Reducing Firearm-Related Injuries and Deaths in the United States: Executive Summary of a Policy Position Paper From the American College of Physicians

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In 1995, the American College of Physicians (ACP) issued its first statement that raised concern about the epidemic of firearm violence in the United States and advocated for policies to reduce the rate of firearm injuries and deaths (1). Nineteen years later, although rates of firearm-related death, injury, and disability have decreased, firearm-related mortality rates in the United States remain the highest among industrialized countries (2).

The mass shooting that occurred in December 2012 at Sandy Hook Elementary School in Newtown, Connecticut, which left 6 adults and 20 children dead, and other mass shootings have brought firearm violence to the forefront of national discussion. It is critical that strategies are developed to prevent massacres like those that occurred in Newtown; in Tucson, Arizona; at Virginia Tech University; in Aurora, Colorado; at Columbine High School; and at the Washington Navy Yard. Yet, the ACP is equally concerned about the deaths and injuries that affect our nation on a daily basis when persons are injured or killed or commit suicide with firearms. Each year, firearms kill more than 32,000 persons in the United States, or approximately 88 per day (3). These deaths include homicides, suicides, and unintentional fatalities. Firearm injury is the second leading cause of death due to injury after motor vehicle crashes (4). Homicide and suicide by firearms result in 11,000 and 19,000 deaths, respectively, each year (5). The number of nonfatal firearm injuries in the United States is more than twice the number of fatal firearm injuries, with 73,883 nonfatal firearm injuries documented in 2011 (6). The ACP believes that immediate action is necessary to reduce these unnecessary injuries and deaths.

Firearm violence is not only a criminal justice issue but also a public health threat. A comprehensive, multifaceted approach is necessary to reduce the burden of firearm-related injuries and deaths on individuals, families, communities, and society in general. Strategies to reduce firearm violence will need to address culture, substance use and mental health, firearm safety, and reasonable regulation, consistent with the Second Amendment, to keep firearms out of the hands of persons who intend to use them to harm themselves and others, as well as measures to reduce mass casualties associated with certain types of firearms.

As an organization representing physicians who have firsthand experience with the devastating impact firearm-related injuries and deaths have on the health of their patients, the ACP has a responsibility to participate in efforts to mitigate these needless tragedies. Because patients trust their physicians to advise them on issues that affect their health, physicians can help to educate the public on the risks of firearms and the need for firearm safety through their encounters with their patients. This Executive Summary provides a synopsis of the full position paper, which is available in Appendix 1 (available at www.annals.org).

METHODS

The ACP’s Health and Public Policy Committee, which is charged with addressing issues affecting the health care of the U.S. public and the practice of internal medicine and its subspecialties, developed these recommendations. The committee reviewed available data on the impact of access to firearms on health-related outcomes, the association of mental health conditions and firearm violence, state and federal firearm laws, and the effect of efforts to reduce firearm violence. The ACP also surveyed its members on their attitudes on firearms and firearm injury prevention (7). Draft recommendations were reviewed by ACP’s Board of Governors, Board of Regents, Council of Early Career Physicians, Council of Resident/Fellow Members, Council of Student Members, and Council of Subspecialty Societies, as well as non–ACP members with expertise in mental health and firearm safety. The policy paper and related recommendations were reviewed by the ACP Board of Regents and approved on 7 April 2014.

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Appendix 1: Full Position Paper

This article was published online first at www.annals.org on 10 April 2014.
* This paper, written by Renee Butkus, BA; Robert Doherty, BA; and Hilary Daniel, BS, was developed for the Health and Public Policy Committee of the American College of Physicians. Individuals who served on the Health and Public Policy Committee at the time of the project’s approval were Thomas Tape, MD (Chair); Jacqueline W. Fincher, MD (Vice Chair); Vineet Arora, MD; Ankit Bhatia; James F. Buah, MD; Douglas M. DeLong, MD; Susan Glennon, MD; Gregory A. Hooe, MD; Mary Newman, MD; Kenneth E. Olive, MD; Shakaib U. Rehman, MD; Zoe Tseng; and Jeffrey G. Wiese, MD. Approved by the ACP Board of Regents on 7 April 2014.
ACP POSITION STATEMENTS AND RECOMMENDATIONS

The following statements represent the official policy positions and recommendations of the ACP. The rationale for each is provided in the full position paper (see Appendix 1).

1. The American College of Physicians recommends a public health approach to firearms-related violence and the prevention of firearm injuries and deaths.
   a. The College supports the development of coalitions that bring different perspectives together on the issues of firearm injury and death. These groups, comprising health professionals, injury prevention experts, parents, teachers, law enforcement professionals, and others should build consensus for bringing about social and legislative change.
   b. The medical profession has a special responsibility to speak out on prevention of firearm-related injuries and deaths, just as physicians have spoken out on other public health issues. Physicians should counsel patients on the risk of having firearms in the home, particularly when children, adolescents, people with dementia, people with mental illnesses, people with substance use disorders, or others who are at increased risk of harming themselves or others are present.
      a. State and federal authorities should avoid enactment of mandates that interfere with physician free speech and the patient–physician relationship.
      b. Physicians are encouraged to discuss with their patients the risks that may be associated with having a firearm in the home and recommend ways to mitigate such risks, including best practices to reduce injuries and deaths.
      c. Physicians should become informed about firearms injury prevention. Medical schools, residency programs, and continuing medical education (CME) programs should incorporate firearm violence prevention into their curricula.
      d. Physicians are encouraged, individually and through their professional societies, to advocate for national, state, and local efforts to enact legislation to implement evidence-based policies, including those recommended in this paper, to reduce the risk of preventable injuries and deaths from firearms, including but not limited to universal background checks.
   2. The American College of Physicians supports appropriate regulation of the purchase of legal firearms to reduce firearms-related injuries and deaths. The College acknowledges that any such regulations must be consistent with the Supreme Court ruling establishing that individual ownership of firearms is a constitutional right under the Second Amendment of the Bill of Rights.
      a. Sales of firearms should be subject to satisfactory completion of a criminal background check and proof of satisfactory completion of an appropriate educational program on firearms safety. The American College of Physicians supports a universal background check system to keep guns out of the hands of felons, persons with mental illnesses that put them at a greater risk of inflicting harm to themselves or others, persons with substance use disorders, and others who already are prohibited from owning guns. Clear guidance should be issued on what mental and substance use records should be submitted to the National Instant Criminal Background Check System (NICS). This should include guidance on parameters for inclusion, exclusion, removal, and appeal. States should submit mental health records and report persons with substance use disorders to the NICS. The federal government should increase incentives and penalties related to state compliance. The law requiring federal agencies to submit substance use records should be enforced.
      b. Although there is limited evidence on the effectiveness of waiting periods in reducing homicides, waiting periods may reduce the incidence of death by suicide, which account for nearly two thirds of firearm deaths, and should be considered as part of a comprehensive approach to reducing preventable firearms-related deaths.
      c. Lawmakers should carefully weigh the risks and benefits of concealed-carry legislation prior to passing laws.
      d. The College supports a ban on firearms that cannot be detected by metal detectors or standard security screening devices.
      e. The College favors strong penalties and criminal prosecution for those who sell firearms illegally and those who legally purchase firearms for those who are banned from possessing them (“straw man sales”).
   3. The American College of Physicians recommends that guns be subject to consumer product regulations regarding access, safety, and design. In addition, the College supports law enforcement measures, including required use of tracer elements or taggants on ammunition and weapons, and identifying markings, such as serial numbers on weapons, to aid in the identification of weapons used in crimes.
   4. The American College of Physicians recommends that firearms be subject to consumer product regulations regarding access, safety, and design. In addition, the College supports law enforcement measures, including required use of tracer elements or taggants on ammunition and weapons, and identifying markings, such as serial numbers on weapons, to aid in the identification of weapons used in crimes.
   5. Firearm owners should adhere to best practices to reduce the risk of accidental or intentional injuries or deaths from firearms. They should ensure that their firearms cannot be accessed by children, adolescents, people with dementia, people with mental illnesses or substance use disorders who are at increased risk of harming themselves or others, and others who should not have access to firearms. Firearm owners should report the theft or loss of their firearm within 72 hours of becoming aware of its loss.
   6. The College cautions against broadly including those with mental illness in a category of dangerous individuals. Instead, the College recommends that every effort be made to reduce the risk of suicide and violence, through prevention and treatment, by the subset of individuals with mental illness who are at risk of harming themselves or others. Diagnosis, access to care, treatment, and appropriate follow-up are essential.
      a. Physicians and other health professionals should be trained to respond to patients with mental illness who might be at risk of injuring themselves or others.
      b. Ensuring access to mental health services is imperative. Mental health services should be readily available to persons in need throughout their lives or through the duration of their conditions. Ensuring an adequate availability of psychiatric beds and outpatient treatment for at-risk persons seeking im-
mediate treatment for a condition that may pose a risk of violence to themselves or others should be a priority.

c. Community understanding of mental illness should be improved to increase awareness and reduce social stigma.

d. Laws that require physicians and other health professionals to report those with mental illness who they believe pose an imminent threat to themselves or others should have safeguards in place to protect confidentiality and not create a disincentive for patients to seek mental health treatment. Such laws should ensure that physicians and other health professionals are able to use their reasonable professional judgment to determine when a patient under their care should be reported and should not hold them liable for their decision to report or not report.

7. The College favors enactment of legislation to ban the sale and manufacture for civilian use of firearms that have features designed to increase their rapid killing capacity (often called “assault weapons” or semiautomatic weapons) and large-capacity ammunition and retaining the current ban on automatic weapons for civilian use. Although evidence on the effectiveness of the Federal Assault Weapons Ban of 1994 is limited, the College believes that there is enough evidence to warrant appropriate legislation and regulation to limit future sales and possession of firearms that have features designed to increase their rapid killing capacity and can, along with a ban on large-capacity ammunition magazines, be effective in reducing casualties in mass shooting situations. Such legislation should be carefully designed to make it difficult for manufacturers to get a semiautomatic firearm exempted from the ban by making modifications in its design while retaining its semiautomatic functionality. Exceptions to a ban on such semiautomatic firearms for hunting and sporting purposes should be narrowly defined.

8. The College supports efforts to improve and modify firearms to make them as safe as possible, including the incorporation of built-in safety devices (such as trigger locks and signals that indicate a gun is loaded). Further research is needed on the development of personalized guns.

9. More research is needed on firearm violence and on intervention and prevention strategies to reduce injuries caused by firearms. The Centers for Disease Control and Prevention, National Institutes of Health, and National Institute of Justice should receive adequate funding to study the impact of gun violence on the public’s health and safety. Access to data should not be restricted.

