

7-1-2015

Wollschlaeger, a Patient's Right to Privacy, and a Renewed Focus on Mental Health Treatment

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Recommended Citation

Chad A. Pasternack, *Wollschlaeger, a Patient's Right to Privacy, and a Renewed Focus on Mental Health Treatment*, 23 U. Miami Bus. L. Rev. 451 (2014)

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Wollschlaeger, a Patient’s Right to Privacy, and a Renewed Focus on Mental Health Treatment

Chad A. Pasternack*

In response to doctors pushing gun control agendas on patients, Florida enacted the Firearm Owners Privacy Act. The law, upheld by the Eleventh Circuit in Wollschlaeger v. Governor of Florida, protects patients from intrusive lines of inquiry unrelated to their treatment and from discrimination due to firearm ownership. While patients in Florida benefit greatly from the Firearm Owners Privacy Act, this note argues for more specific language in the law, which would parallel language in the Florida Mental Health Act (“Baker Act”). The proposed changes would limit inquiries into firearm ownership to instances where there is a substantial likelihood of serious bodily harm to the patient or others.

I. INTRODUCTION	452
II. PRIOR REGULATION OF HEALTHCARE.....	454
A. A Brief History of Federal Healthcare Regulation.....	454
1. Surgeon General’s Report on Smoking and Health.....	454
2. Creation of Medicare and Medicaid	456
B. Changing Definition of Healthcare.....	459
1. Preventive Medicine	460
2. Mental Health	460
C. Regulation in Florida.....	462
1. The Baker Act.....	462
2. Patient Records	465
III. FIREARM OWNERS PRIVACY ACT	466
A. Language of the Act	466

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<i>B. Legislative History</i>	470
<i>C. Wollschlaeger v. Governor of Florida</i>	473
IV. LESS DISCRETION, MORE EFFECTIVE	476
V. CONCLUSION	479

I. INTRODUCTION

A young mother is concerned about a rash on her son, so she brings him to a pediatrician. Once inside the examination room, the doctor asks the mother a series of questions about her home, including whether she owns any firearms. Bewildered about and uncomfortable with this question, the mother refuses to answer and pleads with the doctor to focus on her son instead. The doctor frowns, and then he advises the mother that she will have thirty days to find a new pediatrician.

To a physician, the aforementioned scenario may be a reasonable practice of preventive medicine. In fact, counseling patients on firearm safety is a practice encouraged by the American Medical Association.¹ But, the patient on the receiving end of the inquiry may feel vulnerable, threatened, and violated. Particularly when a patient goes to a doctor for a specific purpose, as opposed to for an ordinary wellness visit, it is presumable that the patient neither expects nor desires such intrusive inquiries in the name of preventive care. The physicians' gun control movement is a result of excessive media coverage of mass shootings and inadequate treatment of the mentally ill.² Instead of treating the root causes of gun violence, such as mental illness and breakdown of the family unit, "the public health establishment's histrionic reflex is . . . to control and confiscate."³

In response to this movement among healthcare providers, Florida enacted a law that curtails doctors' ability to question patients on ownership or possession of firearms and ammunition, which is known as

¹ Press Release, President Robert M. Wah, M.D., American Medical Association, AMA Response to Court Ruling on Florida's Gun Gag Law (July 28, 2014).

² Vik Khanna, *Why Public Health Needs a New Gun Doctrine*, AMERICA'S 1ST FREEDOM, Dec. 2014, at 64. While Khanna, a public health professional educated at the Johns Hopkins University Bloomberg School of Hygiene and Public Health, admittedly believes the Second Amendment secures the rights of individuals to own firearms and enjoys firearm ownership, he brings a level of fairness to the conversation by discussing data that typically goes unreported. For instance, he noted a 2013 report produced by the Institute of Medicine was ignored by the media. The report, ordered by the Centers for Disease Control, concluded that defensive uses of firearms occur more than previously recognized, firearm ownership is a crime deterrent, and unauthorized possession of a firearm is a crucial driver of gun related violence. *Id.*

³ *Id.*

the Firearm Owners Privacy Act.⁴ Essentially, the law dictates limits on preventive medicine in regards to firearms. This note will show that the Firearm Owners Privacy Act is indeed a valid regulation of healthcare. To clarify, this note will not discuss the Second Amendment, gun control, or gun rights.⁵

First, this note will explore the evolution of healthcare regulation. Part II will begin with a brief discussion of a few major developments in regulation at the federal level. In particular, regulations pertaining to tobacco usage and Medicare will be used to show how healthcare regulations came about and gained acceptance, and the faculty the federal government has to impose such regulations. Along with the development of regulations, the advancement and changing nature of healthcare itself will be discussed. This note will focus on how mental health treatment, using preventive medicine as a backdrop, has advanced since the mid-1900s. After discussing healthcare at the macro-level, this note will narrow its focus to regulations in Florida, namely the Baker Act⁶ and regulations of patient medical records.

Second, there will be a thorough analysis of the Firearm Owners Privacy Act. Part III will include both an analysis of the plain text of the law and its legislative history. Then, this note will examine the implications of the Eleventh Circuit's interpretation of the Act in *Wollschlaeger v. Governor of Florida*.

Third, this note will propose changes to the Firearm Owners Privacy Act based on its legislative history and the Baker Act. As enacted, the Firearm Owners Privacy Act fails to effectuate its intended purpose, which is to protect the rights of patients by prohibiting agenda-driven inquiries into firearm ownership.⁷ In particular, Section 790.338 should be amended so that the exception to the general prohibition of inquiry

⁴ See *infra* Part III.B; 2011 Fla. Laws 112 (codified at FLA. STATS. §§ 790.338, 381.026, 456.072 (2014)).

⁵ For more information on these issues, see *McDonald v. City of Chicago*, 561 U.S. 742 (2010) (holding the Second Amendment right to keep and bear arms is incorporated by the Fourteenth Amendment and applicable to the states); *District of Columbia v. Heller*, 554 U.S. 570 (2008) (holding the Second Amendment confers an individual right to keep and bear arms); *Peruta v. County of San Diego*, 742 F.3d 1144 (9th Cir. 2014) (holding “the right to keep and bear arms includes the right to carry an operable firearm outside the home for the lawful purpose of self-defense”); *Palmer v. District of Columbia*, ___ F. Supp. 2d ___, Case No. 1:09-CV-1482, 2014 WL 3702854 (D.D.C. July 24, 2014) (holding Washington D.C.’s complete ban on the carrying of firearms outside the home is unconstitutional); Julie Morgan, *Back to the Basics: Restoration of Our Right to Keep and Bear Arms Through a National Reciprocity Act*, 21 U. MIAMI BUS. L. REV. 223 (2013) (discussing the constitutionality and need for a national concealed-carry reciprocity law).

⁶ Florida Mental Health Act, FLA. STAT. §§ 394.451-394.47891 (2014).

⁷ See *infra* Part III.B.

into firearm ownership requires a good faith belief that there is a substantial likelihood of harm, instead of only relevance to the patient's medical care or safety.

II. PRIOR REGULATION OF HEALTHCARE

Like any regulatory scheme, the American healthcare system has developed slowly. If the regulations in effect today were unilaterally imposed overnight, rather than after years of piecemeal evolution, such regulations would have been rejected. But, “[s]light encroachments create new boundaries from which legions of power can seek new territory to capture.”⁸ Concurrent with the evolution of healthcare regulation, the very definition of “healthcare” has undergone change. A brief history of these developments will provide the necessary context for an analysis of our present state of healthcare regulation.

A. A Brief History of Federal Healthcare Regulation

In the mid-twentieth century, the federal government directed an unprecedented amount of its attention towards the nation's healthcare. Two initiatives in particular were monumental in crafting our present healthcare system: the Surgeon General's 1964 report on smoking and health, and the creation of Medicare and Medicaid. The former, a landmark step in policymaking, and the latter, landmark steps in social insurance, are prototypical of federal healthcare regulation.

