Duty to Warn When There Is Accidental Exposure of a Psychiatrist's Residential Address to a Patient With Homicidal Ideation

To the Editor: Psychiatry residents are twice as likely to be exposed to patient violence as their peers in other specialties.[1] We report the case of a patient with homicidal ideation who appeared at the house of the treating resident psychiatrist as a fast-food delivery man.

Case report. An 18-year-old white male college student was involuntarily admitted to an academic psychiatric inpatient unit because of nonspecific homicidal impulses that were not targeted toward any individual. He had entered college 2 months prior to admission and reported financial stressors to which he attributed depressed mood, anhedonia, and social withdrawal. He reported reduced need for sleep, restlessness, difficulty concentrating, feelings of inferiority to more socioeconomically advantaged peers, and racing and intrusive thoughts of homicide with no explicit suicidal ideation. He confided in his girlfriend about fantasies of purchasing a gun and going on a shooting rampage against students who were more privileged than he. His past medical, substance abuse, psychiatric, and legal histories were unremarkable. He did have a history of physical abuse by his mother while growing up, and he acknowledged being physically violent toward his mother and younger sister later in life. While maintaining an apparently stable romantic relationship with his girlfriend, he harbored intense hatred and homicidal thoughts toward women in general, which he linked to his childhood abuse. His physical examination, urine drug screen, complete blood count, comprehensive metabolic panel, and thyroid-stimulating hormone level were within normal limits.

A diagnosis of major depressive disorder with mixed features (*DSM-5* criteria) was made since his symptoms did not necessarily meet the criteria for bipolar spectrum, and his mixed symptoms were not attributable to the physiologic effects of a substance.[2] He was managed with sertraline 100 mg daily for his depression and aripiprazole 5 mg daily for augmentation after which his depressive symptoms and active homicidal thoughts resolved substantially. The intensity and potential lethality of the expressed homicidal ideation made an otherwise routine discharge decision difficult. On the Historical Clinical Risk Management-2[3] (version 3) his H (historical) score, which rates static risk (irreversible) factors, was 7 of 20, which is somewhat elevated but low compared to typical scores in forensic and correctional populations. The C (clinical) and R (risk) scores, reflecting modifiable risk factors, were both 2 of a possible 10, yielding a total scale score of 11 of a possible 40. The patient was polite, well-mannered, and compliant during his inpatient admission, and he developed a favorable relationship with the treatment team, including the young female resident who managed his case. He was discharged to follow-up by an experienced psychiatrist within our system of care on the fifth hospital day.

Two months later, the female resident psychiatrist placed a food order, and in a chance encounter, the patient appeared at her apartment door as the delivery person. He greeted the psychiatrist courteously, asked whether she remembered him (which she most definitely did), informed her that he was doing well, delivered the food, and departed without incident.

Accidental encounters with patients, including the possibility that they encounter a clinician in public, might not be uncommon, but this case was unique because everyone that came into contact with the patient prior to admission felt that he had exceptional potential to become homicidal. Although the patient's demeanor and professionalism during the encounter were beyond reproach, this chance encounter created an elevated anxiety for the psychiatrist because this patient with potential for homicide was now aware of her residence. The resident psychiatrist consulted with other residents and faculty familiar with the patient.

The key questions raised by this encounter concerned reporting obligations and the limits of confidentiality when the treating (or former) psychiatrist believes she could be in danger. The "Tarasoff" obligation, which is fulfilled in the state where this incident occurred by the treating psychiatrist reporting to the potential victim or to law enforcement a potential threat of harm,[4] seemed inapplicable since the potential victim and the treating psychiatrist were one and the same. The general principle that confidentiality can be breached to avert serious harm to the patient or others would be applicable wherein such a threat existed, but under the circumstances presented, the threat assessment per se was not changed by the patient's knowledge of where the psychiatrist lived. Notwithstanding the patient's childhood violence toward women and past fantasies of mass murder, the background risk factors for violence to others had not changed since the time of discharge. Indeed, knowledge of a potential victim's address as part of the risk calculus was already given due consideration when the patient was released into the community in which his girlfriend resided. Accordingly, after deliberation of faculty and residents familiar with the patient, the only action taken was to discreetly confirm that the patient remained in treatment with the outpatient psychiatrist to whom he had been referred earlier.

This case highlights the value of a risk assessment tool in providing a broader context within which to understand a threat that was quite alarming. It also offers some guidance, where there is often little guidance readily available, on managing encounters with former patients who pose potential threats. Key recommendations include the following: (1) consult with other professionals who are not immediately affected by the threat, (2) employ objective assessment of risk that is uncolored by the emotions of the moment, and (3) examine the ethical and legal ramifications of the proposed response, being mindful that sensible, thoughtful, and compassionate clinical action usually is supported by ethics and law.

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