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Clinicians' autonomy till the bitter end – can we learn from the extraordinary case of Harold Shipman?

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ABSTRACT:

Harold Shipman has attained the dubious reputation of being the greatest mass murderer of modern times. A specific feature of his murders was that these were committed during regular general practice care, over a period of 20 years. There are no grounds to assume that Shipman's case is unique in itself, or unique to British general practice and this paper analyses ways in which the medical profession can safeguard itself against future medical murderers.

The 46-year-old R.O. had had a recurrence of her asthma and was visited by her general practitioner (GP). Accompanying chest pain made the GP consider cardiac ischaemia and he administered morphine. R.O. reached the hospital in a comatose state after resuscitation following respiratory arrest. Eyebrows were raised in the hospital at the GP's decision to administer morphine to a patient with asthma. The 'facts' as they presented that day in the hospital had everything for a fascinating performance review. On the one hand, a GP who, in a patient well known to him and presenting with a familiar symptom of acute shortness of breath, had considered an alternative hypothesis to explain her situation – and acted on it. One of the pitfalls of continuity of care is that practitioners find it difficult to look at 'old' symptoms with unbiased eyes. But on the other hand, there was the GP's complete failure to acknowledge the well-known facts of asthma in this patient and its negative interaction with morphine. But there was no critical review of his performance; no formal enquiry was conducted at the time, nor when R.O. died 14 months later without regaining consciousness.

More than five years after the death of R.O. the GP was convicted of murdering 15 of his patients by overdosing morphine. This put the 'facts' on R.O. in an entirely different light, and it can now be confidently assumed that Harold Shipman killed more than 235 of his patients between 1979 and 1999,[1] which makes him the greatest serial killer of modern times. It left general practice – and indeed the medical profession in general – in dire straits as to how this could happen and continue to happen on such a scale and for such a long time in the confines of a small community. Following the murder trial, a series of investigations have been instigated, including an international review seminar of methods to assess (general) practitioners' continued fitness to practice and ways to approach incompetence.

This last seminar, which was held in Manchester in January 2004, presented an interesting comparison as there are clear parallels in the assessment of clinical fitness between the UK and the seminar participants (the Netherlands, US, Canada and New Zealand). In all these countries, registration and the right to practice are restricted in time and depend on proof of the practitioner's competence. But by and large, establishing fitness to practice is based on self-reporting of their participation in continuing medical education (CME) or on performance in testing knowledge. A major gain is the establishment of a culture of accountability (a large majority of practitioners comply with self-reporting and participate in CME) and a breakdown of professional isolation. Practice-in-isolation was a major feature of the Harold Shipman case[2] and GPs, with their extended position in the community, are particularly

vulnerable in this respect. Although in the Netherlands, for example, a minority of GPs are in single-handed practice, a substantial part of the world's population live in remote, rural areas with a single GP – if available at all – the only representative of the medical profession.

Another aspect that has made substantial progress in the past decades has been clinical guidance. Evidence-based medicine (EBM) has truly been taken up by GPs, resulting in ever more guidelines and in the development of CME to master knowledge and skills required to perform these guidelines. But the development of quality systems for general practice is only in its early stages. EBM is a fascinating process but clinical guidance can only be as good as the available evidence. Given its specific clinical domain, there is a substantial need for clinical research in general practice.[3]