1. Surgeon General's Report on Smoking and Health

The government's first major push in its effort to expand healthcare regulation began in 1964 with the Surgeon General's report, *Smoking and Health*.⁹ The report opened with a simple question that held far-reaching effects: “[I]s the use of tobacco bad or good for health, or devoid of effects on health?”¹⁰ Unlike today, the carcinogenic effects of smoking were not common knowledge in the 1960s, nor were they proven scientifically by reliable research methods.

In the early pages of the report, the Surgeon General discussed the problem that plagues most scientific research—causality. Whereas finding a correlation is merely finding a relation between phenomena,¹¹

⁸ Reid v. Covert, 354 U.S. 1, 39 (1957).

⁹ U.S. DEP'T OF HEALTH, EDUC. & WELFARE, SMOKING & HEALTH: REPORT OF THE ADVISORY COMMITTEE TO THE SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE (1964) [hereinafter SURGEON GENERAL REPORT].

¹⁰ *Id.* at 5.

¹¹ MERRIAM-WEBSTER'S COLLEGIATE DICTIONARY 280 (11th ed. 2003).

causation is “an act or agency which produces an effect.”¹² The report noted, “thoughts about causality in the realm of this inquiry were constantly and inevitably aroused in the minds of the members because they were preoccupied with the subject of their investigation—‘Smoking and Health.’”¹³ Causality was determined by analyzing the effect or non-effect of tobacco on the user’s tissues, organs, and other qualities that may affect the user’s health, for better or worse.¹⁴

Scientific methods aside, the importance of the report flows from its findings. It found that the habitual use of tobacco is primarily related to the addictive nature of nicotine.¹⁵ Average smokers had nine to tenfold increases in risk of developing lung cancer, and heavy smokers had upwards of a twenty-fold risk increase.¹⁶ The report stated its conclusion succinctly: “[o]n the basis of prolonged study and evaluation of many lines of converging evidence, the Committee makes the following judgment: Cigarette smoking is a health hazard of significant importance in the United States to warrant appropriate remedial action.”¹⁷

Once presented with this conclusion, it was only a matter of time before Congress acted. That action came in 1965 in the form of the Federal Cigarette Labeling and Advertising Act.¹⁸ The Act made it unlawful “for any person to manufacturer, import, or package for sale or distribution within the United States any cigarettes the package of which fails to bear the following statement: ‘Caution: Cigarette Smoking May Be Hazardous to Your Health.’”¹⁹ While this warning brought public attention to the effects of cigarette smoking, the language was weak and limited only to the package itself. Accordingly, Congress enacted the Public Health Cigarette Smoking Act of 1969,²⁰ which required stronger language to be put on packaging. It prohibited advertising cigarettes on any medium of electronic communication that is regulated by the Federal Communications Commission.²¹ Additionally, it required annual reporting to Congress by the Secretary of Health, Education and Welfare regarding information and recommendations related to smoking,²² as

¹² *Id.* at 196.

¹³ SURGEON GENERAL REPORT, *supra* note 9, at 20.

¹⁴ *Id.* at 21.

¹⁵ *Id.* at 32.

¹⁶ *Id.* at 31.

¹⁷ *Id.* at 33.

¹⁸ Federal Cigarette Labeling and Advertising Act, Pub. L. No. 89-92, 79 Stat. 282 (1965) (codified as amended at 15 U.S.C. §§ 1331-1341 (2012)).

¹⁹ *Id.* § 4.

²⁰ Public Health Cigarette Smoking Act of 1969, Pub. L. No. 91-222, 84 Stat. 87 (1970) (codified as amended at 15 U.S.C. §§ 1331-1341 (2012)).

²¹ *Id.* § 6.

²² *Id.* § 8(a).

well as annual reporting by the Federal Trade Commission of the effectiveness of cigarette labeling and current practices of advertising.²³

The aforementioned series of events set precedent for healthcare regulation. The Surgeon General conducted research and declared that the evidence revealed cigarette smoking to be a health hazard and matter of public concern.²⁴ Within only a few years, the tobacco industry was being regulated by the Federal Trade Commission, the Federal Communications Commission, and the Secretary of Health, Education and Welfare.²⁵

2. Creation of Medicare and Medicaid

The 1960s was a busy decade in the healthcare arena. In addition to combating the perils of smoking, Congress expanded access to healthcare by establishing Medicare and Medicaid through the Social Security Amendments of 1965.²⁶ As originally enacted, Medicare provided health insurance for individuals who attained the age of 65 and were entitled to Social Security benefits or were qualified railroad retirement beneficiaries.²⁷ Medicare coverage includes both hospital insurance and supplementary medical insurance. As for Medicaid, it was created to enable the States to provide medical assistance to “families with dependent children and of aged, blind, or permanently and totally disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services,” as well as rehabilitation and other services to help beneficiaries attain independence.²⁸

The Social Security Amendments of 1965 explicitly prohibit federal interference:

Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the

²³ *Id.* § 8(b).

²⁴ My discussion of the Surgeon General’s report and its effects on policy should not be interpreted as being critical of either the findings of the report nor of the legislative response. Neither of these matters is of concern to this note. Rather, the cigarette smoking legislation is a paradigm of how matters once not thought to be health concerns can quickly morph into leading health concerns, and how the legislative response can be broader in scope than the traditional components of healthcare, *i.e.*, the doctor-patient relationship.

²⁵ Known today as the Secretary of Health and Human Services.

²⁶ Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965) (codified as amended at 42 U.S.C. §§ 1395-1396v (2012)).

²⁷ *Id.* § 101.

²⁸ *Id.* § 121.

selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.²⁹

That said, this prohibition is more appropriately described as a prohibition of *direct* control over the practice of medicine. In other words, the ability to *indirectly* control is retained through the power to regulate: “The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this title.”³⁰

Before proceeding into any further discussion of how healthcare is regulated through Medicare and Medicaid, this note must clarify that healthcare providers *choose* to accept Medicare and Medicaid, thereby agreeing to regulations promulgated by the Department of Health and Human Services.³¹ Even though hospitals and doctors are typically referred to as some variation of the phrase “healthcare provider,” they are businesses and businessmen, respectively. By not accepting Medicare and Medicaid, these healthcare providers would turn away a significant source of revenue. Therefore, it is persuasive for healthcare providers to accept Medicare and Medicaid and to submit to federal regulation.

Because this discussion is meant to be a superficial exploration into Medicare and Medicaid, the only regulations that will be discussed are the Emergency Medical Treatment and Active Labor Act (“EMTALA”)³² and the use of diagnosis-related groups (“DRG”). EMTALA applies to “participating hospitals” that have “entered into a provider agreement under Section 1395cc,”³³ which is the agreement to participate in and receive payments from Medicare. Therefore, in order to access the segment of the market that consists of Medicare patients, hospitals agree, pursuant to EMTALA, to provide a screening examination and stabilizing treatment to any individual who comes to the hospital’s emergency department, regardless of whether the individual is

²⁹ *Id.* § 102.

³⁰ *Id.*

³¹ *See* Ass’n of Am. Physicians & Surgeons v. Weinberger, 395 F. Supp. 125, 134 (N.D. Ill. 1975) *aff’d* Ass’n of Am. Physicians & Surgeons v. Mathews, 423 U.S. 975 (1975) (“each individual physician and practitioner has the ability to choose whether or not to participate in the [Medicare] program. It is true that there will exist economic incentive or inducement to participate in the program. However, such inducement is not tantamount to coercion or duress”).

³² Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2012).

³³ § 1395dd(e)(2).

eligible for Medicare benefits.³⁴ In order to enforce the requirements of the statute, it authorizes a civil money penalty of up to \$50,000 and may exclude doctors from participation in Medicare and Medicaid programs for flagrant or repeated offenses.³⁵

A second type of regulation imposed on healthcare providers through Medicare is the use of a prospective payer system that reimburses hospitals based on diagnoses, not actual cost.³⁶ By reimbursing hospitals through DRGs, which are classifications of different diagnoses and procedures, the government forces hospitals to match their costs to the expected reimbursement.

