

REPORT 03 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (N-21)
Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by
Individuals with Cognitive Deficits Due to Traumatic Brain Injury
(Resolution 424-A-19)
(Reference Committee D)

EXECUTIVE SUMMARY

Objective. This report summarizes the evidence around cognitive deficits, including traumatic brain injury (TBI), the legal landscape of cognitive impairment as it relates to firearm ownership and driving, and the role of the physician in adjudicating fitness. While the resolution specifically cites TBI, there is currently limited research available on TBI and driving or firearm ownership. As such, more well-studied cognitive deficits (such as dementias) are examined to provide context.

Methods. English language reports were selected from searches of the PubMed and Google Scholar databases from January 2011 to July 2021 using the search terms “medical advisory board” and “gun” or “firearm” or “driver license” or “motor vehicle;” “cognitive impairment” or “dementia” or “traumatic brain injury” and “gun” or “firearm” or “driver license” or “motor vehicle.” Additional articles were identified by manual review of the reference lists of pertinent publications. Websites managed by federal and state agencies and applicable regulatory and advocacy organizations were also reviewed for relevant information

Results. The role of the physician in adjudicating fitness for driver licensing and firearm ownership are primarily dictated by individual state policies. Differences in state policies, such as the duration of revocation, severity of symptoms and appeals process were noted. Generally, a medical advisory board is utilized for driver licensing adjudication and appeals. For firearm ownership, cognitive impairment-based removals are more uncommon and extreme risk protection orders have only recently become established in a smaller number of states, with varying roles of physician involvement.

Conclusion. Given the unpredictable nature of symptom progression in an individual living with TBI, it is difficult to compare to the current regulatory framework with other cognitive impairments, such as dementias. Your Council recommends that additional research is needed to understand TBI as a risk factor for harming oneself or others in order to inform the development of policies and protocols for the revocation or reinstatement for the purposes of driver licenses and firearm ownership.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 03-N-21

Subject: Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Injury

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Referred to: Reference Committee D
(Janet West, MD, Chair)

1 INTRODUCTION

2
3 Resolution 424-A-19, “Physician Involvement in State Regulations of Motor Vehicle Operation
4 and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Injury,”
5 introduced by the American Academy of Physical Medicine and Rehabilitation and referred by the
6 American Medical Association (AMA) House of Delegates (HOD) asked:

7
8 That our AMA reaffirm current AMA Policy H-145.999, stating it supports stricter
9 enforcement of current federal and state gun legislation and that our AMA advocate for
10 physician-led committees in each state to give further recommendations to the state regarding
11 driving and/or gun use by individuals who are cognitively impaired and/or a danger to
12 themselves or others.

13
14 This report summarizes the evidence around cognitive deficits, including traumatic brain injury
15 (TBI), the legal landscape of cognitive impairment as it relates to firearm ownership and driving,
16 and the role of the physician in adjudicating fitness. While the resolution specifically cites TBI,
17 there is currently limited research available on TBI and driving or firearm ownership. As such,
18 more well-studied cognitive deficits (such as dementias) are examined to provide context.

19
20 METHODS

21
22 English language reports were selected from searches of the PubMed and Google Scholar databases
23 from January 2011 to July 2021 using the search terms “medical advisory board” and “gun” or
24 “firearm” or “driver license” or “motor vehicle;” “cognitive impairment” or “dementia” or
25 “traumatic brain injury” and “gun” or “firearm” or “driver license” or “motor vehicle.” Additional
26 articles were identified by manual review of the reference lists of pertinent publications. Websites
27 managed by federal and state agencies and applicable regulatory and advocacy organizations were
28 also reviewed for relevant information.

