts to maximize individual autonomy during periods of crisis.[24] This may include, for example, seeking assent (in the case of an incompetent patient) or verbal consent whenever possible.

Physicians should not see themselves as "gatekeepers" controlling access to firearms. For example, extreme risk protection orders are merely *triggered* by physicians — the ultimate determination of fitness to own a firearm is determined by law enforcement and the court system. Physician gatekeeping presents significant concerns for physicians and patients alike. First, it may undermine the foundational trust between physician and patient. Firearm owners may decline to report risk factors or may be deterred from seeking care due to concerns that their weapon may be removed from them without due process. Second, there is no scientifically validated test for fitness to own a firearm.[25] As with non-coercive clinical interventions, physicians are ethically obligated to trigger coercive measures with appropriate patients, when consistent with the law and professional judgment.

Community and Political Advocacy

Physicians' primary obligations remain to individual patients and clinical practice due to their direct agency relationship. However, the principle of beneficence grants physicians license, as part of their professional duties, to engage in public education and political advocacy related to firearm violence. Physicians have long engaged in political conversations related to public health matters, including those surrounding tobacco use, drugs, motor vehicle accidents, and accidental poisoning.[26] In recognition of this long history, the AMA's Code of Medical Ethics includes a provision declaring that "physicians have an ethical responsibility to seek change when they believe the requirements of law or policy are contrary to the best interests of patients."[27]

Framed in this way, public advocacy can be seen as a more general extension of the duties based on beneficence which clinicians have to individual patients as applied to the public writ large. As such, the same guiding principles ought to inform their engagement. When such advocacy is related to medical matters, it should again be supported by rigorous evidence. Advocacy should not be "anti-gun," but rather should focus on risk factors and strategies for mitigating them — mirroring conversations in the clinical setting.

This approach should be distinguished from a second form of advocacy, related to issues affecting the profession itself, which may also be ethically sound. Physicians, like any other profession, should not be prohibited from advocating against policies that negatively impact their ability to perform their job (i.e., caring for patients). One example of this is advocating against "gag laws," or laws circumscribing or dictating the conversations physicians may have with their patients related to firearms. Yet another example is advocating against restrictions on studying firearm violence, for an increase in funding for such research, and for increased training on firearm injury in education programs.

Conclusion

The notion that firearm injury is somehow separate and distinct from other public health matters — and is therefore outside the bounds of physician scope of practice — disregards the reality of clinical practice. Physicians confront gun violence as a daily occurrence;

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it is an integral part of many residency programs, accounts for tens of thousands of emergency department visits per year,[28] and 39,000 annual deaths.[29] Therefore, the correct question is not whether physicians' "lanes" encompass firearm injury, but rather what the scope of those "lanes" should be.

The principles of modern medical ethics require physicians to undertake clinical interventions to reduce risks and mitigate harms caused by firearms to their patients. Voluntary measures such as education and counseling are appropriate first-line interventions for most patients. Coercive clinical interventions may be appropriate for certain high-risk patients, but must be conducted so as to preserve individual autonomy and trust whenever possible. Interventions should be supported by professional expertise and scientific evidence. Finally, public education and political advocacy are ethically permissible and indeed praiseworthy as acts of general beneficence.

Note

The authors do not have any conflicts of interest to disclose.

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