Patient Vignettes

Caring for Patients At Risk For Gun Violence: Medical, Legal, Ethical Issues

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Composite scenarios based on real cases observed by an ER physician in a community emergency practice. They do not represent the full spectrum of gun violence risk or pathology and are intended to spur critical thinking about the treatment of gun violence on an individual, clinical level.
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**Vignette #1.** A 57 y/o depressed male presents to the emergency department (ED) upon the encouragement of a concerned friend. The patient is relatively isolated, lives alone, has a history of alcohol abuse (but is not intoxicated), and faces the one-year anniversary of his wife’s death tomorrow. He admits to intermittent and passive thoughts of suicide, but does not report a plan. He does not endorse suicidal ideation at the moment. His overall assessment yields an estimate of moderately severe depression, but he will not consent to a voluntary psychiatric hospitalization. Even though his condition was severe enough to cause concern by a friend, the patient does not meet criteria for involuntary hospitalization. He does not have insurance and arranging his follow-up is problematic.

a) Is firearm access relevant to suicide risk stratification? 
b) In the context of suicide risk assessment, what information does firearm access convey? 
c) Are there certain types of firearms (i.e., handguns), specific cognitions about, or behaviors with firearms that indicate higher risk? 
d) In the acute phase, patients with depression are more reactively suicidal. Since +/- 33% of all suicides occur on the first attempt, and since 51-53% of suicides are completed with a firearm, is failure to screen for firearms in the acute presentation “nonfeasance” (breach of duty)?

His physician inquired about firearm access, and the patient told him he keeps a loaded handgun in his bed stand, “just in case.” Just in case of what? “Just in case I need it.” The patient does not have local family, and refuses to surrender his firearm to a local friend. He’s been in the ED for several hours now, feels that he’s getting nowhere, and requests to be discharged.

e) What can the physician do, if anything, to mitigate risk in this situation? 
f) If the patient is discharged and commits suicide with his handgun, could there be legal consequences for the physician?

**Vignette #2.** A patient is evaluated for depression in a community ED. The emergency physician conducts an appropriate history and mental status exam. The patient has a number of static and dynamic risk factors for suicide, but also has favorable, protective factors; the physician’s overall assessment of risk is moderate. Consistent with current EM practice habits, the patient was not screened for firearm access.

The patient does not meet criteria for involuntary hospitalization, and he declines an offer of voluntary hospitalization. The patient “contracts for safety” and is discharged to follow up with his primary care physician and an outpatient counseling service. He returns to the same ED by EMS later that evening in extremis due to a self-inflicted gunshot wound (GSW) to the chest. The EP administers bilateral chest tubes and performs a pericardiocentesis, but the patient dies in the ED from his injury.
a) Was this patient “stable” for discharge on his first ED visit?
b) Does firearm access “destabilize” certain patients?
c) Among appropriately selected patients, does firearm access contribute to the determination of an emergency medical condition? If so, what are the selection criteria?
d) Among such patients, is firearm screening a component of the MSE?
e) Is firearm screening among patients at risk for suicide “standard of care?”

Vignette # 3. A 24 y/o male is transported to the ED by police on the basis of a “welfare check.” The request was made by a neighbor who was concerned about the patient’s increasingly erratic and confrontational behavior. At the time of the call, the patient was “patrolling” the perimeter of his suburban yard with a high-capacity rifle, but he did not brandish it, nor did he make a specific threat. The patient is the legal owner of the firearm, and his behavior has not led to legal charges. He believes that groups of individuals, including former co-workers in collusion with his neighbors, are spying on him. He believes also that their spying has led to the termination of his employment. Although he has not made a specific threat against an individual, he broadcasted his conspiracy beliefs on social media, wherein he suggested “retribution.” When asked specifically about what he meant by “retribution,” he responded that he could do any number of things, such as hire an attorney, contact his congressman, or write a letter to the editor of the local newspaper. He denied homicidal ideation.

Upon completion of the clinical evaluation, the physician believes the patient may be suffering from the first presentation of bipolar disease with emerging psychosis, but the degree of his overall impairment is moderate.

a) In the context of potential homicide risk assessment, what information does firearm access convey?
b) Do unsafe firearm behaviors indicate higher clinical risk, e.g., handling or carrying firearm while intoxicated and/or emotionally labile, handling firearm at inappropriate times and/or in inappropriate locations, dry-shooting at inappropriate targets, live fire without a target, etc.?
c) In the acute phase, patients who are impaired and/or suffering from decompensated functional psychiatric disease may be more reactively aggressive when angry. Can/should firearm access and behaviors be interpreted with different standards in the acute presentation?
d) In appropriately selected patients, does firearm access infer homicidal intent? If so, what are the selection criteria?