29
30 OVERVIEW OF COGNITIVE IMPAIRMENT

31
32 Cognitive impairment describes a durable characteristic in which an individual has difficulty
33 concentrating, learning, remembering, or exercising sound judgment during everyday tasks due to
34 illness or injury. Cognitive impairment is not limited to a specific condition or disease, but severe

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1 cases are typically associated with degenerative brain diseases, such as Alzheimer's, Parkinson's or
2 Lewy Body disease. In these cases, cognitive impairment can be measured using the Global
3 Deterioration Scale, which ranges from 1 (no cognitive impairment) to 7 (severe dementia).¹ Age is
4 the primary risk factor for cognitive impairment. Current estimates suggest that there are
5 approximately 44 million individuals worldwide living with dementia, nearly double the number of
6 cases from 1990.² While a portion of this increase can be attributed to improved screening and
7 awareness of dementia, it also is a key indicator of the impending "silver tsunami" as the baby
8 boomer generation (birth years 1946-1964) ages.^{3,4}

9
10 It is generally accepted that individuals experiencing dementia, or other forms of cognitive
11 impairment, may be at increased risk for harming themselves or others. To reduce injuries and
12 deaths, while respecting their autonomy and rights, it is recognized that some activities, such as
13 driving or firearm access, may need to be restricted in this population.

14 15 *Traumatic Brain Injury*

16
17 TBI is an emerging area of scrutiny, not only in the medical profession, but in the public sphere,
18 raising questions as to whether individuals with TBI may be at higher risk of harming themselves
19 or others. TBI occurs when an individual receives a blow to the head. It can be categorized broadly
20 in two ways: mode of injury (closed/non-penetrative or open/penetrative) and severity (mild,
21 moderate or severe).⁵ Secondary injuries from the initial impact may include increased intracranial
22 pressure, decreased cerebral perfusion and intracranial hemorrhage. Persons with TBI commonly
23 experience loss of consciousness, headache, nausea, fatigue, depression, mood swings and
24 difficulty concentrating.⁶ In the most severe cases, persons with TBI may be left with persistent and
25 severe cognitive impairment or they may remain in a comatose state long after their initial injury.
26 While symptoms typically abate after approximately six months, many patients report lifelong
27 complications from even a single, mild incident of TBI.⁷ Common causes of TBI include falls,
28 motor vehicle crashes, sports injuries and gunshot wounds. Unlike other forms of cognitive
29 impairment, persons living with TBI may recover and regain some or all cognitive function and
30 motor skills, this is especially true in cases where rehabilitation is sought. This makes
31 understanding symptom progression particularly difficult.⁸

32
33 It is estimated that approximately 1.1 percent of the U.S. population experiences life-long effects
34 from TBI.⁹ Of particular interest to this report is the connection between TBI and later-in-life
35 development of neurodegenerative disease such as dementias, including Alzheimer's and
36 Parkinson's.¹⁰ Studies have suggested that patients who have experienced at least one incident of
37 TBI in their life are up to 4 times more likely to develop Alzheimer's in their lifetime, with more
38 severe incidents (such as those resulting in loss of consciousness) resulting in the highest risk.¹¹⁻¹³
39 One of the historic difficulties of diagnosing and treating TBI has been managing the sequelae that
40 may not manifest until much later in life. For example, studies have shown that cognitive function
41 post-TBI can steadily improve for up to 10 years only to be followed by a sharp decline.¹⁴

42
43 With regard to whether individuals with TBI may be at higher risk of harming themselves or
44 others, data suggest TBI may be a risk factor for violent behavior and suicide. One study found that
45 approximately 40 percent of patients monitored at 3, 6 and 12 months post-TBI presented signs of
46 aggression.¹⁵ Similarly, several studies have shown TBI is a risk factor for intimate partner
47 violence and violent criminal behavior,¹⁶⁻²¹ and a study of Vietnam war veterans with TBI found a
48 correlation between lesions of the prefrontal cortex and a positive implicit attitude towards
49 violence.²² Additionally, violent behavior may present as self-harm, as a 35-year retrospective
50 study in Denmark found the absolute suicide rate was over double (41 vs 20 per 100,000 person-

1 years) for patients with diagnosed TBI at any severity,²³ and this risk increases with subsequent
2 head traumas.²⁴

