CHAPTER ONE

Introduction

1.1 At the time this Inquiry was set up in January 2001, it was known that Harold Shipman had murdered 15 women patients during the years 1995 to 1998. It was also suspected that he might have killed others over a much longer period. When, at the end of his trial, it came to light that, in 1976, Shipman had been convicted of offences of forgery and obtaining pethidine by deception, many people, particularly the bereaved, began to ask how it was that Shipman had been able to return to unsupervised general practice in 1977, just over a year later. They also wondered how it was that his repeated killing of patients had escaped the notice of the authorities responsible for general practitioners (GPs) such as him. One of the Inquiry's Terms of Reference required me to look into **'the performance of the functions of those statutory bodies, authorities, other organisations and individuals with responsibility for monitoring primary care provision ... and to recommend what steps, if any, should be taken to protect patients in the future'**. I interpreted the word 'monitoring' in its broadest sense, as I am confident that that was the intention of Parliament.

1.2 By the time the Inquiry was ready to embark upon the hearings in connection with this aspect of its work, in 2003, I had already published the First Report, in which I found that Shipman had killed no fewer than 215 patients over the period from 1975 to 1998. Thus, in order to comply with the Terms of Reference, the Inquiry had to examine the provisions for the monitoring of GPs working in the NHS over a period of 23 years. That included consideration of the operation of the General Medical Council's (GMC's) fitness to practise (FTP) procedures during that period because those procedures are an integral part of the monitoring of all doctors, including GPs working in the NHS. As will be seen from this Report, during almost the whole period of Shipman's practice as a GP, the role of NHS bodies at a local level was primarily that of provider and facilitator of GP services to the population. They did not exercise a supervisory role over GPs, who were not employees but independent contractors. Only in the 1990s did family health services authorities and health authorities begin to exercise a monitoring or quasi-management role in respect of the GPs practising in their area.

1.3 Because the Terms of Reference require me to make recommendations for the better protection of patients in the future, the Inquiry also had to examine the monitoring systems in place at the present time and those that are envisaged for the future. I have found that the changes that began in the early 1990s gathered pace, at first gradually and then at an increasing rate. There must have been many reasons for this, not least a change of Government in 1997. However, a series of medical tragedies and scandals, of which that of Shipman was perhaps the most significant, undoubtedly provided a major impetus for change to the arrangements for monitoring GPs within the NHS. Other changes have taken place within the NHS as a whole, as well as within the GMC. These changes too have occurred, at least in part, as a response to tragedies and scandals and the investigations and inquiries that followed.

1.4 In effect, a revolution has taken place in the last six or seven years. The policy underlying these changes can be summed up very briefly. It has been recognised that, in the

provision of medical services, there must be far greater accountability to patients and to the public in general. There is now, throughout the NHS, a duty to monitor and improve the quality of healthcare provided. Accountability also means that there must be much greater openness with the public and patients.

1.5 The main mechanism by which the duty to provide care of an acceptable quality is fulfilled is known as 'clinical governance', a concept to which I shall return on many occasions in this Report. Local NHS bodies – in England these are called primary care trusts (PCTs) – now have a range of methods by which they can monitor the performance of the doctors within their remit, rewarding those who are doing well, and helping those who are doing less well to do better. Now, in the final analysis, they also have the power to remove from the medical list for the locality those who are unwilling to provide – or are incapable of providing – an adequate service.

1.6 As part of the revolution, a number of new NHS bodies have come into existence in recent years. An example is the National Clinical Assessment Authority, which carries out assessments of doctors who are thought to be performing poorly. It also advises PCTs and hospital trusts that wish to carry out their own assessments of a doctor's performance. The Commission for Health Improvement was formed to monitor the performance of all NHS bodies, such as PCTs. However, after only a brief period of existence, this body has now been disbanded and its functions, somewhat modified, have been assumed by the Commission for Healthcare Audit and Inspection, now known as the Healthcare Commission. The National Patient Safety Agency has been formed with a remit to learn from clinical accidents and errors. These new bodies all have a role to play in the monitoring of doctors and the improvement of the quality of care which is to be provided within the NHS.