CONCLUSION

Firearm violence is a public health problem in the United States that requires the nation’s immediate attention. The ACP has long advocated for policies to reduce the rate of firearm injuries and deaths in the United States and once again calls on its members, nonmember physicians, policymakers, and the public to take action on this important issue. Although there is much more to learn about the causes and prevention of firearm violence, the available data support the need for a multifaceted and comprehensive approach that addresses culture, substance use and mental health, firearm safety, and reasonable regulation, consistent with the Second Amendment, to prevent the devastating effects of needless firearm-related injuries and deaths.

From the American College of Physicians, Washington, DC.

Disclaimer: The authors of this article are responsible for its contents, including any clinical or treatment recommendations.

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References


Why Should Physicians Care About Firearm Injury Prevention?

The ACP Ethics Manual states that “Physicians should help the community and policymakers recognize and address the social and environmental causes of disease, including human rights concerns, discrimination, poverty, and violence” (8).

Whether it is a 75-year-old widower who commits suicide; a 17-year-old who accidentally shoots himself; a 20-year-old bystander killed on a city street; or a horrific mass shooting, such as the one that occurred in Newtown, Connecticut, physicians witness firsthand the devastating consequences of firearm violence for victims and their families. In a February 2013 survey of interns, 63% of respondents reported having had patients who were injured or killed by a gun. The survey is discussed in more detail later in this paper. These unnecessary injuries and deaths occur to patients and affect their families and the communities that they are a part of.

Physicians play an important role in intervening with patients who risk injuring themselves or others through the use of firearms. Patients and families of those who risk firearm injury have indicated a willingness to discuss concerns and safety options with their physicians (9). Brief counseling efforts by physicians have indicated a willingness to discuss concerns and safety options with patients about gun use or discussing gun safety (Table 2). Fifty-eight percent of respondents reported never discussing with patients whether they had guns in the home, and 80% reported never discussing whether their patient used guns. Most (77%) reported never discussing ways to reduce the risk for gun-related injury or death or the importance of keeping guns away from children (62%). Respondents indicating that there were gun owners in their homes more often reported asking their patients about guns (54% vs. 40%). Despite this, there is interest in educational programs to help physicians counsel their patients on firearm injury prevention. When asked the extent to which there is a need for an educational program designed to increase the knowledge and skills of physicians in how to counsel patients in firearm injury prevention, 74% indicated “somewhat/to a great extent.” Non–gun owners more often reported support of such a

<table>
<thead>
<tr>
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<th>Appendix 1: Reducing Firearm-Related Injuries and Deaths in the United States: Recommendations From the American College of Physicians</th>
</tr>
</thead>
</table>

Attitudes of Internists on Firearms and Injury Prevention

In February 2013, ACP performed a cross-sectional survey among a large, nationally representative panel of interns in the United States about their attitudes toward firearms and firearm injury prevention. Most respondents (85%) believed that firearm injury is a public health issue.

Respondents’ support for policies related to firearm regulation was strong. Seventy-six percent of respondents agreed that stricter gun control legislation would help to reduce the risk for gun-related injuries or deaths. An overwhelming majority also favored mandatory background checks on all gun purchases (95%); mandatory registration of all firearms (81%); banning the possession of assault weapons (86%), high-capacity magazines (85%), and armor-piercing bullets (87%); preventing persons with mental illness from purchasing guns (85%); and requiring safety features to make guns more child-proof (86%) (Table 1).

Few respondents involved in patient care were asking their patients about gun use or discussing gun safety (Table 2). Fifty-eight percent of respondents reported never discussing with patients whether they had guns in the home, and 80% reported never discussing whether their patient used guns. Most (77%) reported never discussing ways to reduce the risk for gun-related injury or death or the importance of keeping guns away from children (62%). Respondents indicating that there were gun owners in their homes more often reported asking their patients about guns (54% vs. 40%). Despite this, there is interest in educational programs to help physicians counsel their patients on firearm injury prevention. When asked the extent to which there is a need for an educational program designed to increase the knowledge and skills of physicians in how to counsel patients in firearm injury prevention, 74% indicated “somewhat/to a great extent.” Non–gun owners more often reported support of such a
Firearm Violence Is a Public Health Problem

The number of guns owned by civilians in the United States ranges from 270 million to 310 million (16, 17), which amounts to 101.05 firearms per 100 persons (18). The United States ranks first among 178 countries in the number of privately owned guns (16). Each year, more than 32,000 persons are killed in the United States by firearms. This includes homicides, suicides, and unintentional fatalities and amounts to 88 deaths per day (19). Homicides by firearm result in 11,000 deaths each year (19). More than 19,000 firearm deaths are suicides (20). The number of nonfatal firearm injuries is more than double the number of deaths. It is estimated that nearly 74,000 nonfatal firearm injuries occurred in the United States in 2011 (21). Since its peak in 1993, the rate of gun homicide has decreased by 49%; however,

Table 1. Support by Internists for Specific Measures to Deal With Firearm Violence

<table>
<thead>
<tr>
<th>Measure</th>
<th>All Internists (n = 573)</th>
<th>Gun Owner in Home (n = 121)</th>
<th>No Gun Owner in Home (n = 452)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory background check on all gun purchases regardless of whether through an authorized dealer, gun show, or other private sale</td>
<td>95</td>
<td>88</td>
<td>97</td>
</tr>
<tr>
<td>Mandatory registration of all guns, including handguns, rifles, shotguns, and semiautomatic weapons</td>
<td>81</td>
<td>50</td>
<td>89</td>
</tr>
<tr>
<td>Banning the possession of assault weapons except by the military and other authorized persons</td>
<td>86</td>
<td>63</td>
<td>92</td>
</tr>
<tr>
<td>Banning the possession of high-capacity magazines except by the military and other authorized persons</td>
<td>85</td>
<td>68</td>
<td>89</td>
</tr>
<tr>
<td>Banning armor-piercing bullets</td>
<td>87</td>
<td>79</td>
<td>89</td>
</tr>
<tr>
<td>Preventing persons with mental illness from purchasing guns</td>
<td>85</td>
<td>85</td>
<td>85</td>
</tr>
<tr>
<td>Preserving the rights of physicians to counsel their patients on preventing deaths and injuries from firearms</td>
<td>86</td>
<td>84</td>
<td>86</td>
</tr>
<tr>
<td>Improving access to mental health services</td>
<td>97</td>
<td>98</td>
<td>96</td>
</tr>
<tr>
<td>Requiring safety features to make guns more child-proof</td>
<td>86</td>
<td>67</td>
<td>91</td>
</tr>
<tr>
<td>Banning sale of firearms to persons younger than 21 y</td>
<td>83</td>
<td>63</td>
<td>88</td>
</tr>
<tr>
<td>Creating a federal database to track gun sales</td>
<td>79</td>
<td>60</td>
<td>84</td>
</tr>
</tbody>
</table>

Table 2. Frequency of Discussions About Gun-Related Issues

<table>
<thead>
<tr>
<th>Issue</th>
<th>Total Respondents (n = 542)*</th>
<th>Respondents With Gun Owner in Home (n = 112)</th>
<th>Respondents Without Gun Owner in Home (n = 430)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether the patient has guns in his/her home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>3</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Sometimes</td>
<td>39</td>
<td>48</td>
<td>37</td>
</tr>
<tr>
<td>Never</td>
<td>58</td>
<td>46</td>
<td>60</td>
</tr>
<tr>
<td>Whether the patient uses guns even if a gun is not present in the home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sometimes</td>
<td>19</td>
<td>23</td>
<td>18</td>
</tr>
<tr>
<td>Never</td>
<td>80</td>
<td>76</td>
<td>81</td>
</tr>
<tr>
<td>Ways to reduce the risk for gun-related injury or death</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Sometimes</td>
<td>21</td>
<td>28</td>
<td>19</td>
</tr>
<tr>
<td>Never</td>
<td>77</td>
<td>71</td>
<td>79</td>
</tr>
<tr>
<td>Importance of keeping guns in the home away from children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>6</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Sometimes</td>
<td>32</td>
<td>39</td>
<td>30</td>
</tr>
<tr>
<td>Never</td>
<td>62</td>
<td>49</td>
<td>65</td>
</tr>
<tr>
<td>Voluntarily removing the gun from the home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sometimes</td>
<td>22</td>
<td>31</td>
<td>20</td>
</tr>
<tr>
<td>Never</td>
<td>77</td>
<td>68</td>
<td>79</td>
</tr>
</tbody>
</table>

* Percentages may not sum to 100 because of rounding.  
† Respondents who reported time spent in direct patient care.
the change in the overall number of firearm deaths has not been as substantial (39 595 in 1993 vs. 31 672 in 2010) and is still a major concern.

In 2010, 15 576 children aged 20 years or younger were treated in emergency departments for nonfatal firearm-related injuries. Adolescents aged 15 to 19 years had a nonfatal firearm injury rate nearly 3 times higher than the general population (22). Between 2000 and 2010, 703 children aged 14 years or younger were killed by unintentional firearm injuries (23). A 2013 analysis of available data on unintentional or accidental firearm injury and death in 5 states found that official estimates may underestimate the number of accidental firearm deaths in children by as much as half, due in part to inconsistent classification and reporting (24). Misclassification of firearm homicide, suicide, and accidents, particularly in young victims, is of concern with many of the current reporting practices. As much as 38% of true cases of unintentional firearm deaths were missed, as were 42% of cases reported as false-positives in an analysis of firearm death data from the National Violent Death Reporting System, State Vital Statistics Registry, medical examiner or coroner reports, and police Supplementary Homicide Reports (25).

Firearm-related violence cost the United States $174 billion in 2010. The societal cost for each firearm assault injury amounted to $5.1 million for each fatality, $433 000 for each hospitalized patient, and $123 000 for each firearm assault that resulted in only an emergency department visit. The costs included work loss, medical or mental health care, emergency transportation, policy or criminal justice activities, insurance claims processing, employer costs, and decreased quality of life (26).