3 4 DRIVER LICENSING

5
6 There is no constitutionally protected right to maintain a driver license, and there are clear
7 guidelines for the role of the physician in protecting their patients from unsafe driving. In
8 collaboration with the U.S. Department of Transportation and the National Highway Traffic Safety
9 Administration, the AMA previously developed and published guidance for physicians. While this
10 guidance is presented in the context of an aging driver, potential cognitive and noncognitive
11 impairment from a previous TBI can occur at any age.²⁵

12
13 In brief, the guidance suggests that physicians perform a battery of tests to assess driving skills
14 (visual acuity, spatial awareness, dexterity, memory). If a physician believes that their patient is
15 unfit to drive, they are advised to counsel the patient and their family or caregivers to voluntarily
16 retire from driving and surrender their driver license, or they may refer the patient for occupational
17 therapy. In the case of TBI, this is especially critical as surveys have shown that half of drivers
18 recovering from mild TBI have no intention of self-moderating driving behavior.²⁶

19
20 Depending on the state, the physician may also have legal responsibilities as dictated by their
21 medical licensing board. Some states, such as California, mandate that all physicians report to the
22 Department of Motor Vehicles (DMV) any instances of patients with disorders resulting in loss of
23 consciousness or severe impairment of motor vehicle operation. Other instances where a physician
24 has a good faith belief that a driver is a risk to public safety are encouraged to be reported, but not
25 required to do so. Some states, such as Kansas, explicitly do not require a physician to report this
26 information and further require the physician to obtain written consent from the patient before
27 releasing any information to the DMV. Additional state-level differences to be aware of include the
28 legal protection (or liability) that a physician may be entitled to in the event of an accident from a
29 known unsafe driver, and whether the physician may submit a DMV referral anonymously.

30 31 FIREARM OWNERSHIP

32
33 Firearm ownership in the United States is largely controlled by the Second Amendment to the
34 Constitution, which indicates that “the right of the people to keep and bear Arms, shall not be
35 infringed.” However, Supreme Court decisions in *District of Columbia v. Heller* (2008) and
36 *McDonald v. City of Chicago* (2010) found that this right is not absolute and may be limited
37 appropriately by federal, state and local governments.^{27,28} Limits to firearm ownership relevant to
38 this report fall into two categories: cognitive impairment restrictions and risk-based removals.

39
40 It should be noted that instances of interpersonal firearm violence committed by people with
41 mental illness often attract media and public scrutiny. However, only 4 percent of all interpersonal
42 firearm violence in the United States can be attributed to individuals with mental illness.²⁹ By
43 comparison, up to 74 percent of deaths by suicide are related to a diagnosed mental illness.³⁰

44 45 *Firearm Ownership and Possession Restrictions*

46
47 Federal law 18 U.S.C. § 922(d) prevents the sale of a firearm or ammunition to any person that
48 “has been adjudicated as a mental defective or has been committed to any mental institution,”
49 although all but 4 states (Colorado, Indiana, Kentucky and New Hampshire) have additional
50 restrictions related to mental health and firearm ownership.³¹ The resulting patchwork of
51 restrictions and regulatory authorities has been criticized for ineffectiveness. For example, the

1 gunman responsible for the deaths of 32 people at Virginia Tech in 2007 had been found to be
2 mentally unfit by a court in 2005 after accusations of stalking. The shooter was required by the
3 court to attend treatment, but due to his treatment being on an outpatient basis, he was not
4 prevented from purchasing the firearms used in the mass shooting, as federal law requires
5 involuntary commitment.³²

6
7 All states but one (Hawaii) do not allow restrictions on firearm purchases on the basis of diagnosis
8 alone. This practice of requiring an individual risk assessment is consistent with the
9 recommendations of the American Psychiatric Association (APA).³³ While a practitioner may
10 report the status of an individual's diagnosis or treatment to a third party, that is not sufficient to
11 bar the purchasing of a firearm (outside of Hawaii).