1.7 The revolution is not complete and change continues at what seems a dizzying pace. Even within the short period since the Inquiry's hearings in the summer and autumn of 2003, significant changes have been made or announced. The Department of Health has made some changes to the way in which complaints by patients about health service provision are handled; more changes are to be expected after the publication of this Report. The GMC has very recently introduced its new FTP procedures and has announced its proposals for the revalidation of doctors on the UK register of medical practitioners, to be introduced in April 2005.

1.8 If all or most of these changes are designed to bring about improvements that should ensure the better protection of patients in the future, it might be thought that there is no need for an Inquiry such as this to make any further recommendations. Is there anything more that the Inquiry needs to recommend? As will be seen, although it is indeed my view that most of the changes introduced and proposed are for the benefit of patients, there does remain more to be done.

1.9 During the Inquiry, I have received evidence from many doctors and have read quite widely from the medical press. I have become aware that some doctors have welcomed the changes of which I have spoken. Many have not. That does not in the least surprise me. The extent of change and the speed with which it has been effected must have been profoundly unsettling for many. I know that some feel embattled by what they perceive as

over-regulation, loss of professional independence, interference in their clinical work and damage to their relationships with patients. There is resentment that the 'powers that be' have overreacted to the Shipman case; it is said that the profession is being held to blame and will be punished for the actions of 'a murderer who just happened to be a doctor'. I know that, in some quarters of the profession, there is concern and anxiety about the Inquiry. I suppose that it is feared that the Inquiry will recommend yet further demands, restrictions, testing, inspection and general 'shaking-up'. I understand and sympathise with those fears and hope to allay them.

1.10 I think it would be a mistake for the medical profession to regard Shipman as 'a murderer who just happened to be a doctor'. He was a doctor – and in many ways not a bad one – who perverted his skill, knowledge and the trust of his patients to evil ends. It was the fact that he was a doctor that enabled him to do what he did. In his Pioneer Lecture, given to honour Sir Donald Irvine, at the Forum on Quality in Healthcare on 13th January 2004, Professor Richard Baker said:

> **'Since beginning to investigate Shipman in 2000, I have been trying to understand how it was that he could kill so many patients without detection. There were, of course, some system failures, but it has been impossible to avoid the question as to why the system weaknesses were tolerated to the extent that Shipman was able to murder not merely one or two patients, but over 200. The conclusion I have come to is that all doctors, and not general practitioners alone, share responsibility for creating the circumstances that enabled Shipman to be so successful a killer.'**

I think that what Professor Baker had in mind was the culture of mutual self protection within the profession and the attitude of paternalism towards patients and those outside the profession. This culture and attitude are no longer acceptable and are disappearing. They are being replaced by the culture of patient-centred medicine. Nonetheless, they linger on. But, in my opinion, no right-thinking doctor would seek to defend them today.

1.11 I recognise that the overwhelming majority of doctors are trustworthy, competent, hardworking and justly proud of their profession. Shipman was certainly not one of that majority. He breached the trust of his patients and fellow professionals to a greater extent than any other doctor is known ever to have done. Of course, it would be wrong to impose upon the whole profession regulatory requirements designed only to catch a mass murderer. Doctors who murder their patients are, fortunately, extremely rare. Others have been detected and it is not unknown for healthcare professionals, such as nurses, to use their position of trust to kill their patients. It would be folly to assume that there have not been others who have not been detected or that there will never be any similar instances in the future. No right-thinking doctor would wish a colleague who deliberately harms a patient to go undetected or to remain in practice.

1.12 Not all doctors who harm their patients intend to do so, as Shipman did. Some are reckless as to whether they cause harm. Among those, I would include doctors who indecently assault their patients. Such doctors seek their own gratification and, while not positively wishing to harm their patients, are reckless as to whether they in fact do so. One has only

to read the newspapers to see that such cases are by no means uncommon. Another form of recklessness as to patient safety is seen in doctors who continue in practice while under the influence of alcohol or mind-affecting drugs. All right-thinking doctors would agree that such colleagues should be stopped from practising until they have ceased such self-abuse.

1.13 There are also doctors who harm patients because they were inadequately trained or have failed to keep their knowledge up to date or because they have a personal, medical or psychiatric problem which affects their ability to provide safe care for their patients. They may be personally trustworthy and conscientious and yet cause harm unwittingly. Again, all right-thinking members of the profession would agree that steps must be taken to protect patients of such doctors from harm while the doctor undergoes treatment or remediation. I think they would also agree that, if the problem proves intractable, the doctor will have to give up practice or be prevented from continuing.