**Firearm Violence and Mental Health**

Studies have shown that “stranger homicide” is still a relatively uncommon occurrence, and psychosis has not been shown to be an accurate predictor in the risk for such homicides (27). Additional epidemiologic research has shown that persons with mental illness are less likely to seek treatment before committing a violent act; thus, no disqualifying patient or criminal record would exist to prevent the person from purchasing a firearm (28). Certain psychiatric conditions also have a stronger association with violent behaviors than others. A survey on the frequency of violent behavior in persons with mental illness found that certain psychiatric disorders were indicators of an increased risk for violent behavior. The results of the survey showed that those with anxiety or depressive disorders were 3 to 4 times more likely to engage in violent behavior, and those with bipolar disorder or alcohol and other substance use disorders were up to 9.5 times more likely to develop violent behavior (29). A study by the National Institute of Mental Health (30) revealed that persons with serious mental illness (schizophrenia, major depression, or bipolar disorder) were 2 to 3 times more likely than those without serious mental illness to commit acts of aggression. The study also found that those with serious mental illness had a lifetime prevalence of violence of 16% compared with a 7% prevalence among those without mental illness (7%). However, because serious mental illness is rare, the attributable risk to the overall rate of violence in the general population is only 3% to 5% (30). Thus, the overwhelming majority of persons with mental illness do not pose a threat of violence to others or themselves.

Studies that have looked at various types of mental illness in conjunction with substance abuse have established drug and alcohol use or abuse to be a stronger predictor of violent behavior than mental health alone. One study (31) found that persons with mental illness are no more likely to be violent unless they also have a substance use disorder or a history of violence. Fazel and colleagues (32) found that persons with substance use disorders but no mental health disorders had a risk for violence similar to that of persons with substance use disorders and some level of mental health disorder. A study of 132 persons with mental illness (33) revealed that they were 1.7 times more likely to engage in serious violent on days when they consumed alcohol and 3.4 to 7.1 times more likely to engage in serious violent when they used alcohol and other substances.

**Access to Firearms Increases Likelihood of Injury and Death**

Although some studies suggest that firearms can serve as a protective function (34), evidence suggests that firearm availability increases the likelihood that persons will be killed, either by homicide or suicide. A study by Kellermann and Reay (35) that examined all firearm deaths in King County, Washington, over a 6-year period found 1.3 accidental deaths, 4.5 criminal homicides, and 37 suicides involving firearms for every death associated with self-defense or protection. A study that compared the frequency with which guns in the home are used for self-defense with the number of times the weapons were involved in accidental injury, suicide attempt, or criminal assault or homicide in 3 U.S. cities (36) found that for every time a gun was used in self-defense or for a legally justifiable reason, there were 4 accidental shootings, 7 criminal assaults or homicides, and 11 attempted or completed suicides. A report on firearm injury prevention by the Firearm & Injury Center at the University of Pennsylvania (37) found several associations among ownership of a firearm, firearm availability, and presence of firearms in the home and an increased risk for homicide and suicide by firearm. Even general ownership of a gun has been associated with a net increase in the risk for death by firearm compared with a typical person (38). The association between having a firearm in the home and homicide risk is of particular relevance because persons are more likely to be killed by a family member or intimate acquaintance than a stranger (39). Although an assessment of reports from the Federal Bureau of Investigation (FBI) Uniform Crime Reporting Program showed that the rate of homicide is still higher for men than women, the risk of being killed by a firearm is high among women. More than twice as many women were shot and killed by their husband or an intimate acquaintance than by strangers using guns, knives, or other means (40).

An analysis of data on homicides that occurred in the home in 3 metropolitan counties (41) showed that keeping a gun in the home increases the risk for homicide in the home independent of other factors. The same study found that a significant portion of
homicides in the home (76.7%) are committed by someone known to the victim, such as a family member or intimate acquaintance. The relative risk for homicide or violent death has been shown to continue for up to several years after the initial purchase of a weapon. This long-term relative risk is also reflected in the potential for suicide among gun owners several years after purchase (42).

Access to firearms in the home and general access have been shown to contribute to the increase in the risk for suicide among adolescents and adults (43–48). A 6-year study of handgun purchases among California residents aged 21 years or older (42) found that the primary cause of death in the group was suicide within the first year after the purchase and that the suicide rate among the group in the first week after the purchase was 57 times higher than in the general population. The fact that access to a firearm can increase the risk for suicide by firearm has been well-established; however, it has been shown that a decrease in household ownership of firearms is associated with a decrease in the rate of suicide. Miller and colleagues (49) explored the change in suicide rates compared with the decrease in firearm ownership from 1981 to 2002 among 4 census regions. They found a reduction in firearm ownership across all 4 regions. After adjustment for multivariate and regional factors, the study found an association with significant reductions in the rate of firearm suicides and suicides overall (4.2% and 2.5%, respectively) for each 10% decrease in household firearm ownership. Children aged 0 to 19 years were affected the most; in that population, for each 10% decrease, the rate of firearm suicide decreased by 8.3% and the rate of suicides overall decreased by 4.1%.

Although the focus of most firearm safety efforts has been geared toward households with children, evidence suggests that firearms in the home may also be a danger to elderly persons. Geriatric persons are more likely to suffer self-inflicted accidental or intentional gunshot wounds. The most common suicide method for this population is a firearm (50). A study of elderly persons with memory impairment (51) found that they frequently have access to firearms, often unlocked and with readily available ammunition.

Recommendations of the American College of Physicians

1. The American College of Physicians recommends a public health approach to firearms-related violence and the prevention of firearm injuries and deaths.

   a. The College supports the development of coalitions that bring different perspectives together on the issues of firearm injury and death. These groups, comprising health professionals, injury prevention experts, parents, teachers, law enforcement professionals, and others should build consensus for bringing about social and legislative change.

   The preventable loss of more than 32,000 lives per year; the preventable injury of nearly 74,000 persons per year due to firearms; and the resulting pain, suffering, cost, and consumption of human and health care resources demand that firearm injuries be considered a public health issue requiring immediate attention. According to the Institute of Medicine, “a public health approach involves three elements: a focus on prevention, a focus on scientific methodology to identify risk and protective factors, and multidisciplinary collaboration to address the issue” (52). The College strongly supports this approach toward reducing firearm violence. Such an approach has produced major achievements in the reduction of tobacco use, motor vehicle fatalities, and unintentional poisoning (53). Although firearms should not be equated with these other hazards, many lessons can be learned from the approaches used to increase awareness of the risks associated with tobacco use and to increase common-sense safety policies to promote the safe use of automobiles and medications. It should be noted, however, that there are significant differences in how a public health approach to firearms might be implemented compared with other public health interventions because firearm ownership is a constitutionally protected right, unlike using tobacco, driving, or taking medications.

   A national public health effort to reduce firearm-related injuries and deaths would need to address cultural, behavioral, educational, and safety issues related to firearms. First and foremost, availability of good data and adequate funding for analyses of the data are essential in order to obtain a greater understanding of the issue and better assess and target interventions. Other actions include education on safe practices to reduce the risk for accidental or intentional deaths in homes; physician counseling of patients on such risks and how to mitigate them; advocacy for public health interventions, including access to mental health, treatment for substance and alcohol abuse, screening for depression, and child-proofing guns; changing social norms, including the way that firearm violence is depicted in advertising, television, and video games; and educational campaigns to reduce firearm violence, suicides, and unintentional deaths and to recognize persons at risk for harming themselves or others.

   Firearms are becoming the leading cause of trauma-related death and disability in the United States; in 12 states and the District of Columbia, firearm-related deaths equaled or exceeded deaths from motor vehicles (54). The rate of deaths resulting from motor vehicle accidents decreased from 15.2 to 11.7 per 100,000 persons between 2005 and 2009 (55). Meanwhile, the number of deaths from firearm-related injuries has increased over a similar time frame (2005 to 2010) despite the rate of firearm deaths remaining at a similar level (10.3 and 10.1 per 100,000 persons, respectively) (23, 56). A national effort must be devoted to reducing firearm injuries and deaths.

   Any effort to reduce firearm violence will require a real and lasting commitment from all stakeholders to work together to find meaningful solutions that address culture, substance abuse and mental health, firearms safety, and reasonable regulation to keep firearms out of the hands of persons who will use them to harm themselves and others. No community is immune from firearm injuries and deaths. Collaboration is critical to bringing about social and legislative change.

   2. The medical profession has a special responsibility to speak out on prevention of firearm-related injuries and deaths, just as physicians have spoken out on other public health issues. Physicians should counsel patients on the risk of having firearms in the home, particularly when children, adolescents, people with dementia, people...
with mental illnesses, people with substance use disorders, or others who are at increased risk of harming themselves or others are present.

a. State and federal authorities should avoid enactment of mandates that interfere with physician free speech and the patient–physician relationship.

b. Physicians are encouraged to discuss with their patients the risks that may be associated with having a firearm in the home and recommend ways to mitigate such risks, including best practices to reduce injuries and deaths.

c. Physicians should become informed about firearms injury prevention. Medical schools, residency programs, and continuing medical education (CME) programs should incorporate firearm violence prevention into their curricula.

d. Physicians are encouraged, individually and through their professional societies, to advocate for national, state, and local efforts to enact legislation to implement evidence-based policies, including those recommended in this paper, to reduce the risk of preventable injuries and deaths from firearms, including but not limited to universal background checks.

The ACP’s 2013 survey of internists revealed that 66% of respondents believed that the rights of physicians to counsel their patients on preventing deaths and injuries from firearms should be preserved. The College is pleased that the 2011 Florida gun law that forbade physicians from discussing a patient’s gun ownership was found by U.S. District Judge Marcia Cooke to be a violation of physicians’ First Amendment rights. In her written argument, Judge Cooke stated, “The Act does not impose a mere incidental burden on free speech. Rather, truthful, non-misleading speech is the direct target of the Act.” Cf. Gentile, 501 U.S. at 1034. I am unconvinced that the State’s interest in regulating the medical profession outweighs practitioners’ free speech rights” (57). The U.S. District Court relied heavily on the argument made by the American Academy of Pediatrics, the American Academy of Family Physicians, and ACP’s Florida Chapter that any such law was an unconstitutional abridgment of a physician’s First Amendment right to free speech and would deprive patients of their First Amendment rights to receive potentially life-saving information on safety measures they can take to protect their children, families, and others from injury or death resulting from unsafe storage or handling of firearms. It is important that the sanctity of the physician–patient relationship continue to be preserved. Free speech between physicians and patients, as protected by the Constitution, is necessary in order to provide the highest-quality care.

The College was disheartened to find that in the 2013 survey of internists, 58% of respondents reported never asking their patients about guns in their homes. Internists who are gun owners are more likely to ask their patients about guns than non–gun owners (54% vs. 40%). This may be due to their familiarity with guns and appropriate safety measures. Physician engagement with patients on the topic of gun safety and gun violence prevention can help in normalizing what can sometimes be a polarizing dialogue (58). Although it may not be practical or necessary to include such counseling in every patient encounter, internists should be prepared to offer such patient education, as appropriate, within an overall regimen of preventive health care.