12
13 At the federal level, individuals adjudicated to be mentally unfit to own a firearm are reported to
14 the National Instant Criminal Background Check System (NICS). Firearm dealers who hold a
15 federal firearms license must process all potential buyers through NICS prior to selling them a
16 firearm. Since 1998, firearm sales have been denied 1,970,264 times due to failing a NICS
17 background check, but only 3 percent of them have been due to mental health concerns.³⁴ Several
18 factors may have contributed to this relatively low rate of rejection, such as a lack of mandatory
19 reporting of mental health data by states, the inability for states to report violations of their stricter
20 purchasing restrictions, and a lack of clarity around NICS reporting and the Health Insurance
21 Portability and Protection Act (which was clarified in 2016).^{35,36}

22 23 *Firearm Removals*

24
25 Once an individual has legally purchased a firearm, the primary means for removal are through
26 extreme risk protection orders (ERPOs), although they may go by other names depending on the
27 state, such as gun violence restraining orders (California), or risk warrants (Connecticut).
28 Currently, 19 states (and the District of Columbia) have some version of ERPO law that allows for
29 the petitioning of a court to remove firearms from the possession of someone deemed high risk.³⁷
30 ERPO laws have recently gained momentum, with 8 of the 20 states having passed legislation
31 during the 2018 session immediately following the school shooting in Parkland, Florida. In June
32 2021, under the direction of President Biden, the Department of Justice released model legislation
33 for states to follow if they wished to enact ERPO laws.³⁸ A 2018 report from this Council further
34 discusses the role of the physician in firearm safety and ERPOs.³⁹ ERPO laws are still new, but
35 research suggests that while public awareness remains low, California's approach has shown signs
36 of success in removing firearms from individuals threatening mass shooting events.^{40,41}

37
38 By contrast, Oklahoma passed an anti-ERPO law in May 2020 which prohibits any county or local
39 government from enacting ERPO laws. Texas, Alaska, Georgia, Minnesota and Kansas legislatures
40 have all introduced anti-ERPO laws which have not passed at the time of writing. State legislators
41 in these jurisdictions have argued that ERPO laws may infringe upon the First, Second, Fourth and
42 Fifth Amendment, but in limited court proceedings, these arguments have been rejected.^{37,42-44}

43
44 The exact implementation of ERPO laws varies from state to state, but broadly they allow for a
45 process in which a court can hear a petition to remove firearms and ammunition from the
46 possession of an individual.⁴⁵ The laws largely differ in three major areas: who may petition the
47 court, the burden of evidence required to approve the removal, and the duration of the removal and
48 the overturning of the individual's rights to otherwise possess a firearm. The most narrowly drafted
49 state legislation allows law enforcement officers or their agencies to petition a court to remove
50 firearms, where other states allow some combination of household members, intimate partners,
51 employers, coworkers, or school officials to additionally file an ERPO. Most relevant to this report,

1 Maryland and the District of Columbia allow healthcare providers to file ERPO petitions as well,
2 although professional groups have varying ways of defining and measuring risky behavior.⁴⁶ An
3 individual may or may not be notified that a petition for an ERPO against them has been made, and
4 law enforcement may be empowered to seize an individual's weapons within 24 hours and then to
5 prevent the individual from regaining possession of their firearms until a hearing has been held,
6 which, per some state statutes, can extend for up to a year.

7 8 *Firearm Ownership and Cognitive Impairment*

9
10 Studies have indicated that up to 60 percent of outpatients living with dementia are in households
11 containing firearms, placing them at higher risk for death by suicide.^{47,48} Older adults die by suicide
12 at rates disproportionate with the general population and firearms are the most common means.⁴⁹
13 Caregivers for those with dementia have been surveyed and over 70 percent feel that the caregiver
14 plays a key role in firearm safety, but only 5 percent of caregivers had training or guidance.⁵⁰ The
15 Veteran's Health Administration has developed guidance for counseling family or caregivers on
16 creating a safe environment if firearms are accessible to a person living with dementia.⁵¹

17
18 As described above, the progression of TBI is unpredictable. Some report no behavioral or physical
19 effects for many years only to be followed by a steep decline, while others report a full recovery of
20 function. Currently, conditions such as chronic traumatic encephalopathy (CTE) from sports
21 injuries can only be diagnosed posthumously which would make any blanket policy around TBI
22 and firearm ownership difficult to craft and implement. However, TBI does increase the risk of
23 developing other neurological conditions, such as dementias which have more established
24 protocols for evaluating cognitive fitness.^{10,52-54} Depending on the progression of TBI, a similar
25 approach to that used for dementia may be appropriate.