Under cost-based reimbursement, each hospital was treated as a singular entity entitled to receive its unique costs of treating Medicare patients. In contrast, under DRG-based reimbursement, each hospital is treated as a member of a group and it is entitled to reimbursement only by virtue of its status as part of that group. Each hospital receives reimbursement for the average of a type of case in an average class of hospitals in an average location.³⁷

As a result, hospitals are incentivized to cut costs, which may occur at the expense of patients' treatment. For example, reducing lengths of patient stays reduces costs, but also inhibits physicians' abilities to monitor patient recoveries.³⁸ Yet the incentives resultant from fixed reimbursement go beyond increasing efficiency. A hospital that cannot match its costs to the reimbursement would suffer a loss; and conversely, a hospital that can treat a patient for less than the prospective payment will turn a profit.³⁹ Regardless of the wisdom of this tradeoff, the federal

³⁴ § 1395dd(a)-(b). This note is not critical of EMTALA. EMTALA saves lives. Yet, EMTALA is a prime example of how regulations can be imposed on healthcare providers by the federal government through healthcare providers' acceptance of Medicare and Medicaid.

³⁵ § 1395dd(d).

³⁶ See David M. Frankford, *The Complexity of Medicare's Hospital Reimbursement System: Paradoxes of Averaging*, 78 IOWA L. REV. 517, 570-71 (1993).

³⁷ *Id.* at 577.

³⁸ For a more thorough analysis of the effects of a prospective payment system on hospital behavior, see Martin F. Grace & Jean M. Mitchell, *Regulation of Health Care Costs: The Implications of the Prospective Payment Reimbursement System*, 2 U. FLA. J. L. & PUB. POL'Y 125 (1989).

³⁹ Pamela H. Bucy, *Health Care Reform and Fraud by Health Care Providers*, 38 VILL. L. REV. 1003, 1015 (1993) (arguing that DRGs have encouraged fraud, including cost shifting to non-Medicare patients, false reporting of costs, and false diagnoses of patients).

government, by being the insurer of such a large segment of the population, is able to place controls on hospital behavior so as to reduce its own costs. While the government cannot *directly* control the practice of medicine, its role as insurer gives it considerable influence over healthcare practitioners. By controlling the money, the government is able to regulate the process.

B. Changing Definition of Healthcare

Healthcare *n*: the field concerned with the maintenance or restoration of the health of the body or mind.⁴⁰

Webster's published this definition in 1998. In 2004, Webster's published the following definition:

Healthcare *n*: the provision of medical and related services aimed at maintaining good health, especially through the prevention and treatment of disease.⁴¹

As medical science continually improves, what we consider "healthcare" will continually change. For example, look to the use of antihistamines to treat allergies. Prior to the 1900s, little was known about allergic reactions.⁴² Over the course of a few decades, scientists learned how allergens affect the body. By the early 1940s, antihistamines were invented and administered. Side effects of these early drugs included sedation and dry mouth.⁴³ While one can function with dry mouth, sedation is more inhibiting. Fortunately, by the 1980s, pharmaceutical companies were able to produce non-sedative antihistamines.⁴⁴ In under a century, people went from experiencing unexplained physiological reactions to understanding that their reactions are caused by "allergies," which can be treated with over-the-counter medication.

In order to maintain the relevancy of how different areas of healthcare have developed, this note will only discuss the shift to preventive medicine and changes in mental health treatment.

⁴⁰ WEBSTER'S UNABRIDGED DICTIONARY 882 (2d ed. 1998).

⁴¹ WEBSTER'S DICTIONARY OF THE ENGLISH LANGUAGE 867 (2d ed. 2004).

⁴² M.B. Emanuel, *Histamine and the Antiallergic Antihistamines: A History of Their Discoveries*, 29 CLINICAL AND EXPERIMENTAL ALLERGY, 1 (Supp. 3 1999).

⁴³ *Id.* at 9.

⁴⁴ *Id.*

1. Preventive Medicine

Stated simply, preventive medicine is a mixture of science and philosophy that encourages patients to be proactive in maintaining their health. Instead of merely treating conditions as they occur, practitioners of preventive medicine are more forward looking in their approach to patient treatment. By treating conditions sooner or by controlling risk factors, health outcomes improve and costs decrease.

Preventive medicine can be broken down into three levels: primary prevention, secondary prevention, and tertiary prevention.⁴⁵ At the primary prevention level, the goal is to keep new problems from developing. This can be accomplished through the use of vaccines and immunization programs, or by making lifestyle changes, such as exercising, quitting smoking, and reducing alcohol consumption. Preventive medicine is always forward looking—lose weight and stop smoking now to reduce the risk of developing heart disease later.

Despite a patient's best efforts, some conditions are not preventable. But, with secondary prevention, conditions can be detected early and treated promptly.⁴⁶ Wellness visits to physicians are encouraged because many conditions are asymptomatic.⁴⁷ Examples of conditions that are commonly detected and treated at this stage of care are breast cancer, hypertension, high cholesterol, and skin cancer.⁴⁸ Unlike the primary prevention stage, the goal here is to prevent the condition from advancing to a point where it causes health to deteriorate.

Along the same lines, the objective of tertiary prevention is to prevent existing conditions from worsening, often through treatment, rehabilitation, or surgery.⁴⁹ Although there is much debate over whether this is in fact preventive medicine and not purely reactive medicine, the conditions dealt with are typically progressive, so the focus remains on the future.⁵⁰

2. Mental Health

Over the past half-century, the mental health system in the United States has undergone a dramatic transformation. Prior to the 1960s, mental health treatment consisted, in large part, of detention in state

⁴⁵ William Rakowski, *The Definition and Measurement of Prevention, Preventive Healthcare, and Health Promotion*, 18 GENERATIONS 18 (Spring 1994).

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *See id.*

mental hospitals,⁵¹ otherwise known as asylums. During the deinstitutionalization movement that took place between 1955 and 1980, over 400,000 people were released from mental hospitals.⁵² Afterwards, attention turned to community support programs, which had goals of continuous community treatment and support services, as well as assertive crisis and outreach services.⁵³ Instead of focusing on containment and restraint, the newer system emphasized rehabilitation. Patients were taught social skills and skills that support independent living and employment.⁵⁴

By the 1990s, the mental health system transformed again, this time to focus on recovery. “Central to recovery principles is the idea that people can live meaningful and personally satisfying lives without the complete elimination of psychiatric symptoms.”⁵⁵ Because the current focus is on helping patients recover, healthcare providers and related organizations spend large amounts on outreach initiatives so that more people seek and receive treatment.⁵⁶ A study of data from the Veterans Health Administration from 1997 to 2005 shows a significant increase in usage of mental health services. During that period, there was a 7% annual growth in usage,⁵⁷ and the number of veterans who received at least one mental health contact increased 117.6%.⁵⁸

The current mental health landscape involves three main changes: (1) focusing on health rather than illness,⁵⁹ (2) reducing negative stigmas associated with mental health treatment,⁶⁰ and (3) increasing collaboration between primary care and mental health.⁶¹ Together, these changes are designed to make mental health treatment both more accessible to more people and to make more people willing to seek and

⁵¹ Catherine H. Stein et al, *Mental Health System Historians: Adults with Schizophrenia Describe Changes in Community Mental Health Care Over Time*, 85 PSYCHIATRIC QUARTERLY 3 (Oct. 2, 2014).

⁵² *Id.*

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ Eric D. A. Hermes et al, *Recent Trends in the Treatment of Posttraumatic Stress Disorder and Other Mental Disorders in the VHA*, PSYCHIATRIC SERVICES 471, 472 (May 2012).

⁵⁷ *Id.* at 471.

