COMMENTARY

Physicians, Firearm Counseling, and Legal Liability

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ABSTRACT: To explore the potential legal consequences to physicians of counseling their patients about gun violence, I consider the question: If a patient divests herself of a firearm upon the advice of her physician and is subsequently the victim of a rape, robbery, aggravated assault, or homicide, could she or her survivors argue convincingly that her physician was negligent? In attempting to answer this question, the four elements that a patient must establish to prevail in a malpractice action against a physician are discussed, and possible strategies for establishing them in the hypothetical case are explored. I conclude that plausible arguments can be made against the hypothetical physician engaged in firearm counseling as described. Conversely, physicians not engaging in discussions of gun safety face substantially lower liability risks.

RECENTLY, there have appeared in the medical literature a number of calls for physicians to take a more active role in the prevention of gun violence.[1-4] The American Medical Association has recently published a *Physician Firearm Safety Guide* to assist physicians in this endeavor.[5]

Medical literature addressing the subject of gun violence, however, noticeably lacks dialogue on the question of whether physicians are properly the persons to be imparting gun information to patients. Likewise, little, if any, discussion of the legal implications of physician involvement in this area has occurred. This article is an attempt to explore the potential legal ramifications of physicians' counseling their patients about gun violence. Toward this end, I will consider the following narrow question: If a patient divests herself of a firearm upon the advice of her physician and is subsequently the victim of a rape, robbery, aggravated assault, or homicide, may she or her survivors argue convincingly that her physician was negligent? I shall assume that the gist of the counsel given by the hypothetical physician to the patient is the following: as concerns guns, the risk of harm outweighs the benefits afforded by self-protection.[6-11]

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MEDICAL MALPRACTICE—AN OVERVIEW

A patient who brings a negligence action against a physician must establish four elements to prevail. First, she must establish that the physician owed her a duty to conform to the standard of care established by law for the protection of patients against an unreasonable risk of harm. Second, the patient must establish that the physician breached that duty—in other words, that the physician's conduct fell below the standard of care. Third, she must establish that the defendant physician's breach was both the actual cause and the legal or "proximate" cause of her injuries. Fourth, the patient must establish that she was in fact injured. As already noted, for the purposes of this article, we are assuming the occurrence of an injury.

Duty

United States law, with a few exceptions, does not require one person to act affirmatively to assist another. Once a person acts, however, he is under a legal duty to act in a reasonably prudent manner. Thus, even though physicians have no legal duty to counsel their patients about guns, the physician who undertakes to counsel a patient owes a duty to do so non-negligently.

Breach of Duty and the Standard of Care

Medical Custom. Assuming that a physician advises his patients on gun safety, what should he tell those patients? Stated otherwise, what

would the standard of care be as it pertains to advising patients about firearms?

Generally, "the physician is under an obligation to exercise the same degree of knowledge, skill, diligence and care that the ordinary competent practitioner would exercise under the same or similar circumstances."[12] This circular definition means that, as a rule, the medical profession itself sets the standard of care in medical malpractice cases. To prove that he has met the standard of care, the defendant physician argues not that his treatment or recommendation is effective in the patient's condition; rather, he argues that he did what was medically customary.

In fact, the defendant physician need not even show that he did what most physicians would have done under the circumstances. In most states, all he must show is that a "respectable minority" of physicians would have done what he did.[13]

Under this doctor-friendly standard, physicians or surgeons wishing to counsel patients to dispose of their firearms could probably do so in relative safety. I qualify this assertion because while Cassel et al[1] have reported that 19.7% (arguably a "respectable minority") of responding internists and surgeons claim to "talk to patients about having a gun in the house," the content of those conversations was not reported. Whether a physician who has told his patient "as concerns guns, the risk of harm outweighs the benefits afforded by self-protection" has met the standard of care would be a question of fact to be decided by weighing the testimony of dueling expert witnesses.

The "Lay Standard." Since physicians warning their patients about guns are imparting information that is arguably nonmedical, courts might refuse to accord the medical profession the same deference that they normally do. Thus, conformance to customary practice might not be given conclusive weight.