26 27 *Medical Advisory Boards*

28
29 Legal requirements and medical thresholds for firearm ownership and driver licensing in the event
30 of cognitive impairment vary from state to state. To ensure that the physician's voice is heard in the
31 process, states can implement a medical advisory board (MAB) at several different points: to create
32 best practices guidelines, to perform the medical assessment, or to evaluate appeals for
33 reinstatement.

34
35 MABs are much more commonly utilized in the case of driver licensing. A summary of MAB roles
36 from state to state can be found in a 2017 NHTSA publication.⁵⁵ In brief, the MAB may be
37 involved in all steps of the process. In New York, input from the MAB is given to the DMV for
38 developing the regulations dictating a driver's fitness. Other states use their MABs on a case-by-
39 case basis. Louisiana's MAB is forwarded complaints from the DMV for evaluation, whereas
40 Maine's MAB is engaged only on driver appeal. Some states, like Montana, do not retain a MAB at
41 all. It should also be noted that the function of state MABs are dependent not only on statutory
42 authority but also on funding, which has historically not been consistent.

43
44 For firearm ownership, there are no known MABs in the country. In Texas, a MAB has been used
45 to review cognitive fitness for concealed handgun licenses, but the MAB is not used for purchasing
46 firearms or reviewing ERPOs. In 2020, a bill was introduced in the New York state legislature
47 (S7065) to require anyone seeking to purchase a firearm to submit to a mental health screening, but
48 it did not receive a vote in the committee that first had hearings on the bill. Countries as diverse as
49 Argentina, Turkey, Ukraine, Croatia, France, Spain, Japan and Israel require either a mental health
50 evaluation or access to medical records prior to purchasing any firearm.⁵⁶

1 Given the unpredictable nature of symptom progression in an individual living with TBI, including
2 the potential for recovery, the role of a MAB in both driver licensing and firearm ownership
3 becomes more critical. For example, many states utilize their MAB to develop a protocol for
4 reinstating the driver's license of an individual living with epilepsy, a disease which can be
5 managed with medication or other interventions. A typical procedure involves the revocation of the
6 driver's license, followed by an appeals process in which the individual must go a set amount of
7 time without a seizure event (3-18 months depending on the state) followed by an individual risk
8 assessment performed by the MAB.⁵⁷ More research is needed to understand TBI as a risk factor
9 for harming oneself or others in order to inform the development of policies and protocols for the
10 revocation or reinstatement for the purposes of driver licenses and firearm ownership.

11 12 CURRENT AMA POLICY

13
14 The AMA has a multitude of policies regarding firearm violence, mental health and/or driver
15 licensing as listed in the appendix of this report. AMA policy clearly defines firearm violence as a
16 public health threat and aims to limit high-risk individuals from possessing firearms in order to
17 protect themselves and others from morbidity and mortality. Most relevant to this report include
18 AMA policies on "Medical Advisory Boards in Driver Licensing" (H-15.995), "Firearms and
19 High-Risk Individuals" (H-145.972) and "Violence Prevention" (H-145.970).

20 21 DISCUSSION

22
23 When creating and implementing policy related to TBI, one must acknowledge the non-linear
24 progression of even mild TBI. Many people who suffer a concussion will go on to live
25 complication-free lives after their initial recovery, whereas others may be at risk of cognitive
26 decline decades later. The potential for increased risk, even after long symptom-free periods, need
27 to be balanced with individual dignity, constitutional rights, and physician liability.