Psychiatric consultations are not available at this community hospital, but the physician discusses the case with the patient’s primary care provider, who recommends the initiation of a mood-stabilizing medication. The patient has decisional capacity, does not agree with his
physician’s assessment, and requests to be discharged. The patient will continue to have access
to his firearm and ammunition upon discharge.

e) Is there anything the physician can/should do to mitigate risk?
f) Could there be medical legal consequences for this physician if the patient harms others with
his firearm upon discharge?

Vignette #4. A 32 y/o male is brought to the ED by police on a “welfare check.” He lives with
his parents, who were concerned that he was leaving the house with his high-capacity rifle and
three loaded 30-round magazines after an argument. There was no allegation of a specific
threat. The police did not have grounds to prosecute him, and his possession and handling of
his firearm were legal according to state law. He was transported by police to the ED because
he was angry and has a history of “mental issues.”

The patient does not endorse suicidal/homicidal ideation, is not psychotic, but is generally
uncooperative: “Why am I here? You can’t keep me here. I’m fine”. He reports that the
argument with his parents was about domestic responsibilities. The patient does not show
overt signs of impairment or decompensated mental illness, and states that he was planning on
selling the firearm and ammunition privately, and using the funds to move out. Private sales of
firearms are legal, and “besides, it’s none of your business.”

By her review of the electronic medical record (EMR) and the state narcotic prescription
monitoring database (currently also a requirement for many state medical licensures and
incorporated in mandatory CME), the physician recognized that the patient is opioid dependent,
likely abuses them, perhaps event diverts. She also recognized that the patient had recently
been treated for facial injuries from an assault. The patient was not intoxicated, and had
medical decisional capacity. He did not consent to any diagnostic testing, asserted that he
didn’t need treatment, and refused further evaluation. Based on the context of his presentation
and past medical history, the physician was concerned that the patient may have intended to
use the firearm to procure drugs or money for drugs. She was also concerned about the recent
assault. The patient did not report symptoms of pain, and did not request pain medications.

a) Can the protected health information obtained from the physician’s review of the EMR and
the prescription monitoring database be shared with, or reported to police?
b) Is this patient an imminent public safety risk, likely risk, or no risk at all?

The patient requested to be discharged.

c) Is there anything the physician can/should do to mitigate risk?
d) Could there be medical legal consequences for this physician if the patient harms others with

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his firearm upon discharge?

Vignette #5. A 45 y/o male is brought to ED after police discovered him intoxicated and asleep on the sidewalk. There was no report of injury, an on-site breathalyzer estimates BAC at 0.290 (legal limit 0.08), and the patient is brought to the ED at 11 PM for evaluation, treatment and protection of welfare. The patient is acutely intoxicated, he has no medical complaints, and his physical exam reveals no sign of acute injury, infection or severe metabolic emergency.

As the patient is being further undressed by nursing staff, a 9 mm handgun falls out of his pocket onto the floor, but does not discharge. Concealed-carry is legal in this state. Against the patient’s objections, the ED staff secures the weapon due to his degree of impairment and, hence, lack of decisional capacity. The patient falls asleep.

a) Is this patient an imminent public safety threat, a likely threat, or not at all?
   i) Should the physician alert police of a public safety threat?
   ii) If the patient did not have a firearm, would he be a public safety threat?

b) Should the ED staff contact law enforcement to inquire if the firearm is legal, and/or to inquire if the patient is permitted to own or carry a gun in accordance with the laws in this state, and would this be permitted under HIPAA?

c) If the patient is not permitted to own a firearm according to state law, and/or if the firearm is illegal, should this be reported to police, and would this be permitted under HIPAA?

The patient wakes up after a few hours and requests to be discharged. At this point, it is estimated that his BAC has been metabolized to 0.215, but the patient has a clear sensorium and normal gait. He requests to have his firearm returned. The patient calls his brother for a ride home, who agrees to meet him in the ER waiting room.

d) Should the physician return the patient’s firearm at this time?

The patient’s brother doesn’t show up, and he sleeps in the ED until the morning, at which time it is estimated that his BAC has been metabolized to 0.06. The patient has a clear sensorium and a normal physical exam. He requests to have is firearm returned and to be discharged. The physician reviewed the patient’s electronic medical record (EMR), and discovered that he has had multiple other visits for alcohol intoxication, including a recent evaluation for traumatic facial injuries sustained during a fight while intoxicated.

e) Should the physician return the patient’s firearm at this time?

f) What can the physician do to mitigate risk?
Vignette #6. A 22 y/o male is brought to the ED by a work colleague, who left after triage. No police involvement. The patient has been agitated lately, and allegedly punched out a window at work; he presented with injuries to his right hand. The patient had decisional capacity, but was not particularly cooperative. The physician conducted an appropriate history and mental status exam. The story about the broken window and how it happened, whether it was accidental or intentional, was he-said/she-said, but it was clear that the patient was angered by thoughts about an unfavorable workplace dynamic. His perceptions appeared paranoid almost to point of delusional, but who knew? Maybe they really were looking for a reason to fire him.