In such a case, the court might allow the jury to weigh without expert testimony the reasonableness of advice the doctor has given the patient. One way of doing this would be to employ the "lay standard" many states use in "informed consent" cases. Under this standard, physicians must provide their patients with that information which the ordinary, reasonable patient would want to know.[14]

Under this more patient-friendly but less doctor-friendly standard, the legal risk to our defendant physician would probably be greater. Although a discussion of the strengths and weaknesses of each side of the gun control debate is beyond the scope of this article, the following brief digression will help clarify the risk to physicians under this standard.

It has been suggested that, as concerns firearms, the prevailing view being promulgated in medical and public health literature differs substantially from the view emerging from criminologic literature.[15] Kellermann et al[16-18] have argued that the family gun is more likely to kill you or someone you know than to be used in self-defense. However, criminologist Kleck[19] has estimated that there were 2.5 million episodes of defensive gun use per year in the United States during the period 1988 to 1993, of which about 400,000 "were claimed by the [defensive gun users] to have certainly or almost certainly saved a life."[20] This figure dwarfs the 35,957 total deaths attributable to firearms annually.[5] Indeed, "As of 1995, at least fifteen surveys indicated 700,000 or more annual [defensive gun uses] (which would equal or exceed the number of criminal misuses of guns), while just one indicated fewer than 100,000."[20] For our purposes, however, whether the 700,000 plus figure is correct does not matter so much as whether a patient being advised about gun ownership would find it relevant that a number of criminologists[21-24] and physicians[25,26] believe that it is correct. Certainly, the argument that a patient would find such information relevant as she weighs the risks and benefits of gun ownership—and consequently that the counseling physician omitting such information had not met the standard of care—would not be a difficult one to make.

Judicial Risk-Benefit Balancing. Rarely, courts may engage in judicial risk-benefit balancing to dictate the standard of care themselves.[27] The best known example of this in a medical context is the case of *Helling v Carey*.[28] In that case, the defendant ophthalmologists proved that it was not medically customary to test persons under the age of 40 for glaucoma. Nevertheless, the Washington State court held as a matter of law "that the reasonable standard that should have been followed . . . was the timely giving of this simple, harmless pressure test . . . ."

Under this latter formulation of the standard of care, the legal risk to our defendant physician would probably be comparable to his risk under the lay standard. Courts would engage in the same risk-benefit balancing used by patients under the lay standard discussed, and would be free to consider directly the arguments of each side of the gun control debate.

Causation

Actual Causation. As noted, in order for the patient to prevail in her action against the physician, she must prevail on all four elements. Let us assume, therefore, that the physician's advice is determined to have fallen below the standard of care. The plaintiff patient would next need to prove that the negligence of the physician was both the actual cause and the proximate (or legal) cause of her injury.

Actual causation is a factual issue decided by the jury. Most commonly, the test for actual causation is the "but for" test—the defendant's act is the actual cause of the plaintiff's injury if it can be said that the injury would not have occurred but for the defendant's act. Thus, in our firearm scenario, the plaintiff would need to establish that but for the physician's advice, she would not have been injured. This is a two-part argument: but for the physician's advice, she would have been armed at the time of the attack, and her being armed would have prevented the injury.

Establishing the first part would necessitate convincing the jury that the patient would not have been without her firearm but for the advice of her physician. The majority of American jurisdictions would employ an objective "reasonable patient" test, which asks what the reasonable patient would have done had the physician's advice met the standard of care.[29]

Several arguments could then be made as tending to show actual causation in this case. First, in our hypothetical case, timing strongly suggests actual causation: the patient owned a gun and disposed of it after her visit to the doctor's office. Second, the patient could argue that as a reasonable patient, she heeded the advice—couched as medical advice—of her doctor. Indeed, the mere fact that the physician engaged in such counseling constitutes an implicit assertion on his part that he had the power to influence patient behavior in this regard.

Establishing the second part would involve convincing the jury that being unarmed resulted in the plaintiff's being assaulted or raped or murdered. Of course, there is no way to prove with metaphysical certainty that the availability of a firearm would have prevented the injury; however, the law does not require such certainty. Under the "loss of a chance" doctrine, "if there was any substantial possibility of survival and the defendant has destroyed it, he is answerable."[30] What evidence might be offered that the armed plaintiff would have had a substantial possibility of avoiding the injury in question? Let me suggest that such evidence might be found in the criminologic literature. Thus, it has been shown that robbery[31] and assault victims who resist with a gun are less likely to suffer an injury than those who use other means of resistance or those who do not resist at all.[32,33] Would-be rape victims who resist with arms of all types (knives, guns, or other weapons) are less likely to have the rape against them completed.[34,35] Likewise, "gun possession appears to make people virtually invulnerable to fatal attacks except by attackers who are also armed with guns."[20]