28
29 With respect to driver licensing, AMA policy is clear, guidance has been published in collaboration
30 with the U.S. Department of Transportation, and physicians are being utilized on MABs in 32
31 states as of 2015.⁵⁵ With respect to firearm ownership, the AMA supports the establishment of
32 laws, such as ERPOs allowing family members, intimate partners, household members, and law
33 enforcement personnel to petition a court for the removal of a firearm when there is a high or
34 imminent risk for violence.

35
36 In CSAPH Report 4-A-18, "The Physician's Role in Firearm Safety," the Council identified those
37 individuals considered to be high-risk of firearm violence to themselves or others and the report
38 supported common-sense laws allowing for the removal of firearms in certain circumstances. In the
39 case of TBI, where there can be a large range of severity, non-linear progression and a lack of
40 conclusive diagnostic testing, a diagnosis alone may not be sufficient to quantify risk of harm to
41 oneself or others.

42
43 With the Biden administration signaling an interest in passing a federal ERPO law and increasing
44 pressure on states to pass standardized ERPO laws, opportunities may exist to develop guidance for
45 physicians and courts, similar to the work previously done around driver licensing. The AMA has
46 developed a CME module to prepare physicians to counsel their patients on firearm safety.⁵⁸ The
47 module is designed to assist physicians in recognizing risk factors that increase the potential for
48 firearm injury and death, identifying barriers to communicating with patients about firearm safety,
49 and effectively communicating with patients to reduce the risk of firearm injury and death.

1 RECOMMENDATIONS

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The Council on Science and Public Health recommends that the following be adopted as amended, and the remainder of the report be filed:

1. Our AMA encourages the National Institutes of Health and other funders to expand research on cognitive impairment, including traumatic brain injury (TBI), as a risk factor for ~~harm to self or others that may impact~~ driving and/or firearm ownership, and the role of the physician in policy advocacy and counseling patients so as to decrease the ~~preventing~~ ~~decreasing~~ risk of morbidity and mortality (New HOD Policy).
2. That Policy H-15.995, “Medical Advisory Boards in Driver Licensing,” advocating for state governments to create and maintain medical advisory boards to oversee driver licensing, be reaffirmed. (Reaffirm Current HOD Policy)
3. That Policy H-145.972, “Firearms and High-Risk Individuals,” which advocates for ERPO laws and protocols for removing firearms from those deemed to be high-risk in the wake of a petition from concerned parties, be reaffirmed. (Reaffirm Current HOD Policy)
4. That Policy H-145.970, “Violence Prevention,” calling upon state and federal government entities to strengthen and promote the use of the NICS background check system, be reaffirmed. (Reaffirm Current HOD Policy)
5. That Policy H-145.976, “Firearm Safety Counseling in Physician-Led Health Care Teams,” which protects the right of a physician to counsel a patient and/or their family about the risks of gun ownership and appropriate safety measures, be reaffirmed. (Reaffirm Current HOD Policy)

Fiscal Note: Less than \$1000

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RELEVANT AMA POLICY

H-470.954, “Reduction of Sports-Related Injury and Concussion”

1. Our AMA will: (a) work with appropriate agencies and organizations to promote awareness of programs to reduce concussion and other sports-related injuries across the lifespan; and (b) promote awareness that even mild cases of traumatic brain injury may have serious and prolonged consequences.
 2. Our AMA supports the adoption of evidence-based, age-specific guidelines on the evaluation and management of concussion in all athletes for use by physicians, other health professionals, and athletic organizations.
 3. Our AMA will work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the ability of physicians to prevent, diagnose, and manage concussions and other sports-related injuries.
 4. Our AMA urges appropriate agencies and organizations to support research to: (a) assess the short- and long-term cognitive, emotional, behavioral, neurobiological, and neuropathological consequences of concussions and repetitive head impacts over the life span; (b) identify determinants of concussion and other sports-related injuries in pediatric and adult athletes, including how injury thresholds are modified by the number of and time interval between head impacts and concussions; (c) develop and evaluate effective risk reduction measures to prevent or reduce sports-related injuries and concussions and their sequelae across the lifespan; and (d) develop objective biomarkers to improve the identification, management, and prognosis of athletes suffering from concussion to reduce the dependence on self-reporting and inform evidence-based, age-specific guidelines for these patients.
 5. Our AMA supports research into the detection, causes, and prevention of injuries along the continuum from subconcussive head impacts to conditions such as chronic traumatic encephalopathy (CTE).
- CSAPH Rep. 3, A-15; Appended: Res. 905, I-16.