⁵⁸ *Id.* at 472.

⁵⁹ A. Kathryn Power, *Focus on Transformation: A Public Health Model of Mental Health for the 21st Century*, 60 PSYCHIATRIC SERVICES 580 (May 2009).

⁶⁰ Eric R. Pedersen & Andrew P. Paves, *Comparing Perceived Public Stigma and Personal Stigma of Mental Health Treatment Seeking in a Young Adult Sample*, 219 PSYCHIATRY RES. 143 (2014).

⁶¹ Stephen Petterson et al, *Mental Health Treatment in the Primary Care Setting: Patterns and Pathways*, 32 FAMILIES, SYSTEMS, & HEALTH 157 (June 2014).

receive treatment. The focus on health, rather than illness, and the goal of reducing negative stigmas are part of an attitudinal change in medicine, which corresponds closely to the rise in preventive medicine. The modern healthcare attitude, which is gaining acceptance, is that going to a doctor should be a routine part of life and that doing so allows us to live better and longer.

C. Regulation in Florida

Our discussion thus far has been on healthcare at the national level. Most healthcare regulation, however, is imposed at the state level.⁶² In Florida, most laws regulating healthcare can be found in Title XXIX, Public Health, and Title XXXII, Regulation of Professionals and Occupations, of the Florida Statutes. This note will limit its discussion to those statutes pertaining to mental health treatment and medical records.

1. The Baker Act

The Florida Mental Health Act, more commonly known as the Baker Act, establishes the state's goals and policies for mental health treatment.⁶³ In passing the Baker Act, it was "the intent of the Legislature . . . to evaluate, research, plan and recommend . . . programs designed to reduce the occurrence, severity, duration, and disabling aspects of mental, emotional, and behavioral disorders."⁶⁴ There is a clear policy favoring medical treatment, rather than pre-institutionalization-style containment.

Treatment programs "shall include, but [are] not limited to, comprehensive health, social, educational, and rehabilitative services to persons requiring intensive short-term and continued treatment in order to encourage them to assume responsibility for their treatment and recovery."⁶⁵ The goal is to help patients recover and lead meaningful lives. But, that can be a difficult goal to attain considering that many suffering from mental health conditions either go undiagnosed or will not consent to treatment. In such circumstances, it is the intent of the Legislature

that any involuntary treatment or examination be accomplished in a setting which is clinically appropriate and most likely to facilitate the person's return to the community as soon as possible; and that individual

⁶² See U.S. CONST. amend. X.

⁶³ Florida Mental Health Act, FLA. STAT. §§ 394.451-394.47891 (2014).

⁶⁴ FLA. STAT. § 394.453 (2014).

⁶⁵ *Id.*

dignity and human rights be guaranteed to all persons who are admitted to mental health facilities or who are being held [for involuntary examination].⁶⁶

Yet, even when treating or examining an involuntary patient, restraint and seclusion is justified only in response to imminent danger to the patient or others.⁶⁷

Along the same vein of legislation geared towards the treatment of communicable diseases, the Baker Act recognizes the competing interests of the patient and the public in mental health treatment: (1) the patient recovering and functioning in society, and (2) protecting the public from people who are dangerous due to their mental illnesses. Mental health is defined as a person's "state of mind characterized by emotional well-being, good behavioral adjustment, relative freedom from anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope with the ordinary demands and stresses of life."⁶⁸ Treatment, on the other hand, is "the administration of appropriate measures (e.g., drugs, surgery, therapy) that are designed to relieve a pathological condition."⁶⁹ Therefore, the missing component of the equation is mental illness. The Baker Act defines mental illness as "an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person's ability to meet the ordinary demands of living."⁷⁰ However, developmental disabilities, intoxication, and conditions manifested only by antisocial behavior⁷¹ or substance abuse are not included as mental illnesses.

As previously discussed, EMTALA requires hospitals that have entered into Medicare provider agreements to provide stabilizing treatment to all individuals who enter the hospital's emergency department, regardless of their ability to pay.⁷² The value society places on human life is greater than the value it places on emergency stabilizing

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ AMERICAN PSYCHOLOGICAL ASSOCIATION DICTIONARY OF PSYCHOLOGY 568 (1st ed. 2007) [hereinafter APA DICTIONARY].

⁶⁹ *Id.* at 956.

⁷⁰ FLA. STAT. § 394.455(18) (2014).

⁷¹ Antisocial behavior is defined as "aggressive, impulsive, and sometimes violent actions that violate the established rules, conventions, and codes of a society, such as the laws upholding personal and property rights." APA DICTIONARY, *supra* note 68, at 62.

⁷² *See supra* Part II.A.2.

treatment.⁷³ Like EMTALA, the Baker Act grants patients the right to treatment. “A person shall not be denied treatment for mental illness and services shall not be delayed at a receiving or treatment facility because of inability to pay.”⁷⁴ But, after mental health services are provided, hospitals are entitled to make every reasonable effort to collect appropriate reimbursement—they simply cannot condition treatment on payment.⁷⁵ Particularly because people with mental illnesses may be a danger to themselves or others, public policy dictates that they receive prompt treatment.

Dangerous mentally ill patients, however, do not always seek treatment when they should. Accordingly, the Baker Act provides for involuntary examination and placement. A person can be compelled to undergo examination if,

[w]ithout care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or . . . [t]here is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.⁷⁶

An involuntary examination is a drastic measure, but it is a necessary step to save lives, *i.e.*, it is the preliminary step to involuntary placement. A person may be placed in involuntary inpatient placement if “[t]here is substantial likelihood that in the near future he or she will inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm.”⁷⁷ People

⁷³ Therefore, providing a patient emergency treatment for mental illness is the functional equivalent of providing life-saving treatment to a patient in an emergency department. In effect, they are both lifesaving measures.

⁷⁴ FLA. STAT. § 394.459 (2014).

⁷⁵ § 394.459(2)(a).

⁷⁶ FLA. STAT. § 394.463(1)(b) (2014). The statute also requires that either the person refused examination after conscientious disclosure of the purpose of examination, or the person is unable to determine for himself or herself whether the examination is necessary. § 394.463(1)(a).

⁷⁷ FLA. STAT. § 394.467(1)(a) (2014). In addition, criteria for involuntary inpatient placement requires the person be mentally ill, and refuse or be unable to determine whether voluntary placement is necessary. Instead of a substantial likelihood of inflicting harm, a person may be placed in involuntary placement if he or she is manifestly incapable of surviving alone or with the help of family and friends. In all circumstances,

who continually exhibit behavior that qualifies them for involuntary inpatient placement may be placed into involuntary outpatient placement.⁷⁸ While the Baker Act does have the “teeth” necessary to protect mentally ill patients from inflicting harm on themselves or others, its ultimate goal remains helping patients recover.⁷⁹

2. Patient Records

Under Florida law, a patient’s medical records are confidential.⁸⁰ The information contained in medical records is personal, and by prohibiting disclosure, the patient’s privacy, along with the sanctity of the doctor-patient relationship, is protected. Without privacy protections, patients may be reluctant to seek treatment or be forthright with their doctors, for fear that third parties may stumble upon that information. Accordingly, in Florida, medical “records may not be furnished to, and the medical condition of a patient may not be discussed with, any person other than the patient, the patient’s legal representative, or other health care practitioners and providers involved in the patient’s care or treatment, except upon written authorization from the patient.”⁸¹

In spite of the need to protect the privacy of patients, there are exceptions to the rule. For instance, medical records may be disclosed without written authorization to “any person, firm, or corporation that has procured or furnished such care or treatment with the patient’s consent”⁸²; when compulsory physical examination is made during the course and scope of litigation⁸³; “[i]n any civil or criminal action, unless otherwise prohibited by law, upon the issuance of a subpoena from a court of competent jurisdiction and proper notice to the patient or the patient’s legal representative by the party seeking such records”⁸⁴; or to a healthcare provider’s attorney in a medical negligence action.⁸⁵

Whether the purposes of the exceptions to the rule are for economic and judicial efficiency or because they present equitable solutions, the effect is that patient records may be disclosed without authorization and over the objection of the patient. Even though patients have relatively strong federal privacy protections regarding their medical records, under

all available less restrictive alternatives must have been judged to be inappropriate. *See* § 394.467(1).