Communities across the country face different dangers and have differing views and uses for firearms. Members of a rural community may have reasons for owning a gun that are different from those of persons in heavily populated urban communities. An analysis by The Washington Post of data from the Centers for Disease Control and Prevention (CDC) on firearm death between 2008 and 2010 (59) showed that the rate of firearm suicides is higher in rural areas, whereas the rate of firearm homicide is greater in urban areas. Some parts of the country have a strong culture of firearm use. However, no community is immune from firearm injuries and deaths. Wyoming is among the states with a strong culture of firearm use and has a low firearm homicide rate; however, it has the highest rate of suicide and the largest number of suicides by firearm per capita (59). A report by the Wyoming Department of Health (60) found that the state’s suicide rate could be placed among the 10 countries in the world with the highest suicide rate for which the World Health Organization has data. Physicians need to recognize how firearms are used in their community and counsel patients accordingly. When counseling patients on firearm safety, physicians should also consider the demographics of the patient and the type of firearm involved. For example, in a study of firearm ownership and safety practices in rural and nonrural settings, gun type was associated with storage habits, with handgun owners more likely to keep their weapons loaded. Owners of long guns were more likely to keep ammunition separate from the firearm but not to keep the firearm in a locked gun safe or cabinet (61).

Best practices to mitigate the risk of firearms in the home include storing firearms and ammunition separately in secure and locked safes, using trigger locks, and encouraging firearm owners to obtain expert training on their use and safety. In households with children; adolescents; mentally ill persons; and others at greater risk for firearm-related accidents, violence, or suicide, the physician may recommend that the patient consider not keeping firearms in the home.

Nearly 3 out of 4 non–gun owners in ACP’s survey of internists expressed support for educational programs to help them counsel their patients. Such evidence-based programs could be developed and offered by medical schools, residency programs, and organizations that provide continuing medical education. Not only is it important for physicians to become properly educated about the risks of gun ownership and the need for safety measures, it is also essential that they be taught how to communicate this to their patients through proper screening, counseling, and education.

3. The American College of Physicians supports appropriate regulation of the purchase of legal firearms to reduce firearms-related injuries and deaths. The College acknowledges that any such regulations must be consistent with the Supreme Court ruling establishing that individual ownership of firearms is a constitutional right under the Second Amendment of the Bill of Rights.

a. Sales of firearms should be subject to satisfactory completion of a criminal background check and proof of satisfactory completion of an appropriate educational program on firearms safety. The Ameri-
The American College of Physicians supports a universal background check system to keep guns out of the hands of felons, persons with mental illnesses that put them at a greater risk of inflicting harm to themselves or others, persons with substance use disorders, and others who already are prohibited from owning guns. Clear guidance should be issued on what mental and substance use records should be submitted to the National Instant Criminal Background Check System (NICS). This should include guidance on parameters for inclusion, exclusion, removal, and appeal. States should submit mental health records and report persons with substance use disorders to the NICS. The federal government should increase incentives and penalties related to state compliance. The law requiring federal agencies to submit substance use records should be enforced.

b. Although there is limited evidence on the effectiveness of waiting periods in reducing homicides, waiting periods may reduce the incidence of death by suicide, which account for nearly two thirds of firearm deaths, and should be considered as part of a comprehensive approach to reducing preventable firearms-related deaths.

c. Lawmakers should carefully weigh the risks and benefits of concealed-carry legislation prior to passing laws.

d. The College supports a ban on firearms that cannot be detected by metal detectors or standard security screening devices.

e. The College favors strong penalties and criminal prosecution for those who sell firearms illegally and those who legally purchase firearms for those who are banned from possessing them (“straw man sales”).

A recent study (62) found that the number of firearms per capita per country strongly correlated with and was an independent predictor of firearm-related deaths. The authors found that the United States, with the most firearms per capita in the world, has the highest rate of deaths from firearms, whereas Japan, which has the lowest rate of firearm ownership, has the lowest rate of firearm deaths. Within the United States, analyses comparing the quantity and type of gun laws enacted in states find an association between stringent gun laws and lower firearm death rates. A summary of existing gun laws can be found in Appendix 2. The Law Center to Prevent Gun Violence, an organization that issues grades to states by using a points-based formula, found that 7 of the top 10 states with the most stringent gun laws had the lowest rates of firearm deaths (63). The correlation between stringent gun laws and reduction in firearm violence can be seen in the turnaround between the high levels of gun violence in California during the early 1990s and the relatively low rate of gun violence after the adoption of state laws and city and county ordinances aimed at reducing gun deaths. In the early 1990s, California had a rate of gun violence 15% higher than the national average—17.48 compared with 15 per 100 000 persons. The rate of gun violence in California has since decreased substantially: The number of Californians killed by gunfire decreased by 56% between 1993 and 2010 to 7.7 per 100 000 persons compared with the national average of 10.1 per 100 000 persons (64, 65). The abundance of firearms in the United States is a public health hazard, and sensible regulations must be put in place to ensure that persons who should not possess firearms are unable to access them.

### Background Checks

The College supports requiring criminal background checks for all firearm purchases, including sales by gun dealers, sales at gun shows, and private sales. The “gun show loophole” should be closed to ensure that prohibited purchasers, such as felons, persons involuntarily committed for mental illness or otherwise “adjudicated mentally defective,” and others prohibited from owning firearms cannot make purchases. Such a system will only be successful if records are complete and submitted in a timely manner.

In 2010, according to the FBI and state officials (66), more than 14 million persons submitted to a background check to purchase or transfer possession of a firearm and 153 000 persons were denied purchase. However, in the United States, it is estimated that up to 40% of gun transfers take place without a licensed dealer, including online and at gun shows. From that calculation, it can be estimated that 6.6 million guns were sold to a buyer with no background check (67).

Evidence suggests that states with laws to address the gun show background check loophole export fewer guns later used in crime. States with laws limiting or eliminating the gun show loophole have an average export rate (controlled for population) of 7.5 crime guns per 100 000 inhabitants. In contrast, 34 states that do not require background checks for all handgun sales at gun shows have an average export rate of 19.8 crime guns per 100 000 inhabitants (68).

There is considerable public support for a comprehensive background check requirement and for closing the private seller and gun show loopholes. The College’s February 2013 survey of internists revealed that respondents overwhelmingly favored universal background checks (94%). A survey conducted in January 2013 by the Pew Research Center for the People and the Press (69) found that 85% of Americans favored closing the loopholes, with a similar level of Democratic and Republican support; in May 2013, when the poll was conducted again, 81% of all Americans favored expanded background checks. The Pew Research Center published a report in March 2013 showing that 74% of households with National Rifle Association members favored background checks, and surveys and polls conducted by Quinnipiac University (70), CNN/Opinion Research Corporation (71), CBS (72), and The Washington Post (73) found similar positive support for background checks. In addition, a survey conducted by the UC Davis Violence Prevention Research Center found that 55.4% of gun dealers in 43 states supported comprehensive background checks on firearm purchases; 37.5% said they were strongly in favor (74).

Despite mostly positive public opinion toward comprehensive background checks, a bill introduced in the Senate in 2013 by Senators Joe Manchin (D-WV) and Pat Toomey (R-PA) that would have required background checks on all commercial gun sales did not gain enough support to proceed. The Public Safety and Second Amendment Rights Protection Act would have expanded background checks to online sales and sales at gun shows and would have cleared the way to send information on violently mentally ill persons to the NICS database by clarifying Health Insurance Portability and Accountability Act of 1996 (HIPAA) laws (75).
Concealed-Weapons Laws

argue that most persons who legally carry a concealed firearm are less likely to attack someone who they believe to be armed. They also argue that most persons who legally carry a concealed firearm abide by the law and do not misuse their firearms. Opponents of concealed-carry laws argue that concealed firearms increase the risk for preventable injuries and deaths and may increase impulsive acts of violence. Research on the topic of concealed-carry laws ultimately found that any increase or decrease in firearm-related criminal activity cannot be considered statistically significant to determine the efficacy of the laws. A study by Romero and colleagues (81) compared the violent crime rate of the state of California, a “may-issue” state, with that of a small town in Sacramento County, California, that granted concealed-carry permits to anyone who applied and passed a standard background check. The authors followed up 3 years later to examine the violent crime arrest records for the 691 persons issued a concealed-weapons permit with only a background check and found a slightly higher rate of violent crime per 100,000 person-years.

A national study that evaluated the effect of 5 types of state gun laws on homicide rates on all 50 states and the District of Columbia over a 10-year span (a “shall-issue” law, a minimum age requirement for handgun purchase, a minimum age requirement for handgun possession, a 1-gun-per-month purchasing restriction, and a junk gun ban) (82) found that states with a shall-issue law had a higher rate of firearm homicides than those without the law; however, none of the laws was associated with a statistically significant reduction in firearm homicide or suicide rates.

Additional data from studies looking at violence related to concealed-carry laws on homicide rates, suicide rates, and types of crimes committed by incarcerated criminals who possessed concealed-carry permits can only suggest that concealed-carry laws may increase the incidence of certain violent crimes. Although other studies have shown little statistical significance between the enactment of a concealed-carry law in a jurisdiction and increases or decreases in homicide rates (83), studies indicate that policymakers need to carefully weigh the risk and benefits of concealed-carry legislation before passing such laws (84).

The College cannot make an evidence-based recommendation on concealed-carry laws on the basis of the available evidence but recommends that lawmakers carefully consider the risks and benefits of concealed-carry legislation before passing such laws.

Undetectable Firearms

Under the Undetectable Firearms Act of 1988, it is a federal offense to manufacture, sell, import, export, deliver, possess, transfer, or receive a firearm capable of passing through an airport metal detector undetected or unseen. It requires that any firearm, minus the stock, grips, and magazine, have an x-ray detection signature no less than that of a calibration sample containing 3.7 ounces of stainless steel (85). The law contained a sunset provision after 10 years and was allowed to expire in 1998. A 5-year extension of the law was signed by President Bill Clinton in 1998, and a 10-year extension was signed by President George W. Bush in 2003. On 9 December 2013, the law was reauthorized for an additional 10 years.