H-25.991, “Alzheimer's Disease”

- Our AMA: (1) encourages physicians to make appropriate use of guidelines for clinical decision making in the diagnosis and treatment of Alzheimer's disease and other dementias;
- (2) encourages physicians to make available information about community resources to facilitate appropriate and timely referral to supportive caregiver services;
 - (3) encourages studies to determine the comparative cost-effectiveness/cost-benefit of assisted in-home care versus nursing home care for patients with Alzheimer's disease and related disorders;
 - (4) encourages studies to determine how best to provide stable funding for the long-term care of patients with Alzheimer's disease and other dementing disorders;
 - (5) supports the use of evidence-based cost-effective technologies with prior consent of patients or designated healthcare power of attorney, as a solution to prevent, identify, and rescue missing patients with Alzheimer's disease and other related dementias with the help of appropriate allied specialty organizations;
 - (6) supports increased awareness of the sex and gender differences in incidence and etiology of Alzheimer's disease and related dementias; and
 - (7) encourages increased enrollment in clinical trials of appropriate patients with Alzheimer's disease and related dementias, and their families, to better identify sex-differences in incidence and progression and to advance a treatment and cure of Alzheimer's disease and related dementias.
- CSA Rep. 6, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Appended: Res. 503, A-16; Appended: Res. 915, I-16.

H-15.954, “Older Driver Safety”

- (1) Our AMA recognizes that the safety of older drivers is a growing public health concern that is best addressed through multi-sector efforts to optimize vehicle design, the driving environment, and the individual's driving capabilities, and:
 - (a) believes that because physicians play an essential role in helping patients slow their rate of functional decline, physicians should increase their awareness of the medical conditions, medications, and functional deficits that may impair an individual's driving performance, and counsel and manage their patients accordingly;
 - (b) encourages physicians to familiarize themselves with driver assessment and rehabilitation options, refer their patients to such programs whenever appropriate, and defer recommendations on permanent driving cessation until establishing that a patient's driving safety cannot be maintained through medical interventions or driver rehabilitation;
 - (c) urges physicians to know and adhere to their state's reporting statutes for medically at-risk drivers; and
 - (d) encourages continued scientific investigation into strategies for the assessment and management of driving safety in the clinical setting.
 - (2) Our AMA encourages physicians to use the Physician's Guide to Assessing and Counseling Older Drivers as an educational tool to assist them in helping their patients.
- CSA Rep. 6, A-03; Reaffirmed: CSAPH Rep. 1, A-13.

Ethics Opinion 8.2, “Impaired Drivers & Their Physicians”

A variety of medical conditions can impair an individual's ability to operate a motor vehicle safely, whether a personal car or boat or a commercial vehicle, such as a bus, train, plane, or commercial vessel. Those who operate a vehicle when impaired by a medical condition pose threats to both public safety and their own well-being. Physicians have unique

opportunities to assess the impact of physical and mental conditions on patients' ability to drive safely and have a responsibility to do so in light of their professional obligation to protect public health and safety. In deciding whether or how to intervene when a patient's medical condition may impair driving, physicians must balance dual responsibilities to promote the welfare and confidentiality of the individual patient, and to protect public safety.

Not all physicians are in a position to evaluate the extent or effect of a medical condition on a patient's ability to drive, particularly physicians who treat patients only on a short-term basis. Nor do all physicians necessarily have appropriate training to identify and evaluate physical or mental conditions in relation to the ability to drive. In such situations, it may be advisable to refer a potentially at-risk patient for assessment.

