A Personal Reflection on Psychiatrists and Homicidal Threats

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"There is a threat to your life." I remember the words well from the morning I was called in to the local station of An Garda Síochána (Irish for "guardians of the peace," i.e., the Irish police force) to be served notice of a serious threat to my life. They had received a *Tarasoff* disclosure that I was the named target of a homicide plan by a prisoner due for release and that a firearm had reportedly been procured for the act. I had seen this prisoner, Mr. B (the prisoner's initial has been changed to protect his identity), about a year prior to these events. I knew that he had a personality disorder, and that he had been unhappy with my clinical opinion. Mr. B had been a member of a gang and had served time for serious violence with weapons, including firearms.

By way of context, I work as a prison psychiatrist in a city in western Ireland that has had a troubled relationship with violence. The former doctor in my post, a gentle and inspiring colleague, had been seriously injured in a violent incident a decade ago, suffering multiple life-changing stab wounds while at work.

As I sat across from the two armed detectives on that winter morning, my first thought was a feeling of guilt. Had I let down Mr. B? Why did he choose to communicate the threat through a third party rather than ask to see me? Could I have done things differently?

My second thought was that of alarm. Mr. B had been a member of a gang with access to firearms. I was informed that he had disclosed the make and color of my vehicle despite being in prison for years beforehand. My vehicle had been broken into and ransacked outside my home a week previously, and forensic scientists had found no fingerprints. Could this have been related? I left the police station to alert my family of the threat.

Doctors are programmed to overcome heightened emotion. This comes from years of training as interns and house officers where it is not unusual to lead a crash team after 24 hours of on-call duty while fighting emotional and physical exhaustion. I found myself in this autopilot mode. I alerted relevant colleagues, asking if there was a local or national protocol in the health service that I might follow. There wasn't one. No doctor, as far as they knew, had ever been served formally with a "GIM 1," a Garda Information Message used by the Irish police to formally inform an individual of a credible risk to his life.

The forensic psychiatrist in me (or perhaps it was the psychological defense of denial) believed that a completed homicide outcome following a threat was unlikely. On the other hand, I considered the first rule of violence risk assessment in forensic psychiatry: "Past behavior is the best predictor of future behavior." Psychiatrists are not uncommonly victims of physical assault, with one Irish study reporting that over half of all consultant psychiatrists surveyed had been victims.[1] In 2018, the homicide of a forensic psychiatrist, Dr. Steven E. Pitt, by a former patient in Arizona had shaken the profession.[2]

I was asked to provide a victim statement. As a potential victim, there was now a conflict of interest that precluded further clinical contact with Mr. B. He was due to be released from prison in 10 days.

I was concerned for his well-being. I wrote to request that he be afforded a consultation with another psychiatrist prior to his release from prison, and to request that clinical care would be arranged after release.

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Such care would primarily be of importance to Mr. B's well-being, but it also could potentially reduce the risk associated with the disorder. Those with a history of incarceration often have difficulty accessing services following their release due to the stigma of a forensic history.

A few days before Mr. B's release, I was visited at home by protective policing, a section of the police force that is responsible for the prevention of serious crime. I was advised that my postcode had been added to the police control room for an urgent response in case of a 999 emergency call. I was advised to install closed circuit television and panic buttons around the house. I was told not to drive home directly from work in the weeks and months that followed. These seemed like reasonable precautions to take.

Worried colleagues advised me to stay away from work altogether until things settled down. It was difficult to know what to do or how worried to be. A homicide after a death threat is, thankfully, a rare outcome, I thought. Yet one of the quagmires of risk assessment is a low likelihood event with catastrophic impact. Should I ensure that my affairs were in order? Should I stay away from my family so that they were not incidental victims in a shooting? Was I overreacting? Was I underreacting?

I decided not to take any time off work. In a relatively deprived area of the country with few resources, the likelihood was that there would be no clinical help for my other patients if I chose to take any significant time off. Additionally, the threat was not time-limited. That is, there was no guarantee that the homicide threat would recede after, say, several weeks or months unless the person making the threat were prosecuted and incarcerated. How would I know when it would be safe to return?

It has been some time since these events. I was recently advised that the Director of Public Prosecutions, the equivalent of a district attorney in the United States, will not be pursuing charges. This was unsurprising. Existing literature reports that death threats against doctors are rarely reported and, even when reported, rarely lead to prosecution. I did not challenge the decision. A prosecution would have done little for the care that Mr. B would be able to access in the future, potentially adding to the stigma he already faced. A period of incarceration may have temporarily reduced the risk, but it could potentially increase it in the longer term.

These events have given me an opportunity to reflect on death threats toward doctors. These are not uncommon, although psychiatrists are at greater risk of such threats. There is little contemporary research on the matter.[3-5] Doctors are often left with feelings of guilt and worry that they have done something wrong. Their family and professional lives face disruption, which can be left unresolved for long periods.[6] At the same time, perpetrators of threats have often lived difficult lives; some have mental disorders and are themselves prone to adverse outcomes.[7]

I think of Mr. B and hope that he has, since his release from prison, been able to develop a trusting relationship with a psychiatrist or psychotherapist. People with a history of personality disorder and lengthy imprisonment often lead unfulfilling lives. I know many find it challenging to return to stable and meaningful relationships, employment, or education. My hope is that he finds the supports to achieve these outcomes.

I think of the many questions that will likely remain unanswered for me. Has the threat gone away? I reflect on colleagues who have been seriously injured, like my predecessor, or those who have lost their lives in the course of their duties, like Dr. Pitt, who will be remembered for his pioneering contribution to the specialty.[8] I think of colleagues who may find themselves in situations like mine. They would certainly be appreciative of thoughtful guidance for these clinically and ethically complex scenarios.[9] Perhaps the conversation starts here.

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