⁷⁸ FLA. STAT. § 394.4655 (2014).

⁷⁹ *See* FLA. STAT. § 394.4573 (2014).

⁸⁰ *See* FLA. STAT. § 456.057 (2014).

⁸¹ § 456.057(7).

⁸² § 456.057(7)(a)(1).

⁸³ § 456.057(7)(a)(2).

⁸⁴ § 456.057(7)(a)(3).

⁸⁵ § 456.057(7)(a)(d).

Florida law, they face the risk, in certain circumstances, of having their medical records disclosed to third-parties.

III. FIREARM OWNERS PRIVACY ACT

On June 2, 2011, Florida Governor Rick Scott signed the Firearm Owners Privacy Act into law.⁸⁶ The law, often referred to as the “Docs vs. Glocks” law, protects patients’ privacy by restricting inquiry into firearm ownership and prohibiting discrimination by physicians against patients due to firearm ownership.⁸⁷ Four days after being signed into law, several physicians’ groups initiated litigation seeking an injunction to enjoin enforcement and a declaration that the law is unconstitutional.⁸⁸ Thereafter, the district court issued its opinion in *Wollschlaeger v. Farmer* (the “District Court Opinion”), enjoining the State from enforcing the majority of the law.⁸⁹

In the District Court Opinion, the court noted “as part of the practice of preventive medicine, practitioners routinely ask and counsel patients about a number of potential health and safety risks, including household chemicals, swimming pools, drugs, alcohol, tobacco, and firearms.”⁹⁰ For this reason, both the American College of Physicians and its Florida chapter argued that a physician has an obligation to provide preventive injury counseling on firearm safety.⁹¹

Ultimately, the court granted the plaintiffs’ injunction based on its finding that the Firearm Owners Privacy Act is unconstitutional due to vagueness.⁹² The constitutionality of the Firearm Owners Privacy Act, however, was upheld on appeal, and the District Court Opinion was reversed.⁹³ Consequently, the focus of this note will be on the effectiveness of the law—not its constitutionality.

A. Language of the Act

By enacting the Firearm Owners Privacy Act, the Florida Legislature created or amended three statutes: Section 790.338, Medical privacy concerning firearms, prohibitions, penalties, exceptions; Section

⁸⁶ 2011 Fla. Laws 112.

⁸⁷ See *infra* Parts III.A, C.

⁸⁸ Complaint for Declaratory and Injunctive Relief, *Wollschlaeger v. Farmer*, 880 F. Supp. 2d 1251 (S.D. Fla. 2012).

⁸⁹ *Wollschlaeger v. Farmer*, 880 F. Supp. 2d 1251, 1270 (S.D. Fla. 2012).

⁹⁰ *Id.* at 1257.

⁹¹ *Id.*

⁹² *Id.* at 1267-69.

⁹³ See *infra* Part III.C.

381.026, Florida Patient's Bill of Rights and Responsibilities; and Section 456.072, Grounds for discipline, penalties, enforcement.⁹⁴

First, Section 790.338, although grounded in the actions of healthcare practitioners, is located in Chapter 790 of the Florida Statutes, which is entitled "Weapons and Firearms."⁹⁵ If a significant portion of the Act is located in the chapter on Weapons and Firearms, then is the law a regulation of healthcare or a regulation of firearms? Despite the location of the restrictions on physician conduct in the Florida Statutes, the statute is a regulation of healthcare. This note contends that the deliberate placement of this part of the Firearm Owners Privacy Act was a strategic decision to emphasize the rights of firearm owners as patients—the majority of the Act is patient-centric—and not merely to dictate what healthcare providers can or cannot do.

Section 790.338 begins by prohibiting healthcare providers and facilities from "intentionally [entering] any disclosed information concerning firearm ownership into the patient's medical record if the practitioner knows that such information is not relevant to the patient's medical care or safety, or the safety of others."⁹⁶ The central theme of the statute is relevance. If the information is not relevant, then it need not be entered into a patient's medical records. Considering that patient medical records may, under certain circumstances, be disclosed without the patient's authorization, Section 790.338(1) protects the patient's privacy in personal information unrelated to his or her treatment.

Next, Section 790.338 instructs healthcare providers on making inquiries into firearm ownership and possession:

(2) A health care practitioner licensed under chapter 456 or a health care facility licensed under chapter 395 shall respect a patient's right to privacy and should refrain from making a written inquiry or asking questions concerning the ownership of a firearm or ammunition by the patient or by a family member of the patient, or the presence of a firearm in a private home or other domicile of the patient or a family member of the patient. Notwithstanding this provision, a health care practitioner or health care facility that in good faith believes that this information is relevant to the patient's medical care or safety, or the safety of others, may make such a verbal or written inquiry.

⁹⁴ 2011 Fla. Laws 112.

⁹⁵ FLA. STAT. Chapter 790 (2014).

⁹⁶ FLA. STAT. § 790.338(1) (2014).

(3) Any emergency medical technician or paramedic acting under the supervision of an emergency medical services medical director under chapter 401 may make an inquiry concerning the possession or presence of a firearm if he or she, in good faith, believes that information regarding the possession of a firearm by the patient or the presence of a firearm in the home or domicile of a patient or a patient's family member is necessary to treat a patient during the course and scope of a medical emergency or that the presence or possession of a firearm would pose an imminent danger or threat to the patient or others.⁹⁷

Upon reading subsection (2), one is left to ponder, what does it mean to have a good faith belief that information regarding firearm ownership or possession is relevant to a patient's medical care or safety, or the safety of others? The juxtaposition of these two subsections enables application of the interpretive maxim *noscitur a sociis*—"a word may be known by the company it keeps."⁹⁸ Subsection (3) uses the phrase "a firearm would pose an imminent danger or threat to the patient or others."⁹⁹ By choosing to use this phrase in subsection (3) but not in subsection (2), the Legislature must have decided that an "imminent danger or threat to the patient or others" is not a necessary prerequisite for a healthcare provider to have a good faith belief that an inquiry is relevant to a patient's medical care or safety. So, what is necessary? If a physician maintains a generalized belief that firearms are dangerous and are a threat to the patient's and others' safety, may the physician make the inquiry? What if the physician does not maintain such a generalized belief, but instead, treats a clumsy patient? May the physician, concerned that the clumsy patient will unintentionally discharge a firearm, make the inquiry then?

The remainder of Section 790.338 is less troublesome in interpreting:

(4) A patient may decline to answer or provide any information regarding ownership of a firearm by the patient or a family member of the patient, or the presence of a firearm in the domicile of the patient or a family member of the patient. A patient's decision not to answer a question relating to the presence or ownership of a firearm does not alter existing law regarding a physician's authorization to choose his or her patients.

⁹⁷ §§ 790.338(2)-(3).

⁹⁸ *Russell Motor Car Co. v. United States*, 261 U.S. 514, 519 (1923).

⁹⁹ § 790.338(3).

(5) A health care practitioner licensed under chapter 456 or a health care facility licensed under chapter 395 may not discriminate against a patient based solely upon the patient's exercise of the constitutional right to own and possess firearms or ammunition.

(6) A health care practitioner licensed under chapter 456 or a health care facility licensed under chapter 395 shall respect a patient's legal right to own or possess a firearm and should refrain from unnecessarily harassing a patient about firearm ownership during an examination.