To serve the interests of their patients and the public, within their areas of expertise physicians should:

- (a) Assess at-risk patients individually for medical conditions that might adversely affect driving ability, using best professional judgment and keeping in mind that not all physical or mental impairments create an obligation to intervene.
- (b) Tactfully but candidly discuss driving risks with the patient and, when appropriate, the family when a medical condition may adversely affect the patient's ability to drive safely. Help the patient (and family) formulate a plan to reduce risks, including options for treatment or therapy if available, changes in driving behavior, or other adjustments.
- (c) Recognize that safety standards for those who operate commercial transportation are subject to governmental medical standards and may differ from standards for private licenses.
- (d) Be aware of applicable state requirements for reporting to the licensing authority those patients whose impairments may compromise their ability to operate a motor vehicle safely.
- (e) Prior to reporting, explain to the patient (and family, as appropriate) that the physician may have an obligation to report a medically at-risk driver:
 - (i) when the physician identifies a medical condition clearly related to the ability to drive;
 - (ii) when continuing to drive poses a clear risk to public safety or the patient's own well-being and the patient ignores the physician's advice to discontinue driving; or
 - (iii) when required by law.
- (f) Inform the patient that the determination of inability to drive safely will be made by other authorities, not the physician.
- (g) Disclose only the minimum necessary information when reporting a medically at-risk driver, in keeping with ethics guidance on respect for patient privacy and confidentiality.

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H-15.995, "Medical Advisory Boards in Driver Licensing"

Our AMA (1) endorses the establishment of state motor vehicle department medical advisory boards to improve licensure of vehicle operators and to reduce incidence of injury and death and (2) urges state medical associations to encourage establishment of such boards and to work actively with them.

Res. 2, A-72; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20.

H-160.972, "Physician Representation on State and National Health Care Advisory Bodies"

The AMA urges Congress, and others who select members of state and national health advisory bodies, to increase the proportion of physicians in active clinical practice serving on these bodies, with selected members being recommended by state or national medical associations.

Sub. Res. 110, A-88; Reaffirmed: Sunset Report, I-98. Reaffirmed: BOT Rep. 23, A-09; Reaffirmed: BOT Rep. 09, A-19

H-145.975, "Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care"

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18

D-145.995, “Gun Violence as a Public Health Crisis”

Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban.
Res. 1011, A-16; Reaffirmation: A-18; Reaffirmation: I-18.

H-145.996, “Firearm Availability”

1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.
3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.
Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16; Appended: Res. 433, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18

H-145.999, “Gun Regulation”

Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.
Sub. Res. 31, I-81; Reaffirmed: CLRPD Rep. F, I-91; Amended: BOT Rep. I-93-50; Reaffirmed: Res. 409, A-00; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17; Reaffirmation: I-18.

H-145.972, “Firearms and High-Risk Individuals”

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.
CSAPH Rep. 04, A-18; Reaffirmed: BOT Rep. 11, I-18.

H-145.991, “Waiting Periods for Firearm Purchases”

The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country.
Sub. Res. 34, I-89; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17; Reaffirmation: A-18; Reaffirmation: I-18

H-145.970, “Violence Prevention”

Our AMA: (1) encourages the enactment of state laws requiring the reporting of all classes of prohibited individuals, as defined by state and federal law, to the National Instant Criminal Background Check System (NICS); (2) supports federal funding to provide grants to states to improve NICS reporting; and (3) encourages states to automate the reporting of relevant information to NICS to improve the quality and timeliness of the data.

H-145.976, “Firearm Safety Counseling in Physician-Led Health Care Teams”

1. Our AMA: (a) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.

2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.

Res. 219, I-11; Reaffirmation A-13; Modified: Res. 903, I-13; Appended: Res. 419, A-17; Reaffirmed: CSAPH Rep. 04, A-18.

H-145.971, “Development and Implementation of Recommendations for Responsible Media Coverage of Mass Shootings”

Our AMA encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations and/or best practices for media coverage of mass shootings, including informed discussion of the limited data on the relationship between mental illness and gun violence, recognizing the potential for exacerbating stigma against individuals with mental illness.

Res. 212, I-18; Modified: Res. 934, I-19.