

Geriatric Patients, Firearms, and Physicians

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Increasing public attention has been devoted in the past several years to gun-related injuries. Some of the concern has centered on the safety of individuals, especially and understandably on children, who live in homes with guns. The proper role of physicians in contributing to child safety at home (and elsewhere) is an important, albeit controversial, topic (1). However, gun safety is also a major issue in homes in which geriatric individuals reside.

The presence of firearms in the home may pose lethal dangers to elderly persons, although at present the evidence base regarding this broad topic is poorly developed. Many geriatric persons may have firearms available to them in their homes. Even individuals with memory impairment often have access to firearms, most of which are unlocked and with readily available ammunition (2). Geriatric persons are more likely than younger people to suffer self-inflicted (either accidental or intentional) gunshot wounds, especially to the head. Use of firearms has become the most common suicide method for both geriatric men and women. To safeguard these persons as well as the rest of the population, a public health approach to preventing gun violence, with physician engagement as a central element, is essential (3).

Physicians have a legal right to engage in firearm-related inquiries. Although the issue of physicians asking patients or family members about the presence of firearms in the home has generated some heated discussion, no federal law (including the Patient Protection and Affordable Care Act) (4) or state statute or regulation forbids such questioning. Moreover, such a legal provision would probably be invalidated by the courts as a violation of the physician's right to freedom of speech as guaranteed under the First Amendment (5). Even the 2012 Florida statute that some critics characterized as a "Docs vs. Glocks" confrontation expressly provides that a physician (with no restriction regarding medical specialty) who believes that information about firearm ownership or presence in the home is relevant to the safety of the patient or others may inquire accordingly (6). In practice, that exception would virtually always justify physician inquiry.

Some physicians may be deterred by a concern about patient autonomy. "[I]ssues of safety must be balanced against the rights and freedoms of the individual and the possibility of discrimination against older people should be considered" (7), especially when the Second Amendment is involved. However, deferring to a patient's autonomous choices only makes sense when that patient is capable of making decisions, and some geriatric patients with unsecured firearms in the home are not autonomous decision makers. In addition, although the Supreme Court has

ruled that government may not outright ban private possession of firearms in an individual's own home, reasonable regulation of such possession is permissible (8).

Once information about the presence of firearms in a patient's home has been documented, the physician should explore the possible effect of the patient's physical and mental situation on the risk for gun-related injury. That risk may be substantially increased by a number of conditions that disproportionately affect the geriatric patient population, including dementia, delusions and memory disorders, depression, and visual and hearing impairments.

The physician's evaluation of an elderly person's firearm-related health risks might lead to action in the form of anticipatory intervention (9). When geriatric patients have cognitive or emotional deficits, complemented by deteriorating behavioral symptoms, to the extent that they pose a reasonably foreseeable risk for harm to themselves or others if armed, the primary care physician should consider recommending to family members (or their functional equivalents) that the firearm either be removed from the patient's home or unloaded and stored under lock and key (9). Interactions that most physicians already engage in with family members of impaired geriatric patients regarding restricting or eliminating driving or cooking might serve in many instances as a useful template for firearm-related conversations (9).

When the reasonably foreseeable risks are substantial and the family is uncooperative, the danger may be categorized as a form of adult abuse or neglect. In every state, physicians have either a mandatory or permissive responsibility to report suspected danger to the local Adult Protective Services agency for investigation and, where appropriate, intervention. Physicians may fear that confidentiality laws bar reports of suspected risks to an agency without the patient's permission, but good faith reporting of suspected abuse or neglect constitutes an exception to the usual confidentiality restrictions.

Moreover, the physician's right to engage in firearm-related inquiries could actually be characterized as a legally enforceable obligation. Once it is broadly recognized by medical expert witnesses and juries that prudent, reasonable physicians would make such inquiries of their patients or patients' family as part of routine practice (2), a primary care physician who does not ask about firearms may be held liable for deviation from the legally acceptable standard of care if injury results. The idea of routine physician inquiries as part of the standard of care will be strengthened as professional organizations and other respected entities create and disseminate applicable clinical practice guidelines, presumably on the basis of a developing evi-

dence base that establishes the value of physician screening and intervention. Physicians who alter their behavior to comply with this evolving evidence-based standard of care will be practicing a form of positive defensive medicine.

As stated by Greene and colleagues,

Healthcare providers . . . have a . . . direct role to play in educating patients and their families about the risks of firearm availability. After determining that an older adult has access to a firearm, the provider who suspects some cognitive impairment should initiate evaluation of the client and develop a plan for working with family members to confront, supervise, or exhort the older adult to relinquish access to a firearm (10).

Physicians must be educated to appreciate that the law not only does not interfere with their fulfillment of this important therapeutic and ethical role, but that it actually supports and indeed mandates diligent effort in this complex realm of personal and public health.

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