(7) An insurer issuing any type of insurance policy pursuant to chapter 627 may not deny coverage, increase any premium, or otherwise discriminate against any insured or applicant for insurance on the basis of or upon reliance upon the lawful ownership or possession of a firearm or ammunition or the lawful use or storage of a firearm or ammunition. Nothing herein shall prevent an insurer from considering the fair market value of firearms or ammunition in the setting of premiums for scheduled personal property coverage.¹⁰⁰

In effect, the preceding subsections create a "protected class" of firearm owners in terms of how healthcare providers may treat them. Like an employment relationship, a physician may terminate the doctor-patient relationship at will. In spite of the at-will nature of the relationship, doctors are no longer free to use firearm ownership as a cause for termination of the relationship.¹⁰¹ Further, because of the discrimination provision, doctors may not charge firearm owners more, make firearm owners wait longer, limit the days in which firearm owners may schedule appointments, or carry out any other discriminatory practices against firearm owners.

Subsection (6) leaves some room for the imagination. It deals with unnecessary harassment, so unlike the subsections before it, it does not

¹⁰⁰ §§ 790.338(4)-(7).

¹⁰¹ Admittedly, this is a somewhat inaccurate statement of the law. *See* Wollschlaeger v. Farmer, 880 F. Supp. 2d 1251, 1264-65 (S.D. Fla. 2012) ("the State itself acknowledges that the law does not prevent a physician from terminating the doctor-patient relationship"). It does not alter existing law pertaining to termination of the doctor-patient relationship, but by terminating the relationship because of firearm ownership, the doctor is subject to discipline. By being subject to discipline, the doctor *can* terminate the relationship, but is not *free* to do so.

necessarily pertain to inquiry. By its language, it is not clear if the subsection prohibits anything, or is merely a recommendation. In the former clause,¹⁰² the term “shall” is used, which means “[h]as a duty to; more broadly, is required to.”¹⁰³ On the other hand, the latter clause¹⁰⁴ uses the term “should,” which does not possess significant legal meaning and is not defined in Black’s Law Dictionary.¹⁰⁵ Was this merely an oversight on the part of the drafters, or was it their intention that the latter clause be a recommendation?

As for subsection (7), the Legislature foreclosed on any argument that firearm ownership makes a firearm owner an inherently riskier candidate for insurance. The Legislature then concluded Section 790.338 with subsection (8), which designates violations of subsections (1)-(4) as grounds for discipline.¹⁰⁶

Second, Section 381.026, the Florida Patient’s Bill of Rights and Responsibilities,¹⁰⁷ was amended to add several provisions complementary to those already discussed. If the amendment of Chapter 790 left any doubt that the Firearm Owners Privacy Act is a regulation of healthcare, the amendment of Section 381.026 should eliminate that uncertainty. Subsections (2), (4), (5), and (6) of Section 790.338 have counterparts in Section 381.026, wherein they are subsections (8), (9), (10), and (11), respectively.¹⁰⁸

Third, Section 456.072 was amended to give teeth to the Firearm Owners Privacy Act. Now, violations of any of the provisions of Section 790.338 constitute grounds for discipline.¹⁰⁹

B. Legislative History

Recall the earlier hypothetical in which a young mother who refused to answer a pediatrician’s question about firearm ownership was told to find a new doctor.¹¹⁰ A similar scenario unfolded in Ocala, Florida.¹¹¹

¹⁰² § 790.338(6) (“A health care practitioner licensed under chapter 456 or a health care facility licensed under chapter 395 **shall** respect a patient’s legal right to own or possess a firearm”) (emphasis added).

¹⁰³ BLACK’S LAW DICTIONARY 1585 (10th ed. 2014).

¹⁰⁴ § 790.338(6) (“A health care practitioner licensed under chapter 456 or a health care facility licensed under chapter 395 . . . **should** refrain from unnecessarily harassing a patient about firearm ownership during an examination.”) (emphasis added).

¹⁰⁵ See BLACK’S LAW DICTIONARY (10th ed. 2014).

¹⁰⁶ § 790.338(8).

¹⁰⁷ Florida Patient’s Bill of Rights and Responsibilities, FLA. STAT. § 381.026 (2014).

¹⁰⁸ §§ 381.026(8)-(11) (2014).

¹⁰⁹ FLA. STAT. § 456.072(1)(mm) (2014).

¹¹⁰ *Supra* Part I.

¹¹¹ See Health & Human Servs. Comm., Fla. H.R. Staff Analysis, H.R. 0155C, at 2 (Apr. 7, 2011).

There, a pediatrician asked a patient's mother whether there were firearms in her home. When she refused to answer, the doctor advised her that she had thirty days to find a new pediatrician, and that he asks all of his patients about their firearm ownership in order to provide safety advice. After receiving much media attention, the incident in Ocala "led many to question whether it should be an accepted practice for a doctor to inquire about a patient's firearm ownership."¹¹² As noted in the District Court Opinion, many physicians groups encourage inquiry into patients' firearm ownership.¹¹³ According to legislative findings, the American Medical Association recommends its members inquire as to the presence of firearms in the home and educate patients on the dangers of firearms to children.¹¹⁴ Further, the Legislature found the American Academy of Pediatrics recommends physicians include questions about firearms in their patient history taking.¹¹⁵

During the legislative drafting process of the Firearm Owners Privacy Act, the bill went through a series of revisions. The first Committee Substitute of the original bill in the Florida House of Representatives contained language pertaining to both the mental health of the patient and whether the possession of firearms would pose an imminent danger to the patient or others. The bill read:

(6) Notwithstanding any other provision of this section, it is not a violation for:

(a) Any psychiatrist as defined in s. 394.455, psychologist as defined in s. 490.003, school psychologist as defined in s. 490.003, clinical social worker as defined in s. 491.003, or public or private physician, nurse, or other medical personnel to make an inquiry prohibited by paragraph (1)(a) if the person making the inquiry in good faith believes that the possession or control of a firearm or ammunition by the patient or another member of the patient's household would pose an imminent danger or threat to the patient or others.

(b) Any public or private physician, nurse, or other medical personnel to make an inquiry prohibited by paragraph (1)(a) if such inquiry is necessary to treat

¹¹² *Id.*

¹¹³ *See supra* notes 90-91 and accompanying text.

¹¹⁴ Crim. Justice Comm., Fla. H.R. Staff Analysis, H.R. 0155, at 2 (Mar. 4, 2011).

¹¹⁵ *Id.*

a patient during the course and scope of a medical emergency which specifically includes, but is not limited to, a mental health or psychotic episode where the patient's conduct or symptoms reasonably indicate that the patient has the capacity of causing harm to himself, herself, or others.

(c) Any public or private physician, nurse, or other medical personnel to enter any of the information disclosed pursuant to paragraphs (a) and (b) into any record, whether written or electronic.¹¹⁶

Notably, subsection (6)(a) requires a good faith belief that possession of a firearm would pose an imminent danger, and not just a vague good faith belief that possession of a firearm would be relevant to a patient's medical care or safety.¹¹⁷

Further, although subsection (b) specifies that it is not limited to mental health or psychotic episodes, their specific mention is telling of the drafters' intent. It was wise, though, to not limit the exception only to mental health or psychotic episodes. The House of Representatives' Staff Analysis points out that "[i]n certain instances, questions about gun ownership may be necessary to the treatment of a patient (e.g., psychiatrists treating suicidal patients, emergency room physicians treating gun shot victims who need to know the type, caliber, etc. of firearm and ammunition used, etc.)."¹¹⁸ Stated differently, the legislative history indicates that, to be relevant to a patient's treatment, the dangers associated with gun ownership must be concrete, not abstract or hypothetical.

In fact, the first Committee Substitute of the bill explained abstract conceptions of danger do not satisfy the requirements for the exception. Following subsection (6) above, a hanging paragraphing stated:

However, a patient's response to any inquiry permissible under this subsection shall be private and may not be disclosed to any third party not participating in the treatment of the patient other than a law enforcement officer conducting an active investigation involving the patient or the events giving rise to a medical emergency.