1.14 It is with these categories of doctor that the Inquiry is concerned, not with the great majority, who, as I have said, are trustworthy, competent and hardworking. Nobody suggests that there are many doctors in these categories, even when all are put together. There is no definitive view as to the extent of the problem. During the Inquiry, various suggestions have been made – some based on research, some little more than guesstimates – as to the proportion of practising doctors whose performance gives rise to an unacceptable risk of harm to patients. It could be as many as 5%; it may be as little as 1%. Professor Sir Graeme Catto, President of the GMC, suggested that there might be up to 10% about whose practice there was cause for some concern. Even if the proportion of unsafe doctors were as low as 1%, that would mean that there would be about 1000 unsafe doctors practising in the UK. Such doctors, if allowed to continue in practice, not only harm patients but do a disproportionate amount of damage to the reputation of the profession. It is primarily upon the weeding out of those unsafe doctors that the recommendations of the Inquiry will focus.

1.15 It may be said that, if the Inquiry is interested only in protecting patients from unsafe doctors, it should have focussed on those doctors alone and should not have considered provisions that affect *all* GPs. In my view, protecting patients from harm must be approached in two ways. There must be measures designed to identify those who are not performing to an acceptable standard and there must also be measures that will help doctors who are performing satisfactorily to improve with time and experience and not slide backwards. The system must seek to ensure that all who enter general practice are competent to do so and that they remain so. At the moment, it cannot be said with confidence that all practising GPs were competent at the time of entry; the overwhelming majority will have been, but only since 1998 have GPs been required to prove their competence by successfully undergoing summative assessment. A GP's standard of practice ought theoretically to rise as s/he progresses, as s/he adds the benefit of experience to his/her basic knowledge and skills. But, the human condition being what it is, as time passes, some doctors' performance goes downhill rather than up. Medicine is a rapidly developing field and not all doctors keep up to date. Others deteriorate owing to a variety of personal and professional difficulties. It seems to me that the best way to prevent doctors from falling below the level of acceptable performance and to improve the

standard of patient care generally is to provide facilities and opportunities for continuous professional development and to require that those opportunities are taken. My view is that those opportunities should be provided in a formative way and not in an atmosphere of criticism or inspection. That does not mean that the process of continuing education should not be challenging. Surely no right-thinking doctor would disagree.

1.16 Although the Inquiry's aim is to protect patients, I do recognise that the measures to be recommended must be proportionate to the importance of the aims. The aims are important. Even so, there are other considerations which also are very important, perhaps, arguably, even more important. The measures must not damage the good and trusting relationships that exist between millions of patients and their doctors. They must not deprive GPs of all independence or seek to impose uniformity; I have not recommended that GPs should lose their self-employed status. Nor must the measures go too far in taking doctors away from their primary function of giving clinical care to patients. I am conscious that many GPs complain about the burden of 'form-filling' which, they say, reduces the time they can give to patients. I can see that the requirements of clinical governance and appraisal entail a good deal of non-clinical work. Many doctors feel that such time is well spent; no doubt others disagree. I have tried to ensure that the proposals I have made will not entail further significant increase in the non-clinical work that GPs have to undertake.

1.17 One of the most important ways in which patients can be protected from unsafe doctors is by the thorough investigation of complaints made by and on behalf of patients and also of concerns expressed by fellow professionals. There has, in the past, been a perception in the minds of some doctors that patients who complain are troublemakers. I know from personal experience that it can be very wounding to receive an unwarranted complaint. It is also natural that the person who is the object of the complaint is likely to see it as unwarranted, even though others might not agree. It is well recognised by complaints handling bodies that there are some habitual or vexatious complainers; the evidence I received suggests that they are a tiny minority. My view, at the end of the Inquiry, is that much can be learned from complaints and expressions of concern from patients and fellow professionals. Not only will unsafe doctors be identified but poor practice can be detected, providing an opportunity for improvement. Systems failures might also be discovered and lessons learned for the future. I recognise that the investigation of complaints and concerns is a very uncomfortable experience. However, I think that all doctors – and all professional people – must accept it, not only because such an investigation is the right of the patient or client but also as a learning experience and as an important means of uncovering substandard care and protecting patients from unsafe doctors.

