sis; however, we believe that the fistula was secondary to a progressive infected aortic aneurysm around the endograft rather than the initial source of the patient’s fatal condition. First, the aortoesophageal fistula appeared months after the endograft was performed, whereas dysphagia or hematemesis occurred early in the course of treatment.1,2 Our patient received an endograft for aortic aneurysm 7 years before presentation; he had no hematemesis or dysphagia until the 20th hospital day. Second, his esophagus was well visualized on initial computed tomography, and there was no indication of abnormal soft tissue around the esophagus or in the esophageal wall, findings that are important for the diagnosis of aortoesophageal fistula.1,3 We intended to highlight the critical aortic infection, especially its manifestation on chest radiography. According to the patient’s clinical features and the imaging findings, his septicemia was the most likely cause of the gaseous, infected aneurysm.

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Physician Attitudes and Experience with Permit Applications for Concealed Weapons

TO THE EDITOR: Every U.S. state allows people to carry concealed weapons within certain limits and after varied approval processes.1,2 Although many states require physician participation to help determine competency, it is not known whether physicians are capable of assessing a patient’s competence to carry a concealed weapon.3

We designed a survey to assess physician attitudes, beliefs, and behaviors with regard to concealed weapons. Physician attitudes were assessed on the basis of itemized responses to questions in four categories; their answers ranged from “strongly agree” to “strongly disagree.” Respondents disclosed information on demographics, practice type, and gun ownership. The survey was sent by mail to 600 physicians registered with the North Carolina Medical Board who were in active practice in October 2013.

Of the 600 surveys sent, 45 were returned uncompleted and 222 were returned completed (adjusted response rate, 40%). The majority of respondents were male (66%), had been in practice for more than 15 years (64%), and saw at least 10 patients a day (77%). Approximately one third of respondents (35%) were family physicians; 38% were psychiatrists and 27% were internists. Eighty physicians (36%) indicated that they owned a gun.

Among the 222 respondents, 21% stated that they had been asked to sign competency permits for concealed weapons in the previous year, and the majority of those asked had been requested to sign off on more than three such permits. Among the physicians who were asked to sign competency permits, most (79%) agreed to certify competency. The majority of physicians felt that they could not assess their patients’ physical capability to carry concealed weapons, and a sizable minority did not feel comfortable assessing mental capability to carry concealed weapons (Table 1). Physicians’ beliefs about their capability to assess the physical competence of patients to carry concealed weapons were not significantly related to their actual signing of those permits. Most physicians (84%) also felt that medical assessments for competency should be conducted by physicians specifically trained in making such assessments.

Physician responses to our survey reveal concern about the suitability of many physicians to make recommendations regarding competence to carry a concealed weapon. A majority of physicians were also worried about the potential ethical consequences of participation in this assessment for the doctor–patient relationship. Policymakers may use these data to reexamine
the current role of physicians in the concealed-weapons permitting process. More research is also needed to determine whether the experiences and opinions of physicians from other states differ from those of physicians in North Carolina.

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