Marshall Kapp

FIREARMS, PHYSICIANS AND OLDER PATIENTS

A lot of attention has been devoted in recent years to the safety of children who live in homes with guns. The role of physicians regarding child safety at home (and elsewhere) has received substantial, and sometimes controversial, scrutiny.

However, the presence of firearms in the home may create lethal dangers to older people as well. Research has documented that many older people, including some with significant cognitive or emotional impairments, have easy access to unlocked firearms and ammunition and are relatively more at risk than children for suffering either accidental or intentional gunshot wounds. Effective physician engagement in this geriatric context is not only proper but arguably imperative.

Under the ethical principles of beneficence (doing good for others) and nonmaleficence (preventing harm), which help to define the trust nature of the physician/patient relationship, physicians owe a responsibility to their older patients to assess both whether firearms are present and accessible in the home environment and the effect of a patient's physical and mental status on the risk of injury by those firearms. The physician's ethical responsibility dovetails with a legal right to engage in firearms-related inquiries. Neither federal law (including the Second Amendment of the U.S. Constitution's provisions on the right to bear arms) nor state statute or regulation forbids such questioning, and the physician's freedom of speech under the First Amendment affirmatively protects the right to inquire.

Further, the physician's right to ask about firearms in the home of an elder might reasonably be construed as a positive, legally enforceable duty. It will eventually become broadly recognized – by medical expert witnesses and juries deciding malpractice lawsuits and by medical specialty organizations that develop and publish relevant clinical practice guidelines – that prudent physicians make firearms-related inquiries of their older patients or the patients' family members as part of routine practice. Once that recognition and that endorsement come about, a physician who neglects to ask about firearms availability in the home during the physician/patient encounter will be exposed to liability if injury occurs and can be causally linked to the physician's neglect in this respect. Put differently, routine physician inquiries about firearms in the home are likely to become a basic part of the medical-legal standard of care owed to older patients at risk.

Once the physician has assessed the firearms situation in the older person's home, as well as the risks posed in light of the patient's health and social environment, the physician may contribute proactively to patient safety by recommending various preventive measures, such as removing or unloading the firearms, using trigger locks, storing weapons in a locked cabinet separate from the ammunition, or ensuring that responsible supervision occurs when the firearms are available. In extreme cases, the physician may be legally obligated to report reasonably foreseeable dangers to Adult Protective Services under the authority and immunity of state elder abuse and neglect laws.

Physicians ought to be central actors in the context of firearms and older patients. They must appreciate that the law not only permits them to carry out this therapeutic and ethical function appropriately but actually supports and may indeed require physicians' valuable efforts to safeguard the well-being of older patients.

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