Although labile, the physician could de-escalate his agitation with verbal techniques and redirection. The patient’s personality had narcissistic and antisocial features, and he revealed a grandiose self-perception. The physician suspected that he may have underlying hypomania, but maybe it was just his personality disorder.

He didn’t really want help except for his injured hand, didn’t think there was anything wrong with him, didn’t want to speak to a crisis worker. He did not endorse homicidal ideation, and certainly didn’t appear to be a “serious” or “imminent” threat. His injuries required only supportive care, and he requested to be discharged. He had to get back to work.

Now dressed in his street clothes, and right before he’s about walk out, the physician just happened to notice that his coat pockets were literally stuffed with ammunition, and there were two high-capacity magazines in his cargo pockets. The physician inquired about the ammunition and location of the firearm, to which he responded that he carries a gun for protection. Concealed carry of gun or ammunition is legal in this state.

a) Does firearm quality, quantity and/or location have clinical significance in certain presentations?
b) Do unsafe firearm behaviors indicate higher clinical risk, e.g., handling or carrying firearm while intoxicated and/or emotionally labile, handling firearm at inappropriate times and/or in inappropriate locations, dry-shooting at inappropriate targets, live fire without a target, etc.?
c) When you combine the potential for violence with the opportunity of lethal means, the threat takes on a much more real dimension. Does the weapon make the patient dangerous?
d) Is this patient an imminent public safety threat, a likely threat, or not at all?
   i) Should the physician avert police of a public safety threat?
   ii) If the patient did not have a firearm, would he be a public safety threat?
e) Is good-faith clinical concern enough?
f) Should patients presenting with agitation and/or angry mood be screened for firearms?
g) Could there be medical legal consequences for this physician if the patient above harms his coworkers and/or employer with his firearm upon discharge?
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**Vignette #7.** A mother presents with a chief complaint of anxiety. She has three children, ages 5, 7 and 9. There are numerous marital, domestic and financial stressors, but nothing violent or reportable. Among the things discussed is a concern about her husband’s loaded, unlocked handguns, which are hidden in various places around the house. She believes her children may know where they are hidden, but does not know if they have handled them.

Physicians are mandated to report any suspicion of child abuse or endangerment/neglect to child protective services, and have immunity for good faith disclosures. It is not required that the child about whom the report is filed to be under the care of physician.

a) Does unsafe storage of firearms constitute pediatric endangerment/neglect, and should the physician contact DCFS/child protective services?
b) If the woman believes or knows that her children have handled them, does this constitute a different threshold for reporting?
c) Should physicians screen all families with children for firearms and inquire about storage, or should there be screening criteria?
d) What can or should the physician do, if anything, to mitigate risk in this situation?

**Vignette #8.** An 8 y/o female patient presents to the ED with penetrating trauma to the left cheek after being shot with a BB gun by her sibling while playing at home. She is accompanied by both parents and the sibling, and there is no sign of abuse or neglect otherwise.

a) Should the physician screen the family for firearms? Are there other mechanisms of accidental injury or family behaviors that warrant firearm screening?
b) Should the physician report the case to DCFS for risk of endangerment/neglect?
c) If the injury occurred at the home of a friend, should the physician report the friend/friend’s family?
d) What can or should the physician do, if anything, to mitigate risk in this situation?

**Vignette #9.** A 32 y/o women presents with her husband to the ED for facial injuries. She reports that she slipped and fell down three steps while carrying a glass jar in the kitchen, which resulted in multiple contusions and lacerations to her face. The physician notes that she also had symmetrical mature ecchymoses on her upper arms, consistent with older injuries. The patient’s affect is guarded, but when interviewed alone (surreptitiously between images in the x-ray department), she acknowledged that her husband pushed her down the stairs and previously bruised her arms by gripping and shaking her violently. She will not file charges against him because she believes it will cause him to lose his job, and she is financially dependent on him. She does not permit the physician to disclose any information to her husband.

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a) Should the physician screen for firearms in the home?
b) If present, should the physician inquire about firearm storage and her husband’s behaviors with them?

There are multiple guns in the home, which her husband keeps unlocked and loaded. Her husband also abuses alcohol, and the episodes of domestic violence usually occur when he is intoxicated. At the time of the last assault, there was a handgun on the kitchen table.

c) What can or should the physician do, if anything, to mitigate risk in this situation?