Before the reauthorization, Congressman Steve Israel (D-NY) and Senator Charles Schumer (D-NY) unsuccessfully at-

Mental Health and Substance Abuse Record Reporting

Federal law currently prohibits convicted felons; persons who use or are addicted to unlawful substances; those who have been involuntarily committed to inpatient mental health institutions; and those who have been deemed incompetent to stand trial, found not guilty on the grounds of serious mental illness, or otherwise deemed adjudicated mentally defective from receiving or possessing a firearm (76). Reporting of disqualifying records to NICS by states is voluntary and varies in what and how much states report. In 2007, the NICS Improvement Amendments Act (NIAA) included certain financial incentives and penalties to encourage states to submit disqualifying records to NICS. A U.S. Government Accountability Office (GAO) report examining progress made by states reporting to NICS after NIAA (77) found a 9-fold increase in reporting, growing the database from 126,000 records in 2007 to 1.2 million in 2011, primarily from 12 states. The GAO acknowledged that this increase in records could be a factor in the increase in the number of denials based on mental health records from 0.5% of total purchase denials in 2004 to 1.7% in 2011 (77).

Despite the increase in reporting after NIAA, underreporting of certain records continues to be of concern. One analysis of available reporting data (78) found that even after the enactment of NIAA, 4 states had not submitted any mental health records and 33 states had not submitted any substance abuse records to NICS. In addition, federal departments and agencies are required to report disqualifying records quarterly, as stipulated in NIAA; however, a lag in reporting continues, with most substance abuse and mental health records coming from the federal Court Services and Offender Supervision Agency and the Department of Veterans Affairs, respectively (79).

Waiting Periods

Waiting periods have generally been considered to act as “cooling-off” periods for persons who would commit suicide or an act of violence in the heat of the moment. Opponents of waiting periods believe that they hamper a law-abiding citizen’s right to access firearms and could hinder their ability to protect themselves. The evidence on waiting periods is limited, and more research is needed on the benefits of waiting periods and ideal waiting period times. One study (80) showed that waiting periods enacted in the interim portion of the Brady Handgun Violence Protection Act (Brady Act) slightly reduced suicide rates in adults aged 55 years or older but caused no statistically significant reduction in homicides. The College cannot make an evidence-based recommendation on waiting periods because of the lack of data but believes that they should be considered as part of a comprehensive approach to reducing firearm-related deaths because of the potential positive effect they may have on suicides.

Concealed-Weapons Laws

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Before the reauthorization, Congressman Steve Israel (D-NY) and Senator Charles Schumer (D-NY) unsuccessfully at-
tempted to modify the law to address potential loopholes that may emerge with the advent of three-dimensional (3D) printing technology and the successful 3D printing of guns and gun pieces, such as magazines and triggers. Congressman Israel, in addition to cosponsoring the 10-year reauthorization of the existing law, introduced H.R. 3643, the Undetectable Firearms Modernization Act, which would require plastic guns to have a permanent metal or steel component (86). Senator Schumer attempted to reduce the length of the reauthorization from 10 years to 1 year. Neither H.R. 3643 nor Senator Schumer’s efforts was voted on before reauthorization.

A relatively new process, 3D printing works by using software to map out blueprints of a subject, slicing it into sections for the machine to read and using various materials to layer the sections until the item is built. On 6 May 2013, Cody Wilson, the director and founder of the nonprofit organization Defense Distributed, successfully built and fired the first 3D-printed weapon, which he called “the Liberator.” Wilson previously demonstrated an ability to print magazines capable of firing up to 30 rounds without breaking or melting as well as printing the receiver of a semiautomatic assault rifle, which is considered the primary component of a firearm and is regulated by the government. The process of building the firearm entailed assembling several distinct parts printed individually. The Liberator, which requires standard ammunition and a metal firing pin, shot 1 bullet without damage (87).

Wilson obtained a federal firearms license from the U.S. Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF), which allowed him to manufacture and sell firearms that do not violate the Undetectable Firearms Act. A week after the blueprints were published online, Wilson complied with a request by the U.S. State Department to remove them because of potential violations of International Traffic in Arms Regulations (88). Despite the removal of the blueprints from Wilson’s Web site, they have been downloaded more than 100,000 times and others have modified and printed other 3D weapons and accessories, including a rifle.

In November 2013, the ATF released a question-and-answer sheet explaining its knowledge and monitoring of 3D-printed firearms (89). In conjunction with this release, the agency posted videos of tests conducted under controlled circumstances using various 3D-printed versions of the Liberator gun. Although some of the tests showed the gun firing effectively, others did not and 1 gun exploded into several pieces upon firing. Still, the ATF considers 3D-printed guns to be dangerous and lethal weapons (90).

**Straw Purchases**

Straw purchasers—persons who unlawfully purchase firearms for other persons who are in a prohibited category—move several thousand firearms into criminal channels each year, and penalties for such purchasers must be strong (91). In a 2000 report released by the ATF, *Following the Gun: Enforcing Federal Laws Against Firearms Traffickers* (92), the agency found that over the 2.5-year period between 1996 and 1998, 46% of all trafficking investigations involved straw purchases; approximately a third of illegally diverted firearms were associated with straw purchasing. The proportion is of concern to the ATF, which reported that the numbers underscore a significant public safety problem. A survey of federally licensed firearm dealers in 2011 found that 67.3% of respondents reported potential straw purchases (93), indicating that straw purchasing and attempted straw purchasing remain obstacles in stymieing the flow of guns into the hands of persons who are prohibited from having them.

The month after *Following the Gun* was released, the ATF, the U.S. Department of Justice, the Office of Justice Programs, and the National Shooting Sports Foundation collaborated on the creation of the “Don’t Lie for the Other Guy” campaign to educate gun dealers about detecting potential straw purchases. The program added an awareness component for consumers about the consequences of participating in straw purchasing through the Department of Justice’s Project Safe Neighborhoods initiative in 2008 (94).

4. The American College of Physicians recommends that guns be subject to consumer product regulations regarding access, safety, and design. In addition, the College supports law enforcement measures, including required use of tracer elements or taggants on ammunition and weapons, and identifying markings, such as serial numbers on weapons, to aid in the identification of weapons used in crimes.

There is currently no federal law or regulatory authority to set minimum safety standards for domestically manufactured firearms. The American Academy of Pediatrics, the American Bar Association, and other organizations recommend that firearms meet minimum safety standards in order to protect the public from unreasonable risks for injury. Proven safety features should be required to be incorporated in the manufacture and sale of all applicable firearms, such as gunlocks, load indicators, and magazine-disconnect safeties, to prevent accidents and unauthorized access to guns in the home by teenagers and children. Firearms should also be the subject of product recall authority, injury surveillance data collection, and public safety information dissemination in order to better protect the public (95). According to the Firearm & Injury Center at the University of Pennsylvania, evidence from regulation of consumer products shows that designing safer products and restricting access to dangerous products can prevent injuries and death (37). Informed consumer choice can help reduce household risks from firearms and can increase the value of product safety for firearm design and marketing.

Steps must be taken to assist law enforcement authorities in identifying persons who use guns in criminal activities. Some states and municipalities already require registration of firearms and licensing of gun owners. Registration, use of identification tags, and encryption of identifying markings will help ensure that guns are used as intended if they are to remain available for hunting, target shooting, collecting, self-defense, or other purposes. These measures also facilitate reporting of stolen weapons and aid police in their identification and recovery.

5. Firearm owners should adhere to best practices to reduce the risk of accidental or intentional injuries or deaths from firearms.
They should ensure that their firearms cannot be accessed by children, adolescents, people with dementia, people with mental illnesses or substance use disorders who are at increased risk of harming themselves or others, and others who should not have access to firearms. Firearm owners should report the theft or loss of their firearm within 72 hours of becoming aware of its loss.

Firearm owners, particularly those whose households include children; adolescents; persons with dementia; or persons with mental illness, including substance use disorders, who are at increased risk of harming themselves or others, should take every step possible to reduce the risk for accidental or intentional injuries or deaths from firearms. A disproportionately large share of unintentional firearm fatalities was found to occur in states where gun owners were more likely to store their firearms loaded. The greatest risk occurred in states where loaded firearms were more likely to be stored unlocked (96). Parents of adolescents, who have the highest risk for firearm-related injuries among youths, were found to be more likely than parents of younger children to keep household firearms stored unsafely (42% vs. 29%) (97). A study of rural households (98) found that the prevalence of loaded, unlocked guns in households with a handgun was 4.5 times higher than in households with a long gun only. The study also found that households with someone with a lifetime prevalence of alcohol abuse or dependence were about twice as likely as other households to report having loaded, unlocked firearms. A study of household firearm storage practices in Oregon (99) revealed that an estimated 6.2% of households with children had firearms that were loaded and unlocked, and about 40,000 children lived in these households. Drinking 5 or more alcoholic beverages on 1 or more occasions in the past month or drinking 60 or more alcoholic beverages in the past month were independently associated with living in households with loaded and unlocked firearms. Keeping a gun locked, keeping it unloaded, storing ammunition locked, and storing it in a separate location have each been found to be associated with a protective effect (100).

In addition to taking measures to protect members of their household from firearm injuries or deaths, firearm owners should help protect the public by reporting theft or loss of their firearms within 72 hours of becoming aware of its loss so that law enforcement can track down the firearms and the criminals who use them. Nearly 1.4 million firearms, or an annual average of 232,400, were stolen during burglaries and other property crimes between 2005 and 2010 (101). According to ATF reports, more than a quarter of its criminal gun trafficking investigations involve stolen guns. Seven states (Connecticut, Massachusetts, Michigan, New Jersey, New York, Ohio, and Rhode Island) and the District of Columbia currently require that lost or stolen firearms be reported to law enforcement (102). The College supports these laws and urges law-abiding firearm owners to take every measure possible to keep their firearms out of the hands of criminals and others who should not have access to them.

6. The College cautions against broadly including those with mental illness in a category of dangerous individuals. Instead, the College recommends that every effort be made to reduce the risk of suicide and violence, through prevention and treatment, by the subset of individuals with mental illness who are at risk of harming themselves or others. Diagnosis, access to care, treatment, and appropriate follow-up are essential.

   a. Physicians and other health professionals should be trained to respond to patients with mental illness who might be at risk of injuring themselves or others.

   b. Ensuring access to mental health services is imperative. Mental health services should be readily available to persons in need throughout their lives or through the duration of their conditions. Ensuring an adequate availability of psychiatric beds and outpatient treatment for at-risk persons seeking immediate treatment for a condition that may pose a risk of violence to themselves or others should be a priority.

   c. Community understanding of mental illness should be improved to increase awareness and reduce social stigma.

   d. Laws that require physicians and other health professionals to report those with mental illness who they believe pose an imminent threat to themselves or others should have safeguards in place to protect confidentiality and not create a disincentive for patients to seek mental health treatment. Such laws should ensure that physicians and other health professionals are able to use their reasonable professional judgment to determine when a patient under their care should be reported and should not hold them liable for their decision to report or not report.