All the countries around the table in Manchester agreed that the methods of self-reporting, knowledge testing and CME participation were only second best and assessment of actual performance was to be preferred. This offers the opportunity of personal advice for (remedial) improvement in distinct clinical areas. In this respect, experience in the Netherlands is interesting: a total practice performance method has been developed and validated,[4] and has found its way – on a voluntary basis – to more than 3000 of the approximately 7500 GPs in the country. This may again indicate that the large majority of GPs are actively and independently striving to develop their performance in a culture of accountability and professional interaction.
But a policy entirely based on voluntary professional criteria might fail to pick up the critical cases. Shipman deliberately sought, and was able to find, a way to work independently,[2] and recent experience of the Dutch Registration Chamber also points in this direction: GPs who had had their registration withdrawn for professional misconduct were able to start practicing in the UK before the General Medical Council could intervene, and in Spain, where it is currently not possible to revoke a registration to practice. The concept of 'incompetence' as a mere failure to live up to professional standards is too naive, as some culprits actively avoid control and disclosure. That is the link between professional fitness to practice and Shipman. With hindsight he can hardly be regarded as anything but a shrewd opportunist, using the margins of the professional autonomy of a trusted family doctor. Hence the scandal, and public indignation that forced a strong legal-political response to professional performance. This highlights another international experience that came forward in the Manchester seminar: scandals and incidents drive the supervision of the medical profession to a large extent. What 'Shipman' is for the UK, was a case of failed follow-up of abnormal cervical cytology in New Zealand. As a consequence of that enquiry, patients ('consumers') rather than the medical profession run the supervision of the competence and professional fitness of practitioners. This comes close to the situation in the Netherlands, where the State Inspectorate of Health Care has always been a strong factor. How effective, proactive and transparent self-regulation of the medical profession can be is also demonstrated in the approach to addicted doctors in Canada.[5] A coherent response which treats addiction for what it really is – an addictive disease and not deviant professional behaviour – has resulted in de-criminalisation of alcohol and drugs addiction to the benefit of treatment and supervised return to practice. The success of this programme is such that practitioners with a personal history of addiction are currently at less risk of addiction after successful treatment and return to practice than the 'average' physician.

Early in his career as GP, Harold Shipman was found guilty of morphine use and falsification of prescriptions for his own use, and that brings the story back to him. Much has changed in the supervision of medical competence since he entered the profession. To a large extent these measures will serve to further improve GPs high professional standing. But to what extent will these measures serve to identify or prevent what was after all the reason for this seminar: a 'next Shipman'?
The participants in Manchester could readily agree on two points: 'Shipman' could have happened anywhere, and current procedures of professional supervision that are in place in each country would have had a hard time in identifying him. And that warrants the study of his case. It remains deeply worrying that a GP can kill and hide these killings – through medical methods – amidst colleagues, under the eyes of coroners and police, in a small community where everyone knew everyone, and with one undertaker firm responsible for most of the burials that resulted. His departure from a partnership for single-handed practice coincided with a sharp increase in the number of killings[1] but definitely did not actually create the opportunity to kill. From practice in partnership and its resulting formal and informal peer-review protection of patients might to some extent be expected. But Shipman's killings (and his morphine addiction) started at the time that his practice was a firm part of a partnership and his participation in peer review well documented. Consequently, a mere appeal for group practices – important as it may be for the future of (primary) care – is too simple a solution. This may indicate that what Shipman was able to do in general practice might also happen in hospital-based specialities with their partnership structure. Professional misconduct can also flourish there. A close-knit environment of peer-professionals may respond by isolating rather than addressing the undesired professional behaviour and in that way contribute to its prolonged existence.

Having said this, the highly unusual nature of the Shipman case should not be lost from sight. No one, professionals nor the public, expects GPs to be killers. But an important factor was the way Shipman's deeds were enshrined in a strong personal bond with his victims and their families: the caring, personal doctor who visited his patients regularly and often on his own initiative, in their homes, created the conditions for most of his more than 200 killings in a period of over 20 years. This bond was so strong that many of the surviving relatives initially sided with Shipman when he was arrested.

It is here that general practice can be particularly vulnerable for the backlash of the Shipman case. The personal working relationship provides GPs with a strong method to tailor medical care to individual needs. It would be in nobody's interests if this were to come in disrepute, but it is up to GPs – in the UK and outside – to develop open and transparent methods to account for the use they make of it. A helpful response under the circumstances could be to include in audit of GPs performances and their timely and appropriate use of the personal bond with their patients. This bond is not simply a characteristic of general practice and even less a right for GPs to intrude on their patients' privacy.

Audit of practice death rates is another method that might be used in a more systematic way.[6] The Shipman enquiry has made it clear that the excessively high number of deaths in his practice could have been a valuable pointer to his wrongdoings but would not in itself have proved his case.[7] This is in line with recent experiences in the Netherlands with a nurse suspected of killing patients on a children's' ward – another indication that 'Shipman' is not exclusive to the primary care setting. And that brings us back to the startling situation at the beginning: although methods to safeguard quality of care and practitioners fitness to practice are improving and despite the fact that supervision by peers is becoming the rule in medicine, there is no certainty that a 'next Shipman' can be prevented. It is not likely that it will take another 200-odd patients' lives next time, but it may happen again in the primary or hospital care setting.

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