1.18 I have associated the expression of concern about a doctor by a fellow professional with patient complaints. In my view, they should be so associated because the subject matter might well be the same. I also think that the willingness of one healthcare professional to take responsibility for raising concerns about the conduct, performance or health of another could make a greater potential contribution to the safety of patients than any other single factor. I consider that very few unsafe doctors would escape notice by a fellow professional provided that all healthcare professionals accepted a sense of common responsibility for quality and safety.

1.19 During the Inquiry, the expression 'no-blame culture' has often been used. A current view is that, when a medical mishap occurs, it is more important to learn a lesson so that a repetition of the event may be avoided than to punish the doctor or healthcare professional whose actions have led to the mishap. Put in that way, the principle seems sound. The proponents of this view often claim that most mishaps are due to systems failures rather than personal error. It would be wrong to punish a doctor for the failure of the system in which s/he had to work. Again, put in that way, the principle is sound. However, I do not accept that these views are wholly right. Over the 30 years of my professional life, I have dealt with thousands of cases of accident and injury, suffered on the road, in the workplace and in the course of medical and dental treatment. That wealth of experience leads me to believe that, while some mishaps are caused purely by a personal lack of care or personal incompetence and some are caused purely by a systems failure, the majority are caused by a combination of personal and system factors. Of course, justice requires that no doctor should be held responsible for matters beyond his/her personal control. However, in my view, justice and the safety of patients require that doctors – and other healthcare professionals – should be held to account if they have failed in a respect which lies within their proper sphere. When things go wrong, there must be a proper investigation and identification of the cause. Only then can there be a proper opportunity to learn from the event. A systems failure can only be corrected when it is identified. Only then, if personal error is found, can steps be taken, by disciplinary action or re-education, to safeguard patients in future. Some people call this 'a culture of fair blame'. I would say that what is needed is investigation, justice, learning and protection.

1.20 On a separate but related topic, I am firmly of the view that the profession must accept an even greater degree of openness with patients than has yet been given. The profession and patients have come a long way since the days when the doctor told the patient what was s/he was going to do and the patient accepted it with gratitude but little understanding. As all doctors know, patients have changed. On average, they are better educated and better informed and have greater understanding than ever before. Also, they are less deferential and more questioning. They expect (and deserve) a partnership of equality. Many expect to have full access to their records and to read for themselves the consultant's report on their recent referral. Gone are the days when any doctor would think of writing a personal comment in a patient's record in the belief that it would be seen only by another doctor.

1.21 All these changes are good and most doctors recognise them as such. However, patients are now calling for even greater openness. Although it may be said that there is little opportunity to 'choose' a doctor within the NHS, patients want to make as much of an informed choice as possible and, even if they cannot choose, they want to have their eyes open. Patients want to be able to trust their own doctor implicitly with their health, their welfare and their secrets. Patient surveys show that, in general, they do have that trust, despite the tragedies and scandals of the 1990s. But the same surveys show that the public believes that there are some badly behaved and incompetent doctors who have been allowed to continue practising by the 'powers that be'. Patients want to know that their own doctor is not one of those. They want to know more about their doctor's qualifications, experience and competence. They feel entitled to know if their doctor has

been in trouble with the criminal law or with the GMC. They want to know if their doctor has been found wanting on an assessment of performance and has had conditions placed upon his/her registration. In the USA and Canada, such information is routinely provided to the public on websites supported by either licensing authorities or professional colleges. In my view, more such information should now be made available in this country. It may be that some doctors will feel that publication of such information would entail a loss of privacy and would restrict a doctor's ability to put the problems of the past behind and move on. That may be so. However, my own view is that doctors must demonstrate that they have not acted in such a way as to call into question their patients' trust.

1.22 Those are the ideas and principles which underlie the recommendations in this Report. For those who accept these principles, any changes which might be made as a consequence of my recommendations would cause no surprise, concern or dismay. The Inquiry has been fortunate to hear evidence and receive contributions from many eminent doctors and academics. Most of the ideas and principles I have propounded come from these forward-thinking leaders of the profession. Many of these ideas are already widely accepted within the profession and are seen to bring benefits to patients, the profession and society as a whole. But not all doctors see things in the same way. In a profession as large as medicine, that is not surprising. However, I believe that, with strong and effective leadership, the whole profession will come to accept these ideas as the way to maintain high standards and the trust and confidence of patients.