The exceptions provided by this subsection do not

¹¹⁶ Firearm Owners Privacy Act, H.R. 0155-01 (Fla. 2011).

¹¹⁷ Compare Firearm Owners Privacy Act, H.R. 0155-01 (Fla. 2011) with FLA. STAT. § 790.338(2) (2014).

¹¹⁸ Crim. Justice Comm., *supra* note 114, at 5.

apply to inquiries made due to a person's general belief that firearms or ammunition are harmful to health or safety.¹¹⁹

The former sentence of the hanging paragraph protects patients from disclosures such as those authorized under Section 456.057.¹²⁰ The latter sentence clarifies what is meant by phrases such as “good faith [belief] . . . would pose an imminent danger” and “necessary to treat a patient during the course and scope of a medical emergency.”

Despite the clarity provided by these provisions, they were not written into the final bill. Instead, the Legislature opted to use more general language. The specific language may very well have been too specific—information regarding firearm ownership or possession may be relevant even though the threat or danger is not imminent. Nonetheless, the unrefined language of the prior version of the bill provides valuable insight into the true intent of the Legislature in passing the Firearm Owners Privacy Act.

C. Wollschlaeger v. Governor of Florida

After the district court enjoined the State of Florida from enforcing several core provisions of the Firearm Owners Privacy Act, the Eleventh Circuit reversed, holding that the district court erred in finding the law facially violates the First Amendment and that the law is not unconstitutionally vague.¹²¹ Finding the law to be a legitimate regulation of professional conduct, the Eleventh Circuit stated “[i]t is uncontroversial that a state may police the boundaries of good medical practice by routinely subjecting physicians to malpractice liability or administrative discipline for all manner of activity that the state deems bad medicine, much of which necessarily involves physicians speaking to patients.”¹²²

Before addressing the law itself, the court discussed the need for the law. It noted there is an imbalance of power in the doctor-patient relationship. “When a patient enters a physician’s office, the patient depends on the physician’s knowledge and submits to the physician’s authority So when physicians inquire about the presence of firearms

¹¹⁹ Firearm Owners Privacy Act, H.R. 0155-01 (Fla. 2011) (emphasis added).

¹²⁰ See *supra* Part II.C.2. The House of Representatives’ Staff Analysis acknowledges HIPAA authorizes disclosure of protected health information to certain entities without a waiver or authorization; therefore, if information relating to firearm ownership qualifies as protected health information, the law would conflict with HIPAA. Crim. Justice Comm., *supra* note 114, at 5.

¹²¹ *Wollschlaeger v. Governor of Florida*, 760 F.3d 1195 (11th Cir. 2014).

¹²² *Id.* at 1203.

in patients' homes, some patients may feel that their physicians demand an answer."¹²³ Inside the examination room a patient may feel powerless to deny the doctor an answer.

While the lion's share of the decision discusses First Amendment issues, this note will only address its discussion of vagueness. The plaintiffs argued Sections 790.338(1)–(2) are vague because a requirement that information be "relevant" to a patient's medical care or safety does not specify whether a physician must make a specific finding of relevance for each patient, or whether the firearm information must be relevant at the time of treatment or if future relevance is satisfactory.¹²⁴ Looking to the plain meaning of the word, the court defined "relevant" as "[r]elated to the matter at hand; to the point; pertinent."¹²⁵ Determination of relevancy, according to the court, must be done on a case-by-case basis.¹²⁶ To make that determination, the doctor must analyze particularized information about the patient.¹²⁷

The court points out that essential to the issue of relevancy is the requirement that the doctor believe in *good faith* that firearm ownership or possession is relevant to the patient's medical care or safety.¹²⁸ But, the justification the court provides in support of this proposition seemingly detracts from the purpose of the law. The court reasoned,

Thus, a physician may make firearms inquiries of any or all patients, so long as he or she does so with the good faith belief—based on the specifics of the patient's case—that the inquiry is relevant to the patient's medical care or safety, or the safety of others.¹²⁹

Taking this statement to the extreme, a physician could ask all patients of a given demographic about their firearm ownership if he or she believes that firearms ownership poses an inherent danger to members of that demographic. Such interpretation of the law is untenable. The court further explained that "[i]f . . . the physician seeks firearm information to suit an agenda unrelated to medical care or safety, he or she would not be making a 'good faith' inquiry."¹³⁰ Although the court is correct in that inquiring into firearm ownership for the purpose of promoting an agenda

¹²³ *Id.* at 1214.

¹²⁴ *Id.* at 1227.

¹²⁵ *Id.* (quoting American Heritage Dictionary of the English Language 1098 (William Morris, ed., 1969)) (alterations in original).

¹²⁶ *Id.*

¹²⁷ *Id.* at 1228.

¹²⁸ *Id.*

¹²⁹ *Id.*

¹³⁰ *Id.*

would be contrary to the law, it is unlikely that there will be such a clear demarcation between promoting an agenda and acting on the belief that is the core of the agenda. A doctor who would *promote an agenda* would likely hold strong beliefs about the dangers of firearms. In making the inquiry by virtue of the underlying belief, based on the Eleventh Circuit's opinion, the physician would be in accord with the law.

As for the phrase “unnecessarily harassing,” the court again looked to the plain meaning of the words. It explained harass means “[t]o disturb or irritate persistently.”¹³¹ Similar to other parts of the law, this provision is designed to prevent doctors from pursuing an agenda inside their offices. The “unnecessarily harassing” provision “communicates that health care providers should not disparage firearm-owning patients, and should not continue over a patient’s objection or attempt to speak to the patient about firearm ownership when not relevant to medical care or safety.”¹³² Additionally, the court explained the modifier “unnecessary” “allows physicians the freedom to challenge—i.e., ‘harass’—patients regarding firearms when doing so is necessary for health or safety reasons if the patient might find the physicians’ advice unwelcome.”¹³³ This freedom is necessary for instances such as when a doctor is treating a mentally unstable patient, and the patient objects to the doctor’s inquiries. Not only do physicians have the defense that the harassment was necessary, the Eleventh Circuit pointed out that even if a patient feels harassed, the patient cannot by himself or herself subject the doctor to discipline. A patient can either file a complaint, which will then trigger an investigation, or a civil malpractice action. Regardless, the doctor need not fear an adverse judgment or professional discipline so long as he or she was operating in good faith and the information was relevant and necessary.¹³⁴

To be brief, the court held the record keeping, inquiry, and harassment provisions not void for vagueness. It found “persons of ‘common intelligence’” would experience no difficulty in interpreting and applying the law.¹³⁵

¹³¹ *Id.* at 1229 (alteration in original) (quoting American Heritage Dictionary of the English Language 600).

¹³² *Id.*

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ *See id.* at 1230.

IV. LESS DISCRETION, MORE EFFECTIVE

From examining the legislative history of the Firearm Owners Privacy Act, it is clear that the Legislature intended the exceptions in Section 790.338 be construed narrowly. An expansive reading of these exceptions, as done by the court in *Wollschlaeger*, would render the law fruitless. In prior versions of the bill, the exceptions were formulated in terms such as “imminent danger” and “mental health or psychotic episode.”¹³⁶ By the law’s final passage, all references to the patient’s mental health were removed and replaced with more general language referring to the patient’s medical care or safety.

Even though the Legislature opted to remove the language pertaining to mental health, a patient’s mental state should be a prominent factor in determining the relevancy of information regarding firearm ownership or possession. As previously mentioned, according to the Baker Act, mental illness means “an impairment of the mental or emotional processes that exercise conscious control of one’s actions or of the ability to perceive or understand reality.”¹³⁷ This note posits that any person unable to exhibit control over his or her actions or to properly perceive and understand reality is a dangerous person. An innocuous gesture may be perceived as a threat, and a threat, no matter how slight, may receive a disproportionate response. Not only should healthcare providers have the ability to question someone suffering from mental illness about ownership or possession of firearms, it would be irresponsible and a dereliction of duty to refrain from such inquiry.¹³⁸

In a like manner, the phrase “imminent danger” also places the patient’s mental state under scrutiny, which could be inferred from behavior.¹³⁹ However, a patient would not need to be mentally ill in order to be in a mental state in which he or she poses an imminent danger to himself or herself or others. For example, a patient in a state of rage, although in control of his or her actions and able to perceive reality normally, may pose an imminent threat to others.