Although reducing firearm-related violence requires keeping firearms out of the hands of persons who may harm themselves or others, the College cautions against broadly including those with mental illness in a category of dangerous persons. It is important that firearm restrictions be applied appropriately by limiting access to persons with mental illness who exhibit risk factors for dangerous behavior (103). Mental illness continues to have a stigma in our society, and many persons with mental illness remain unidentified and untreated. Although persons with certain types of serious mental illness are more prone to violence, the overall proportion of violent acts committed by those with mental illness is relatively low (30). Persons with mental illness are more likely to be victims than perpetrators of violence, and those that receive adequate treatment from health professionals are less likely to commit acts of violence (104).

Ensuring access to mental health services is critical. To date, such services have been minimally available, hugely undervalued, and poorly financed. Although positive steps have been taken to expand access to mental health services, more must be done. For example, the College supported the passage of the Mental Health Parity and Addiction Equity Act of 2008, but better access to psychiatric treatment will not be a reality without essential federal and state funding. The College is pleased that the Patient Protection and Affordable Care Act requires all health plans sold in the United States to cover preventive services, such as depression screenings, at no cost to the patient. Mental health and substance use disorder services are classified as part of 10 essential health benefits that all health plans must cover, and the law prohibits health insurers from denying patients coverage or charging them more because of preexisting conditions. The U.S. Department of Health and Human Services estimates that about 3.9 million persons who currently have insurance in the individual market will gain access to mental health or substance use disorder ser-
vices (105). It is vital that access to mental health services continue to be increased and that state, local, and community-based behavioral health systems have the resources they need to provide care, raise awareness, and reduce social stigma. Coordination of mental health care with general health and social services is also essential.

Ideally, a person with mental illness would not become a threat to himself or others. The College supports the American Psychiatric Association’s position that early identification and treatment of mental disorders should be a national priority and would reduce the consequences of untreated mental disorders (106). It is important that the necessary resources are available to those who seek help at any stage. Sufficient investment in the infrastructure is especially critical to accommodate persons with an urgent need for mental health care so that they are not turned away simply because there are not enough inpatient beds, facilities, or health professionals to care for them. According to a study by the Treatment Advocacy Center (107), the number of public psychiatric beds available per 100,000 persons decreased from 340 in 1950 to 17 in 2005. The study suggested a minimum of 50 public psychiatric beds per 100,000 persons and found that 42 states had less than half the minimum number needed. Persons with mental health disorders are increasingly turning to already overcrowded emergency departments because of an inability to access psychiatric care. A study by the Agency for Healthcare Research and Quality (108) found that approximately 12 million emergency department visits in 2007 were due to mental health or substance use disorders in adults. This accounted for one eighth of the 95 million visits to emergency departments by adults that year.

Most states have “duty-to-warn” or “duty-to-protect” laws that permit or require physicians and other health professionals to report patients with mental illness who pose an imminent threat to themselves or others. Several laws, notably the New York Secure Ammunition and Firearms Enforcement Act (NY SAFE Act), require mental health professionals to report patients who, in their professional judgment, are likely to cause serious harm to themselves or others. Because many states have or are considering reporting laws, it is important to establish safeguards on what should be reported and how.

Several concerns have been raised about the reporting provision in the NY SAFE Act and similar laws. One concern is that the law may adversely affect the willingness of persons who would benefit from mental health treatment to seek treatment or continue with ongoing treatment. Another concern is that it does not give health professionals the option to try to treat the patient first through such interventions as hospitalization or altering medication. There is also concern that the law intrudes into the health professional–patient relationship by mandating disclosure of information in circumstances that may not necessarily require immediate action. The American Psychiatric Association believes that laws with blanket reporting requirements “are likely to be counterproductive and should not be adopted.”

The College agrees with the American Psychiatric Association that blanket reporting laws may have unintended consequences that need to be carefully assessed by legislators when they are considering proposals to mandate that physicians and other health professionals report on patients with mental illness who are likely to cause serious harm to themselves and others. However, if states decide to enact such laws, they should be written in a way that protects confidentiality and does not serve as a deterrent for patients seeking mental health treatment. These laws have risks and benefits that should be carefully considered. Although such laws may help prevent avoidable deaths and injuries, they can also stigmatize persons with mental illness, create a disincentive for them to seek treatment, and undermine the patient–physician relationship.

As discussed later in this paper, the College calls for more research on the effect of laws requiring physicians to report persons with mental illnesses or substance use disorders that potentially put them at greater risk of inflicting harm on themselves and others through the use of firearms.

There are times when confidentiality must be breached in order to protect public safety. In these instances, care must be taken to allow health professionals to use their own judgment to determine when a patient presents enough of a threat that they must be reported under the criteria defined by statute as representing an imminent threat to themselves or others. In addition, unless there is evidence of malice or misconduct, health professionals should not be held liable for their decision to report or not report (109). More research is needed on the effect of these laws, methods to assist in the identification of high-risk persons, and interventions to assist the subset of persons with mental illness who are at risk of harming themselves or others.

7. The College favors enactment of legislation to ban the sale and manufacture for civilian use of firearms that have features designed to increase their rapid killing capacity (often called “assault weapons” or semiautomatic weapons) and large-capacity ammunition and retaining the current ban on automatic weapons for civilian use. Although evidence on the effectiveness of the Federal Assault Weapons Ban of 1994 is limited, the College believes that there is enough evidence to warrant appropriate legislation and regulation to limit future sales and possession of firearms that have features designed to increase their rapid killing capacity and can, along with a ban on large-capacity ammunition magazines, be effective in reducing casualties in mass shooting situations. Such legislation should be carefully designed to make it difficult for manufacturers to get a semiautomatic firearm exempted from the ban by making modifications in its design while retaining its semiautomatic functionality. Exceptions to a ban on such semiautomatic firearms for hunting and sporting purposes should be narrowly defined.

The College has long supported a ban on automatic weapons and was in favor of the 1994 Public Safety and Recreational Firearms Use Protection Act (Federal Assault Weapons Ban). This act, which was included as part of the Violent Crime Control and Law Enforcement Act of 1994, sought to reduce the level of gun violence by prohibiting the sale of 18 models and variations of semiautomatic weapons with military-style features or features that seem to have an innately criminal application and create the appearance of an automatic weapon. The ban also applied to copies or duplicates of those weapons. Thus, the law is considered by many to be more of an accessories ban than a ban.
on the actual weapon. Arguably, the most important provision of the law prohibited the use of most large-capacity magazines (LCMs), which could be used by weapons within and outside the scope of the weapons ban. Such magazines are considered to be ammunition-feeding devices with more than 10 rounds of ammunition. When the ban became effective, an estimated 40% of guns not included in the ban had the ability to use LCMs (110). An estimated 18% of civilian-owned firearms and 21% of civilian-owned handguns were equipped with LCM capability when the ban took effect (110).

The law contained a grandfather clause that allowed for the continued possession and use of semiautomatic weapons and LCMs that were banned under the law but were obtained legally before the implementation of the ban. This provision is sometimes cited as the reason that the law did not have as much of an effect on crime rates related to assault weapons or LCMs.

The effect of the Federal Assault Weapons Ban has been greatly debated. Inconsistent reporting after the ban took effect and a large increase in production of assault weapons and LCMs that would be grandfathered under the law before the implementation of the ban made it difficult to accurately judge the effect of the overall law or the assault weapons and LCM bans independently. The Urban Institute published an impact assessment of the law in 1997 (111) and found the grandfathering stipulation to be a limitation to measuring the overall effect of the law. A report submitted to the Department of Justice (111) noted a lack of evidence but suggested that the ban may have reduced crime slightly if it had been in place for an extended period.

Nevertheless, some evidence suggests that the Federal Assault Weapons Ban had an effect on the use of assault weapons in crimes. The final of 3 reports submitted to the Department of Justice on the ban’s impact (112) analyzed crime data in 6 major cities after the ban took effect and found that crimes involving the most common types of assault weapons decreased by 17% to 72% and that the number of assault weapons used in crimes decreased by 24% to 60% in the same areas. The author noted a steady or increasing use of other guns equipped with LCMs in the same jurisdictions studied.

A ban on LCMs has been shown to be effective in reducing the number of casualties associated with mass shootings. One study (91) found that semiautomatic weapons were 34% to 56% more likely to be used in a crime. Such weapons are associated with significantly more wounds per gun in homicides than revolvers or long guns and are associated with higher mortality (113, 114). Semiautomatic and automatic pistols are believed to be capable of inflicting greater injury because more bullets can be fired in a shorter period (115). Thirty-seven percent of police departments surveyed indicated an increase in the use of assault weapons by criminals after the Federal Assault Weapons Ban was lifted (116). When Maryland imposed a more stringent ban on assault pistols and high-capacity magazines in 1994, it led to a 55% decrease in assault pistols recovered by the Baltimore Police Department.

Although evidence on the effectiveness of the Federal Assault Weapons Ban is limited, the College believes that there is sufficient evidence that appropriate legislation and regulation to limit future sales and possession of firearms that have features designed to increase their rapid killing capacity can, along with a ban on LCMs, be effective in reducing casualties in mass shooting situations. Although such a ban may not reduce overall crime or deaths from firearms significantly, it would reduce the number of casualties in mass shooting incidents before the shooter could be disarmed, arrested, or subdued by police. The College acknowledges the need for more research in this area to better inform policy.

8. The College supports efforts to improve and modify firearms to make them as safe as possible, including the incorporation of built-in safety devices (such as trigger locks and signals that indicate a gun is loaded). Further research is needed on the development of personalized guns.

The College advocates for improved engineering controls to improve firearm safety.

Personalized or “smart” firearms are those that can only be fired by an authorized user or that use an internal mechanism incorporated in the design of the weapon as opposed to an external locking device or accessory attached to the weapon. Research and development of gun designs with the potential to prevent unintentional shootings can be traced to the late 19th century but experienced a resurgence in the 1980s and 1990s as a result of several high-profile shootings and greater public outcry for increased gun safety. The idea behind personalized firearms is that if a gun can only be accessed by a single or several authorized users, unintentional deaths and suicides would be reduced and a stolen firearm would be worthless to a perpetrator.

Although personalization technology exists, whether the concept is commercially viable in the United States remains to be seen. The German company Armatix obtained approval to sell its iP1 smart gun in the United States. The gun communicates with a watch (the Armatix iW1) using radio frequency identification signals that activate the gun for use. The watch requires a personal identification number that releases the firing pin lock in the weapon, allowing the user to fire (117). If the watch is outside of the specified range, the gun will not fire. The Utah-based company Kodiak Arms developed an accessory called the Intelligun, a locking system that allows up to 20 authorized users to unlock the weapon using their fingerprint (118). Owner-authorized firearms continue to be researched and developed by companies.

