

COMMENTARIES

As I write these words, in the immediate aftermath of Shipman's apparent suicide, there continues to be considerable public interest in the case and debate about its legacy. Few would argue with Professor Baker's thoughtful and balanced analysis that its significance goes much wider than the stark, shocking, wickedness of an individual doctor who was able to kill at least 215 of his patients before being detected.

Professor Baker wisely warns against the risk of over-reaction, pointing out that all the signs suggest that patients still trust their doctors, despite Shipman. He is right to argue that a general attitude of mistrust between doctors would be a sad, destructive development. My own view is that the ongoing implementation of robust clinical governance locally, improvements in the monitoring of the use of controlled drugs and reform of arrangements for death certification and the investigation of death by coroners should stop another Shipman. Revalidation will contribute to that overall framework, but it has not been devised as a means to detect a devious, ruthless, and determined serial killer and that must not become regarded as the test of its effectiveness.

But while Shipman was a gross aberration, that does not mean that there are not wider lessons to be learned for everyone involved in monitoring or regulating (the two are different) the practice of doctors. It is important that the profession can demonstrate to patients, principally through revalidation, that doctors are up to date and fit to practise. I also fully endorse Professor Baker's view that the doctor-patient relationship must become more open and straightforward, and be made less prone to the manipulation and paternalism which featured so strongly in Shipman's practice. This is at the heart of the General Medical Council's thinking as we take forward the delivery of our reform programme.

With our lay membership recently increased to 40% we are uniquely placed to take forward the development of a framework of values and ethics for doctors, which is both owned by the profession and reflects the views and expectations of the public. Parliament, which in 2002 approved the legislation enabling us to implement our reform programme, has entrusted the General Medical Council to undertake this challenge. That is what we are now delivering.

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Harold Shipman was a murdering psychopath on an unprecedented—let us hope unique—scale. Because he was also a general practitioner, he had more than the "average" murderer's means and opportunity to commit his crimes. Equally importantly, he was able to capitalise on the assumption of trustworthiness which society makes about its doctors. Even if the likelihood of another Shipman is vanishingly remote, it behoves everyone to cooperate in measures of risk assessment and primary prevention on a correspondingly unprecedented scale.

On the other hand, over 30 000 general practitioners do *not* murder their patients, do *not* abuse their professional position or betray their trustworthiness; they are entitled to feel hurt by any implication that they might. One can understand ordinary doctors, while not condoning the laxities that allowed Shipman to escape detection for several decades,

nevertheless resenting the fall-out if it seems based on the assumption that all general practitioners are under suspicion until proved otherwise.

There is therefore a balance to be struck between under-reacting and over-reacting to the Shipman outrage and I am not sure that Richard Baker has quite found it.

Many of the recommendations expected to flow from Dame Janet's Inquiry are non-contentious and long overdue: tighter certification procedures, establishing a culture of vigilance, more thorough checks on doctors displaying known predictors of criminality such as drug dependency or falsification of records. But, as Richard's piece confirms, there is a risk that a number of other issues, peripheral to the Shipman case, will hijack the agenda in the name of "safety", and bounce us into hasty and ill considered proposals that could antagonise the very doctors on whose support they depend for their success. I'm thinking particularly of quality control initiatives such as appraisal and revalidation, and programmes already begun to update the concept of professionalism in a more patient centred way.

Richard Baker suggests that restricting the post-Shipman debate would limit the opportunity for improving medical practice, and renege on the duty owed to the victims. I disagree. The agenda of improving the quality and safety of medical practice does not need to ride piggy-back on one disaster, no matter how extreme. It is an ongoing and self motivating exercise in its own right, and should be allowed to make its own case on its own merit. If the legacy of Shipman were to be the demotivation and paralysis of general practice through over-regulation—that would be the *real* betrayal.

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When the guilty verdicts were brought in on the murder of 15 of Harold Shipman's patients in the winter of 2000,¹ I was asked by the then Secretary of State for Health whether there was any way in which we could establish whether there had been other clinically suspicious deaths. It was on this basis that I commissioned a clinical audit of Shipman's practice from Professor Richard Baker. The question by the Secretary of State for Health to me as Chief Medical Officer and my decision to establish the clinical investigation were quite unprecedented.

The fact that the subsequent report of the clinical audit² judged it likely that Shipman had murdered more than 200 of his patients was shocking. The subsequent analysis of deaths by the rigorous legal processes of the judicial inquiry³ arrived at broadly similar numbers. Baker's medical detective work was ground breaking and has set a gold standard in methodology for the investigation of apparently untoward deaths in clinical practice.

In the paper in this issue of the journal, Baker provides a particularly insightful account of the lessons for general practice for the whole Shipman affair.

The challenges are big ones but, as Baker makes clear, failure to address them is not an option. Developing further the ethos of clinical governance^{4 5} within every clinical team, every general practice, and every primary care organisation is undoubtedly the most important step. A clinical culture which recognises and deals with poor practice, which is founded on team work (not isolated practice), and which is open about problems is at the heart of the transformation required. Linking a culture like this that focuses on the quality and safety of care to strong systems and good

information to maintain and assess the quality of practice is the other important component.

Baker rightly points to the importance of good monitoring data for general practice. This is by no means as easy as it sounds but the development of such data should be a priority. Inevitably, given the imminence of the introduction of an electronic health record, any monitoring requirements will have to be designed into such a system.

Ultimately, the most unforgiving test of the ability of the NHS to improve the quality of care and to protect patients from harm must and should be its ability to learn.

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The view of the cognitive behavioural therapist (the new dominant paradigm in psychiatry) is that it's not what happens to you in life which leads to stress or upset—more it's how you *interpret* what's happened to you. Psychotherapists frequently employ a technique called "reframing" whereby a negative life event can be reconstrued so as to render it less threatening and upsetting. Some self help gurus from an American persuasion even take this approach to an

extreme with the catch phrase "how can I make this problem more perfect"—in other words crisis often represents an opportunity—if you know how to get past the emotional turmoil, recover your composure, and seize the advantages which might conceivably lie among the wreckage.

These sentiments may seem inappropriate when we think of the tragedy of Harold Shipman, but the huge losses may have been easier to bear if the correct lessons could have been learnt which would lead to an improvement in medical standards. Instead it doesn't appear to most doctors that the reforms now being shovelled on to an already burdened profession off the back of Shipman, are likely to make any meaningful difference to clinical excellence. If anything they appear to be yet another tranche of bureaucracy solely designed to frustrate us.

The issue isn't so much the bare facts of the Shipman case (of which much remains uncertain), rather the key question is how the medical profession interprets the event and in particular how it attempts to influence public opinion and government. Sadly, as is all too usual today, the profession—which labours under an 18th century view of public relations—has passively allowed a sequence of events flowing from Shipman to drive the public agenda rather than making any attempt to be proactive.

Modern medicine is supposed to be based on science; there appears so far nothing scientific about the way the key question has been approached in an attempt to understand how Harold Shipman came to be. We need to more robustly defend our profession and our methodology if we are to survive. But because we are an ancient profession, I fear that the government has already penned DNR [do not resuscitate] in our notes.

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