¹³⁶ See *supra* Part III.B.

¹³⁷ FLA. STAT. § 394.455(18) (2014).

¹³⁸ This note speaks only of those currently suffering from mental illness, and not of people who were once deemed mentally ill but are now healthy. *But see* Tyler v. Hillsdale Cnty. Sheriff’s Dep’t, 775 F.3d 308 (6th Cir. 2014) (“The government’s interest in keeping firearms out of the hands of the mentally ill is not sufficiently related to depriving the mentally healthy, who had a distant episode of commitment, of their constitutional rights”).

¹³⁹ Assuming, *arguendo*, that the danger will be caused by the patient. Of course, the patient may also be the victim of violence. Under those circumstances the existence of an imminent danger would be evidenced by external factors.

Being that both phrases from the prior version of the bill dealt with the patient's mental state, why then did the Legislature ultimately enact Section 790.338(2) without any indicator that relevancy requires the patient possess a particular mental state? As a reminder, the *Wollschlaeger* court stated that a doctor may direct firearms inquiries towards all patients, so long as the information is relevant, based on the specifics of the case, to the patient's medical care or safety. Despite not being too vague for constitutional purposes, this interpretation of the law leaves doctors with a healthy dose of discretion to apply their personal beliefs regarding firearms to their relevancy determinations. Would changing the language from "relevant to the patient's medical care or safety" strengthen Section 790.338(2) so that it better effectuates its originally intended purpose?

With regards to the language of the law, there are several phrases that the Legislature has previously considered that better tie in a mental state component. Limiting inquiries only to times when there is "imminent danger" creates risk because some dangers are foreseeable, even probable, but not imminent. Likewise, a requirement that the patient is mentally ill or experiencing a psychotic episode is too narrow. There will be dangerous patients who are fully conscious of their actions and of the world around them. In contrast to the Firearm Owners Privacy Act and its legislative history, the Baker Act uses a combination of these phrases as the criteria for involuntary examination. A patient may be taken for involuntary examination if he or she is mentally ill and either likely to suffer from neglect and such neglect poses a real and present threat of substantial harm to his or her well-being, or there is substantial likelihood that the patient will cause serious bodily harm to himself or herself or others, as evidenced by recent behavior.¹⁴⁰

Consider if, instead of its present form, Section 790.338(2) read in part:

Notwithstanding this provision, a health care practitioner or health care facility that in good faith believes that there is a substantial likelihood that the ownership or possession of a firearm or ammunition by the patient or by a family member of the patient, or the presence of a firearm in a private home or domicile of the patient or a family member of the patient, will cause serious bodily harm to the patient or others in the near future.

¹⁴⁰ FLA. STAT. § 394.463(1)(b) (2014).

By borrowing the language of the Baker Act, the Firearm Owners Privacy Act would more clearly define what is necessary for the inquiry to be relevant. Additionally, the language of the Baker Act is time-tested. The aforementioned language has withstood judicial scrutiny for over twenty-five years.¹⁴¹

In light of the various terms so far discussed, the substantial likelihood of harm exception used in the Baker Act is relatively strong. It does not require a weighing of probabilities, nor is it activated by a mere possibility of harm. However, it has its limitations. As written, this exception is forward-looking only. If a patient presents with a gunshot wound, information on the caliber and type of ammunition would likely aid the treating physician. Section 790.338(3) creates an exception to the general rule for such medical emergencies, but the exception only applies to emergency medical technicians and paramedics. Therefore, in order for the language derived from the Baker Act to be workable, Section 790.338(3) would also need to be amended to expand its scope from emergency services workers to all healthcare providers.

While these changes would make the Firearm Owners Privacy Act more effective, less invasive changes may be sufficient. To reiterate, the problem with the law as currently enacted is that the relevancy inquiry leaves physicians too much leeway. If the amount of discretion physicians have in making the relevancy determination could be limited, the law would be more effective. The law could be improved by amending the previously mentioned subsections. But, there is an alternative path that offers less resistance. In lieu of revising substantial portions of the law, the Legislature should reinstate that portion of the hanging paragraph that excludes from the exception those inquiries made due to a general belief that firearms or ammunition are dangerous.

When the law was originally drafted in the Legislature, it had a purpose. Now it is better written, but to do that, the exceptions were broadened. The phrase “relevant to the patient’s medical care or safety” creates a sensible exception, yet gives doctors the ability to exploit a loophole. With this loophole, physicians with an understanding of the law can act in large part as if Section 790.338(2) does not exist. *Wollschlaeger* states that relevancy must be determined on a case-by-case basis upon particularized information. Other than that, there is no explicit limitation of what type of information will suffice for that determination. If the Legislature added language to indicate that “the exceptions provided by Section 790.338(2) do not apply to inquiries made due to a person’s general belief that firearms or ammunition are harmful to health or safety,” the excessive amount of discretion held by

¹⁴¹ See *Paddock v. Chacko*, 522 So. 2d 410, n.5 (Fla. Dist. Ct. App. 1988).

physicians would be reduced. Thus, it would not fall within the exception for a physician to inquire as to firearm ownership for patients given his or her belief that the patient is part of an at-risk demographic.

In short, the Firearm Owners Privacy Act would be most improved by amending Section 790.338 so that the exception to the general prohibition against inquiries concerning firearm ownership would require a good faith belief that there is a substantial likelihood of serious bodily harm to the patient or others in the near future. By making substantial likelihood of serious bodily harm a *sine qua non* to the exception, clever physicians will be less able to pursue an agenda under the pretext of preventive medicine. If, on the other hand, the Legislature were to find that such a change would be too radical, the law could still be improved by merely adding an explanation that to be relevant, more is necessary than a general belief that firearms are dangerous.

V. CONCLUSION

Certainly, patients benefit when they can enter a physician's examination room without fear of being harassed or being subject to a political agenda. Likewise, physicians have responsibilities that will, at times, require them to broach sensitive subjects. The Florida Firearm Owners Privacy Act recognizes this dichotomy by both explicitly granting patients a right to privacy in regards to their firearm ownership and possession, and by carving out exceptions for when that information is pertinent to treatment.

That said, the exceptions are broader than are necessary for physicians to provide adequate treatment. Amending the law to phrase the exceptions in more specific language will serve to better effectuate the law's purpose by raising the threshold for which the information is deemed relevant. What the law should advise the healthcare consuming public and physicians alike is that firearm ownership is not intrinsically a cause for medical concern. Only when there is an antecedent medical diagnosis or indication that a patient may be harmed or harm others, or during the course of a medical emergency, should a physician ever inquire into firearm ownership or possession.

Earlier, this note mentioned that the federal government regulates healthcare in some ways through Medicare.¹⁴² Currently, the federal government has no regulations in place that either prohibit or compel inquiry into firearm ownership. Nonetheless, the Centers for Medicare & Medicaid Services contends, "nothing in [the Affordable Care Act] prohibits or otherwise limits communication between health care

¹⁴² *Supra* Part II.A.2.

professionals and their patients, including communications about firearms. Health care providers can play an important role in promoting gun safety.”¹⁴³ This is the sentiment that precipitated the need for the Firearm Owners Privacy Act. Florida took the initiative to protect the privacy rights of patients, which in turn improves access to and usage of healthcare. Let Florida’s system serve as a roadmap for other states that wish to put patient care above politics.

¹⁴³ Centers for Medicare & Medicaid Services, *Affordable Care Act Implementation FAQs – Set 11*, http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html (last visited Jan. 7, 2015).