Three states currently have laws for personalized firearms. In 2002, New Jersey enacted legislation requiring all new guns sold in the state to be personalized within 3 years of a personalized gun being introduced for sale in the state (119–121). Maryland law defines personalized or smart gun technology and requires the state Handgun Roster Board to report to the Governor and General Assembly annually on the status of personalized handgun technology (122). Massachusetts law requires that handguns or large-capacity weapons be sold with a safety device that would prevent unauthorized users from firing the weapon and considers personalization an alternative to locking devices, although no personalization technology has been identified as acceptable (123). No federal laws exist that define or consider personalized gun technology.
9. More research is needed on firearm violence and on intervention and prevention strategies to reduce injuries caused by firearms. The Centers for Disease Control and Prevention, National Institutes of Health, and National Institute of Justice should receive adequate funding to study the impact of gun violence on the public’s health and safety. Access to data should not be restricted.

The ACP believes that additional research is needed on proposed or current policy proposals, laws, and regulations for which there are limited or conflicting data on their effectiveness in reducing preventable firearm-related injuries and death. While conducting its literature review, the College identified significant gaps in data where more evidence would be useful to guide policy on firearm violence. These issues should be made a priority in a national research agenda:

The effectiveness of concealed-carry laws on increasing or decreasing firearm-related injuries and deaths, specifically exploring the protective and deterrent value that some argue supports the value of concealed-carry laws versus the risk that such laws may increase the risk for preventable injuries and deaths, as opponents argue. Research should explore the effect of “must-issue” versus “shall-issue” laws.

The effectiveness of “waiting periods” in preventing firearm-related injuries and deaths, particularly exploring the potential preventive value of reducing suicides and spontaneous acts of violence versus limiting access to persons who believe that they have an urgent need for a firearm for self-defense.

Requiring physicians to report persons with mental illness or substance use disorders that potentially put them at greater risk of inflicting harm on themselves and others through the use of firearms. Such research should explore:

- Predictive ability of clinicians to identify patients at risk;
- Potential stigmatization of patients with mental illness;
- Potential for such reporting to deter persons with mental illness from seeking treatment;
- Impact on the patient–physician relationship and confidentiality;
- Better defining what mental health conditions should be reportable and the clinical criteria for making such judgments; and
- Overall effectiveness of reporting requirements in preventing patients who are at risk of harming themselves and others from obtaining firearms, and how to structure reporting laws to have the greatest preventive impact without creating unintended adverse consequences for patients with mental illness.

Several congressional efforts from the 1990s to 2011 limited federal research on firearm violence, greatly reducing the available scientific data on the issue. The College was pleased that an executive order issued by President Obama in January 2013 to reduce firearm violence included a charge to the CDC to research the causes and prevention of firearm violence. The CDC asked the Institute of Medicine and the National Research Council to identify the most pressing research needs for the public health aspects of firearm-related violence. The Institute of Medicine released a report in June 2013 with a recommendation that research should focus on 5 high-priority areas: the characteristics of firearm violence, risk and protective factors, prevention and other interventions, firearm safety technology, and the influence of video games and other media (52).

The College supports this research agenda and urges Congress and the Obama administration to provide adequate funding to the CDC, National Institutes of Health, and National Institute of Justice to study the effect of firearm violence on the public’s health and safety. Access to data should be unrestricted so that researchers can effectively study the causes of firearm violence and develop evidence-based policies to reduce the rate of firearm injuries and deaths in the nation (15).

Conclusion

Firearm violence is a public health problem that requires the nation’s immediate attention. The ACP has long advocated for policies to reduce the rate of firearm injuries and deaths in the United States and once again calls on its members, policymakers, and the public to take action on this important issue. Although there is more to learn about the causes and prevention of firearm violence, the available data support the need for a multifaceted and comprehensive approach that addresses culture, substance abuse and mental health, firearm safety, and reasonable regulation, consistent with the Second Amendment, to prevent the devastating effects of needless firearm-related injuries and deaths.

APPENDIX 2: EXISTING FIREARM LAWS

Background Checks

Federal background checks are mandated by the Brady Act. The NICS, which was established under the Brady Act, was launched on 30 November 1998, and more than 160 million background checks have been requested (with nearly 2 million of them resulting in denials) (124) by federal and state authorities to date. The Brady Act requires a background check if a purchase is being made with a federally licensed firearm dealer but exempts private sellers and sales made at gun shows (gun show loophole). Several states have gone further and adopted legislation to address areas of the gun show loophole, including California, Colorado, Illinois, New York, Oregon, and Rhode Island. The 1986 Firearm Owners’ Protection Act changed a previous definition of a private seller as someone who sells 4 or fewer guns a year to someone who does not sell guns as their primary livelihood, ostensibly making the field of private sellers larger and increasing the access to purchasers who do not want to undergo a background check (125).

NICS Database Overview

The NICS consists of 3 databases: the National Crime Information Center, the Interstate Identification Index, and the NICS Index. Whereas the National Crime Information Center and Interstate Identification Index provide information on criminal history maintained by the FBI, the NICS Index relies heavily on the voluntary participation of state and local authorities to add potentially prohibiting information to NICS, such as mental health records. Of note, no actual medical history or medical records are stored in the system—only a person’s name and other individual identifying information, such as date of birth, is
stored. If a hold or denial is issued, the system does not identify the reason for denial.

**NICS Improvement Amendments Act of 2007**

The NIAA was passed in 2007 and signed into law in January 2008 in the wake of a mass shooting on the campus of Virginia Tech University, which killed 32 persons and injured 17, by a man who had been found to have severe mental illness but was not included in the NICS database because of a loophole in the law. It authorized the U.S. Attorney General to make additional grants to states to improve electronic access to records and provide incentives to states to turn over prohibiting records with an emphasis on domestic violence records and persons adjudicated as mentally defective. It also clarified the standard for mental adjudication:

- No department may provide any such record if the record had been set aside or the person released from treatment.
- The person has been found by a court or board to no longer have the condition that was the basis of adjudication or commitment.
- The adjudication or commitment is based solely on a medical finding of disability without opportunity to be heard by a court or board.

The NIAA also allowed states to be eligible for a 2-year waiver of the matching requirement in the National Criminal History Improvement grants program provided that they supply at least 90% of the records relevant to determining whether a person is disqualified from possessing a firearm under federal or applicable state law (79).

**State Reporting Requirements**

State reporting requirements vary depending on state law. Most states maintain the minimum federal standards for reporting an individual as adjudicated mentally defective, and the most common variations consist of what degree and type of involuntary commitment requires reporting (time of involuntary hold and inpatient vs. outpatient mandated treatment). Concerns about HIPAA Privacy Rule violations by state agencies not explicitly mandated to share information directly with NICS also account for difficulty in determining the strength of state reporting requirements.

A summary of the range in state reporting laws is as follows:

- All persons prohibited by federal or state law from purchasing or possessing a firearm due to mental illness (Illinois, Nebraska, and Pennsylvania; Connecticut, Iowa, and Kentucky only refer to the federal prohibition)
- Any person determined by a court or other lawful authority to be a danger to self or others because of a mental disorder or defect (California, Florida, Illinois, Indiana, Nebraska, Oregon, and Tennessee), including any person ordered to undergo outpatient treatment on this basis (15 states)
- Any person determined by a court or other lawful authority to lack the mental capacity to contract or manage his or her own affairs because of a mental disorder or defect (Florida, Illinois, Tennessee, and West Virginia), including any person appointed a guardian on this basis (11 states)

- Any person formally committed involuntarily to a mental institution or asylum as an inpatient (38 states report at least some persons)
- Any person found not guilty by reason of insanity, mental disease or defect, or lack of mental responsibility in a criminal case (21 states)
- Any person found guilty but insane in a criminal case (Indiana, Nevada, Oregon, Tennessee, and Utah)
- Any person found incompetent to stand trial (20 states)
- Any person who falls within the categories of persons prohibited under state law from possessing firearms (California, Illinois, Nebraska, Pennsylvania, and Texas)
- Any person placed on a 72-hour involuntary psychiatric hold triggers a 5-year prohibition against firearms possession (California)
- Licensed psychotherapists must report particularly dangerous persons, who become prohibited from possessing firearms (California)
- Courts must ensure that information is reported to NICS and to an in-state agency (Colorado, Minnesota, Tennessee, and Washington), which is also charged with ensuring reporting to NICS (Connecticut and Illinois)
- Law enforcement agencies other than NICS that conduct firearm purchaser background checks or issue firearm purchaser licenses have access to any databases containing relevant mental health records (California, Colorado, and Illinois)
- Mental health facilities must report persons who are prohibited from possessing firearms for mental health reasons if such persons are not reported by courts (California and Delaware)
- Mental health records are reported immediately upon adjudication or commitment that renders a person prohibited from purchasing or possessing a firearm (Arkansas, California, and Michigan) (126)

**Interaction of Federal HIPAA Rule and State Law**

A U.S. Congressional Research Service analysis of HIPAA with regard to state privacy law determined:

Although the HIPAA privacy rule provides a federal floor with respect to the uses and disclosures of PHI [protected health information], the overall scope of the privacy rule may be modulated by state law. If a state requires covered entities [health plans, health care providers, or health care providers who transmit health information electronically] to disclose prohibiting mental health records to NICS, the HIPAA privacy rule does not prohibit that disclosure. Therefore, the privacy rule is most relevant as a potential obstacle where prohibiting mental health records are held by covered entities in a state that does not require disclosure of such records to NICS. This would be the case even if the state expressly allowed, but did not explicitly require, disclosure of prohibiting mental health records to NICS because merely permissive state laws are insufficient to exempt disclosure from the HIPAA privacy rule.” (127)
HIPAA privacy mandates have not been shown to be a source of significant difficulty or problematic in the 10 states with the most gun regulations (California, New Jersey, Massachusetts, Connecticut, Hawaii, New York, Maryland, Illinois, Rhode Island, and Michigan) or the 10 states with the fewest gun fatalities (adjusted for population) (Hawaii, Massachusetts, Rhode Island, New York, New Jersey, Connecticut, Minnesota, Iowa, California, and Maine). Except for Rhode Island, the states listed as having the most gun regulations and fewest gun fatalities have some type of NICS reporting mandate, NICS reporting authorization, or system for the collection of mental health records pursuant to state law (127).