Vignette #10. A 45 y/o male presents with an accidental GSW to his right leg. The patient was role-playing self-defense moves with a target in his back yard, when he inadvertently discharged his pistol in its holster, causing a through-through injury to the muscles of his lateral right leg. He did not suffer neurovascular or orthopedic injuries, and does not require surgical intervention. The patient’s wound requires only supportive care and outpatient physical therapy.

a) Should the physician screen for other risk factors for gun violence/accidental injury?

Review of the EMR indicates treatment for two fight injuries while intoxicated in the past four years.

b) Should the physician screen for children in the home?

The physician notices that patient appears to be under the influence of alcohol, although not severely impaired. He requests to be discharged.

c) What can or should the physician do, if anything, to mitigate risk in this situation?

Vignette #11. A 15 y/o boy is brought from home because he was “out of control” and threatened to hurt himself during a confrontation with his parents. The patient had been suspended from school after expressing a threat of violence against others on social media. During the confrontation with his parents about discipline, he “went ballistic” and fled with a pocketknife and a screwdriver which were available in his home, but was subdued by his uncle and brought to the ED.

The patient is well-groomed, but has a restricted affect and makes poor eye contact with the physician. His speech is hesitant, and his responses evasive. His mood is anxious and dysphoric, and when questioned directly, he develops signs of psychomotor agitation. His impulse control
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is tenuous. He does not endorse suicidal or homicidal ideation.

a) Should the physician screen for firearms in the home?
b) If present, should the physician inquire about storage, access and previous behaviors with firearms?
c) If there are firearms in the home, is this patient at risk for gun violence? If so, to what degree?
If the patient does not have access to firearms, is he at risk for gun violence?
d) Should the physician advise family about future firearm access for the patient?
e) What can the physician do to mitigate risk in this situation?


A 27 y/o male patient presented with blunt facial and extremity injuries sustained during a street fight. He was intoxicated and pretty pissed off about everything: the guy who beat him up, his nurse, having to wait, his pain level, me. The whole world was against him. The police were never called, and the patient did not wish to file a police report. His work-up was negative, I stitched him up and off he went - that is, when he finally sobered up. This sort of thing is so routine that I wouldn't have remembered it if it wasn't for what happened next.

Two days later I was working in another ED when EMS rolled in with a patient with multiple gunshot wounds. It did not go well: the airway was a mess, he had a tracheal disruption, and the thoracotomy revealed large vessel and cardiac injuries. A 45 caliber handgun fired at close range does a lot of damage. And - just in case you're wondering - doing a thoracotomy in a rural ED without any access to CT surgery is almost pointless, because unless you find a relatively simple cardiac injury you can sew over or occlude, that patient is going to die.

And he did.

Breaking the news to the family was particularly unpleasant. It was a tight family, some people I knew peripherally. One collapsed on the floor in grief - she saw the whole thing happen.

And the shooter was my patient from the previous night.

But wait - it gets worse: months later, the woman who collapsed on the floor presented to one of my colleagues as an overdose.

You won't find that overdose in any stats about gun violence morbidity and mortality, but I know damn well it counts.
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When I read about my case in the paper, I got to know the patient whom I had treated for fight injuries. He had a history of previous violent conduct, he abused his intimate partners, and he abused alcohol and other substances. Pretty much every relevant risk factor for future violence was present in this guy.

But not functional psychiatric disease.

There is no way I could have foreseen or prevented that homicide when I fixed up that guy’s face that one night. But if there was a resource for assessing interpersonal violence risk and de-escalating crises in the acute phase, then at the very least I could have done that – and that just might be all it takes to prevent catastrophic consequences.

Vignette #13. An 8 y/o boy is brought to the emergency department after an outburst at school wherein he kicked and scratched a teacher, and reported homicidal ideation against the teacher and another individual. The child has a history of repeated, impulsive violent outbursts, but has never caused significant injury. His family is separated, and his time is divided between mother and father.

The patient admitted to his homicidal statements in the ED, and acknowledged a previously stated plan to shoot his teacher with a weapon he could “sneak” out of his father’s home, but lacks insight. He does not endorse current homicidal ideation to the physician, he says he didn’t mean his previous statements, and he apologizes for upsetting people.

The patient does have experience with firearms, and has access to them at his father’s home. He states that the 22 caliber rifle he shoots with his father is locked up, but he knows that there are other accessible firearms in the home. He states that his father teaches him safe firearm handling practices.

a) Should the physician contact the father to inquire about firearm storage, access and previous behaviors?
b) Should the physician advise the family about future firearm access for the patient?
c) Should the physician report the case to DCFS for risk of endangerment/neglect?