Proximate Causation. Proximate causation is a legal issue decided by the judge. The general rule is that the defendant is the proximate cause of the reasonably foreseeable harmful results of his acts. Specifically, where a defendant's negligence creates a foreseeable risk that a plaintiff will be the victim of a crime, the causal link will not be broken by the intervening criminal act.[36] In our scenario, the injured patient could argue that the physician's negligent counseling created a foreseeable risk that the patient would be the victim of a crime by impairing her ability to defend herself.

CONCLUSION

I have tried to show the potential legal risk to physicians who engage in firearm safety counseling. I do not mean to assert that fear of legal liability should prevent physicians from counseling their patients regarding guns and/or gun violence. On the other hand, I would submit that a thoughtful discussion on the issue of whether physicians should counsel their patients about guns and gun violence should be informed by careful contemplation of the relevant contextual considerations, including the potential legal consequences of such involvement.

One might argue that physicians who do not engage their patients in discussions of gun safety also face potential liability; however, I believe their liability risks are substantially lower for a number of reasons.

First and most importantly, the plaintiff patient would have to establish that the defendant physician owed her a legal duty to discuss gun safety. I have been unable to find a single case in which an American court held that such a duty exists. Nor would the case for establishing such a new duty be an easy one to make. Thus, it has been suggested by proponents of the medicalization of firearm injury prevention that this process be analogized to the medical-

ization of motor vehicle injury prevention; however, I have likewise been unable to find any cases in which an American court held that a physician owed his patient a legal duty to discuss seat belt use. Because of the nonmedical nature of the information involved in the firearm context, I believe courts would be reluctant to impose such a duty upon physicians.

Second, the literature suggests that in this situation plaintiff patients would have a difficult time proving that the conduct of the defendant physician (who failed to engage his patient in a discussion of gun safety) had fallen below the standard of care. Cassel et al[1] have asserted that 59% of internists and 73% of surgeons "never" talk to patients about guns. As discussed earlier, although what is medically customary is not always determinative of the standard of care, it usually is.

Finally, the plaintiff patient would have to prove that she would have divested herself of her gun if the defendant physician had only warned her of its dangers—that is, that the physician's failure to warn was the cause of the patient's injury. The physician who chooses not to enter this arena, however, can credibly and in good faith argue that there was no reason for him to foresee, nor is there any reason in hindsight to believe that such a warning would have convinced the patient to rid herself of the gun, since he (the physician) has no special expertise in the area.

No doubt, this is an area where reasonable physicians will disagree, and some may feel morally obligated to give the advice despite the legal risk. Should the fact that some physicians choose to counsel their patients affect the legal situation of those who feel such counseling is improper? The answer is that it should not, but it may where courts confuse the concepts of "duty" and "standard of care." While fixing the standard of care in a particular case is a question of fact most often settled by the jury, the existence of a legal duty is a question of law that should be decided by the judge. However, there have been cases in which courts have effectively delegated this responsibility to juries. Thus, in *Pate v Threlkel*,[37] the issue before the Florida Supreme Court was whether a physician owed a duty to the children of a patient to warn that patient of the genetically transferable nature of the condition for which the physician was treating the patient. The court held that such a duty exists if the standard of care requires that such a warning be given—in effect merging duty and standard of care issues. Within the jurisdictions of courts prone to such delegation, one must be concerned that the voluntary undertaking by some physicians to advise patients about firearms might ultimately give rise to a duty on the part of the entire profession to do so.

Nor are liability concerns limited to individual practitioners. Medical organizations promulgating guidelines, parameters, or protocols "may even expose themselves to liability if poorly crafted guidelines lead to injury, or if they fail to keep the guidelines up-to-date as the medical knowledge advances."[29,38] This may have implications for medical organizations promulgating guidelines on the subject of firearm safety.

In the end, thinking about potential legal liability is useful if it forces us to critically consider the questions that ultimately matter most—whether convincing patients not to own guns saves lives, and whether we as physicians and surgeons are especially qualified to help patients make informed decisions about gun ownership.

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