California NICS Mental Health Reporting Model
California, despite not having a HIPAA reporting mandate, has one of the highest NICS mental health reporting rates. A memorandum of understanding between the state and the federal government directs that the federal government would only use state records for purposes permissible under state law (78). California state law requires that mental health facilities report mental health records to the state department of justice, ultimately removing HIPAA privacy obstacles. California has the highest total number of records submitted to NICS (279,589) and the fifth most records submitted per 100,000 citizens (750.5) (78).

Virginia After the Virginia Tech Shooting
More than a year before the Virginia Tech shooting, the shooter had been determined to be a potential threat to himself and was ordered by a judge to an outpatient mental health treatment program. However, because only those who are ordered into an inpatient treatment program are reported to NICS, he was able to legally obtain some of the firearms used in the attack. Soon afterward, then-Governor Tim Kaine signed an executive order (codified in 2008) requiring that any involuntary treatment order, including outpatient treatment, be reported to NICS (128). In the first 3 years after the order was issued, 438 firearm purchases were ordered to be denied as the result of the new state reporting requirements (126).

Dangerous Persons Laws
Some states have taken a different approach to situations in which the risk for injury to a person or those around them may be heightened. Indiana has implemented a “dangerous persons” law that is not tied to involuntary commitment or even necessarily to having a diagnosis of mental illness but to a determination of dangerousness. In addition, the law focuses on removing current access to guns rather than merely foreclosing the future purchase of a new gun. The Indiana law allows clinicians or the police to take steps to have firearms removed without a warrant from persons who are assessed to pose a danger to themselves or others. An analysis of weapons seizure cases resulting from the law in 2006 and 2007 examined the demographics of defendants and the circumstances of the weapon seizure. Defendants were primarily white men, and risk for suicide was the leading cause of confiscation (56% in 2006 and 71% in 2007) (129).

Another approach to dangerous persons is California’s law allowing seizure of guns from persons with mental illness who are detained for dangerousness in a 72-hour hold, pending a judicial hearing in 14 days. The law provides for a 5-year ban on firearm possession after placement on a 72-hour involuntary psychiatric hold for danger to self or others. However, this restriction does not trigger a federal ban. Were such an individual to attempt to purchase a firearm in another state, the required background check would not reflect the California prohibition (130).

New York State has implemented one of the strictest dangerous person reporting requirements in the nation. The NY SAFE Act, enacted in 2013, requires mental health professionals—physicians, psychiatrists, psychologists, registered nurses, or licensed clinical social workers—to report to their local director of community services (DCS) or their designee when, in his or her reasonable professional judgment, a patient is “likely to engage in conduct that would result in serious harm to self or others.” The DCS then reviews the case to determine whether to report it to the state Division of Criminal Justice Services (DCJS). If the case is reported, the DCJS receives basic information from the DCS that allows it to determine whether the patient has a firearm license and, if so, whether it should be suspended or revoked; whether the patient is ineligible for a license; or whether the patient is no longer permitted under state or federal law to possess a firearm (131). No health records are shared with the DCJS. The information may also be used to determine eligibility for a firearm license in the 5 years after the patient was reported to the DCJS (132). The law allows for an exemption if, in the mental health professional’s opinion, a report would endanger the health professional or increase the risk for danger to potential victims.

Concealed-Carry, Right-to-Carry, and Shall-Issue Laws
All 50 states have concealed-weapons or right-to-carry laws or do not require a permit to carry a concealed weapon. Alaska and Vermont do not require their citizens to obtain concealed-carry permits but will issue them for those who travel to states that honor concealed-carry permits from other states. Forty states are considered shall-issue states (issuing authority is required to grant a permit if certain statutory criteria are met), and 10 states are considered may-issue states (issuing authority has the discretion to grant or deny the permit on the basis of certain factors) (133). It is widely believed that shall-issue states are more lenient than may-issue states, which can deny a person on the basis of state-specific criteria, such as moral character or perceived need (133).

The District of Columbia is considered a “no-issue” jurisdiction, in which one is allowed to carry a weapon in public, either openly or concealed, only under limited circumstances. The Supreme Court decision in District of Columbia v. Heller overturned the District’s ban on weapons possession but did not explicitly address the right to carry, and the issue remains unresolved.

Waiting Periods
A 5-day waiting period was enacted as part of the Brady Act. The waiting period was in effect between 1993 and 1998, when it was replaced by the NICS instant background check system. Since then, states have voluntarily passed additional laws pertin-
Duty to Warn and Duty to Protect

Role of Physicians in Reducing Firearm Injuries and Death

Duty to Warn and Duty to Protect

Duty-to-warn and duty-to-protect statutes can be dated to the California Supreme Court decision in _Tarasoff v. Regents of the University of California_. In the fall of 1969, a college student was murdered by a classmate who had expressed his intent to kill her during a session with a psychologist earlier that summer. The psychologist informed campus police that the man was a potential danger to others, and the man was detained. Campus police released him, claiming that they did not see evidence of irrational behavior. However, neither the woman nor her family was informed of the threat, and she was killed a short time later (138).

Her parents sued the psychologist and university health care providers and administrators. In 1974, the Court determined that psychotherapists have a “duty to warn” prospective victims of violent acts. That ruling was vacated in 1976, and the subsequent ruling by the Court broadened the statute to a “duty to protect,” stating that when a therapist determines “that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim . . . .” (139).

Some states have adopted statutes similar to those adopted in the wake of the Tarasoff case, and case law determined by individual state jurisdictions has broadened or narrowed the scope of legal protection for psychologists, psychotherapists, and health care providers to disclose information (140). Most states require or permit health care providers to share confidential information about patients with the appropriate authorities when their patients make serious and identifiable threats against a third party. Four states do not have duty-to-warn or duty-to-protect laws: Maine, Nevada, North Carolina, and North Dakota.

Multiple Purchases of Firearms and Gun Trafficking or Exporting

Under the Gun Control Act of 1968, federal law requires federally licensed firearm dealers to report multiple sales of handguns to the same purchaser if the individual purchases 2 or more handguns at the same time or within 5 business days of each other but does not limit the number of firearms a person can purchase during a given period. Any record of multiple sales reported to the ATF by state or local law enforcement agencies must be destroyed within 20 days of receipt (135). The ATF was recently authorized to implement similar reporting requirements for multiple sales of certain rifles in Arizona, California, New Mexico, and Texas for a 3-year span.

Only 5 states (California, Maryland, New Jersey, South Carolina, and Virginia) and the District of Columbia have enacted laws limiting the number of handgun purchases or registrations. New York City strictly limits all firearm purchases to 1 handgun and 1 rifle or shotgun every 90 days; however, the restrictions do not apply statewide (136). Two states (South Carolina and Virginia) repealed their 1-gun-per-month restrictions in 2004 and 2012, respectively, over doubts about effectiveness, claims of infringement on Second Amendment rights, and excessive exemptions potentially limiting the value of the law.

Straw Purchases

Straw purchases occur when a person obtains a firearm from a federally licensed dealer with the express intent to sell it to another individual unable to complete the application and pass a background check on the grounds of criminal or mental health history, age, domestic violence convictions, or other federal or state-specific disqualifying criteria. Purchasing a firearm for a person legally prohibited from possessing one is a federal offense punishable by up to 10 years in prison and a $250,000 fine (137). Several states have enacted legislation for straw purchasing, including California, Illinois, Colorado, Delaware, Maryland, Nebraska, Ohio, and Oregon.

Guidance on HIPAA From the U.S. Department of Health and Human Services

The HIPAA Privacy Rule permits a covered entity to disclose protected health information, including psychotherapy notes, when the covered entity has a good-faith belief that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or others and is made to a person reasonably able to prevent or lessen the threat. This may include, depending on the circumstances, disclosure to law enforcement, family members, the target of the threat, or others who the covered entity has a good-faith belief can mitigate the threat. The disclosure also must be consistent with applicable law and standards of ethical conduct, such as those codified at 45 C.F.R §164.512(j)(1)(i). For example, consistent with other law and ethical standards, a mental health care provider whose teenage patient has made a credible threat to inflict serious and imminent bodily harm on one or more fellow students may alert law enforcement, a parent or other family member, school administrators or campus police, or others the provider believes may be able to prevent or lessen the chance of harm. In such cases, the covered entity is presumed to have acted in good faith, where its belief is based on the covered entity’s actual knowledge (such as the covered entity’s own interaction with the patient) or in reliance on a credible representation by a person with apparent knowledge or authority (such as a credible report from a family member or other person). More information can be found in 45 C.F.R §164.512(j)(4).

For threats or concerns that do not rise to the level of “serious and imminent,” other HIPAA Privacy Rule provisions may apply to permit the disclosure of protected health information. For example, covered entities generally may disclose protected health information about a minor to the minor’s personal representative (a parent or legal guardian), consistent with state or other laws, such as 45 C.F.R §164.502(b).
Right of Physicians to Counsel Patients on Firearm Safety

The physician’s first and primary duty is to put the patient first. To accomplish this, physicians and the medical profession have been granted a privileged position by society and the government. In recent years, several states have proposed or adopted legislation or regulations that interfere, or have the potential to interfere, with appropriate clinical practice.

In Florida, legislation expressly restricted health care practitioners from asking patients questions related to gun safety or recording information from those conversations in patients’ medical records on penalty of harsh disciplinary sanctions, including fines and permanent revocation of their licenses to practice medicine. Under the law, physicians following established protocol by informing patients how they may limit the lethal risks posed by firearms could be at risk of losing their medical licenses. The ACP Florida Chapter joined in a suit contesting the law, arguing that it would deprive physicians and other health care practitioners of their First Amendment right to freedom of speech and also would deprive patients of their First Amendment right to receive potentially life-saving information on safety measures they can take to protect their children, families, and others from injury or death resulting from unsafe storage or handling of firearms. The federal district court judge agreed, and an injunction has been issued preventing the law from being enforced. The state of Florida appealed the decision, and arguments were heard by the U.S Court of Appeals for the Eleventh Circuit in July 2013. An opinion has yet to be issued, and the injunction remains in place. In response to the Florida legislation and other recent attempts to introduce regulations that would infringe on clinical practice and patient–physician relationships, the College issued a statement of principles on the role of governments in regulating the patient–physician relationship (141). The College’s Chief Executive Officer, Steven Weinberger, MD, and his counterparts at the American Academy of Family Physicians, American Academy of Pediatrics, American Congress of Obstetricians and Gynecologists, and American College of Surgeons wrote an editorial urging legislators to abide by principles that put patients’ best interests first by respecting the importance of scientific evidence, patient autonomy, and the patient–physician relationship (142).

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121. NJ Stat Ann §2C:58-2.2-2.5.
123. Mass Gen Laws ch 140, §§131K.
131. NY Mental Hyg Law §9.46.