

Making haste slowly: the response to the Shipman Inquiry?

In September this year it will be 10 years since Shipman was arrested. He was convicted of 15 murders in January 2000, and by July 2002 the Shipman Inquiry had published its first report,¹ with the sixth and final report appearing in January 2005.² The Inquiry was given a broad remit by the Secretary of State for Health, and its six reports presented an enormous number of recommendations addressing, among other things, reform of the coroner system, controlled drug prescribing, death and cremation certification, patient complaint systems, appraisal, medical regulation, and the monitoring of GPs by the NHS. The thousands of pages of the Inquiry's reports and the even greater volume of associated transcripts and documents on the Inquiry's website constitute a major body of evidence that signals the need for change in many of the systems underpinning clinical practice in this country, yet the route by which evidence is translated into policy can be tortuous.^{3,4}

In one of its recommendations, the Inquiry called for investigation of methods to monitor patterns of mortality in general practice populations. In this issue of the *Journal*, Bruce Guthrie and colleagues provide evidence on the feasibility of mortality monitoring.⁵ They used a variety of statistical techniques with a simulated dataset in the context of Scottish general practices. The findings are important in showing the limitations of monitoring, including the high level of false alarms and the difficulties caused by the frequency with which doctors switch practices. The authors conclude that monitoring could only be a backstop, and the primary means of detecting killings by doctors must rest on reform of death certification and coroner systems.

It is notable that the government has yet to fund a comprehensive research programme to investigate mortality monitoring for general practice, and a number of questions remain to be answered. For example, more precise

predictions of the patterns of mortality to expect in different practices could be developed from the information on practice populations, including morbidity and comorbidity, now available through Quality and Outcomes Framework data or electronic records. In studying the difference between observed and expected mortality rates, precise predictions of what to expect would improve the sensitivity of monitoring.⁶

Of course, the obligation to respond to the Inquiry does not rest on government policymakers alone. Doctors in Hyde, the town in Greater Manchester where Shipman was in practice, have themselves taken action to tighten up completion of form C of the cremation certificate that corroborates the cause and circumstances of death stated by the attending doctor.⁷ Some Hyde doctors have also taken a lead in introducing systems to allow patients direct access to their electronic records, partly as a means of restoring the trust of their patients.⁸

The regulatory body, the General Medical Council (GMC), was found by the Inquiry to have too often placed doctors' interests before patient safety. The Inquiry said that the GMC was '... incapable of devising and operating its procedures and policies from the viewpoint of patients and patient protection' (paragraph 18.230 Fifth Report).⁹ The Inquiry found that appraisal was not sufficiently rigorous to enable an assessment of fitness to practise (paragraph 26.74), and that the plans for revalidation were not in accordance with the statutory definition of the term and might give a false impression to patients about the performance of doctors (paragraph 26.186–189).

The GMC is introducing a principled package of reforms in response to these criticisms, including changing the composition of its governing body and introducing the civil standard of proof at fitness to practise hearings when making decisions on disputed facts.¹⁰ The considerable criticism levelled by doctors

at the GMC of these proposals suggests that doctors as a whole have yet to recognise the significance of the Inquiry's finding that doctors (through the GMC) have sometimes placed their own interests before patient safety. It is time for doctors to accept these findings as a devastating criticism of a central feature of professionalism, and support the GMC in its planned reforms.

Most of the Inquiry's recommendations require government action, either in the form of legislation or in new regulations, and it is right to acknowledge that the government has introduced, or is in the course of introducing, a broad package of reform. There have been significant changes to controlled drug procedures, consequent upon changes to the 2001 Misuse of Drugs Regulations and the 2006 Health Act, and further changes are to follow.¹¹ The changes include new obligations on healthcare organisations for self-assessment and periodic declarations, and tighter regulations on the requisition, administration, and recording of controlled drugs. These amount to substantial improvement and should give GPs confidence about administering these drugs when patients need them.

The NHS complaints procedure has undergone a number of revisions since the publication of a consultation document in 2001.¹² Following another period of consultation, changes have again been proposed.¹³ The new proposals are intended to simplify the process, reduce fragmentation, improve transparency, strengthen advocacy for people making a complaint, and increase accountability. The success of past attempts to improve the complaints process has been limited, and it is too early to judge whether the new changes will prove more effective.

The Inquiry's fifth report made 109 recommendations,⁹ and the government's responses to these have been set out in a report to parliament,¹⁴ a white paper, and

new legislation (the Health and Social Care Bill). Numerous changes are underway, involving investigation of complaints by Primary Care Trusts, appraisal, recording and monitoring of prescribing, practice accreditation, procedures to enable staff to raise concerns about colleagues, and a package of changes for the GMC. The Bill will establish a Care Quality Commission with wide powers to monitor performance and inspect providers, empower the Secretary of State to set standards for the NHS, and introduce reforms of regulation of health professionals, including the creation of an adjudication body.

With respect to reform of the coroner service and associated changes to cremation and death certification, which are key to detecting unlawful killing by health professionals,⁵ progress has been slow. The Department for Constitutional Affairs has presented a draft bill for consultation, but the rather modest proposals of the Bill were heavily criticised. Consequently, further consultation on aspects of the draft Bill is being undertaken, and it is not clear when the Bill will reach parliament. The Department of Health has consulted on improving death certification, including proposals for creation of the post of medical examiner to scrutinise certificates, and introduction of a unified certification process for both burials and cremations. It is likely that these proposals will be explored in pilot schemes during 2008,

but it is unclear when a new format will eventually be introduced.

The Inquiry was probably the most searching review of the monitoring and regulation of doctors since the creation of the NHS. The reforms that have followed are breathtaking in scope and detail, and may have provoked anxiety among many doctors about the risk of increased regulation, monitoring, and control. But as yet, our profession has not debated the meaning for us of the Inquiry's fifth report and how we should restore medical professionalism, but instead has focused most concern on the impact of largely reasonable new government policies. Until the Inquiry's criticism is faced by doctors, it will be impossible to convince policymakers that medical professionalism can be relied on to place patient safety before doctors' interests.

Richard Baker,

Head of Department and Professor of Quality in Health Care, Department of Health Sciences, University of Leicester, Leicester

REFERENCES

1. The Shipman Inquiry. *First Report. Death disguised.* The Shipman Inquiry, 2002. <http://www.the-shipman-inquiry.org.uk/firstreport.asp> (accessed 9 Apr 2008).
2. The Shipman Inquiry. *Sixth Report. Shipman: the final report.* The Shipman Inquiry, 2005. <http://www.the-shipman-inquiry.org.uk/finalreport.asp> (accessed 9 Apr 2008).
3. Lavis JN, Lomas J, Hamid M, Sewankambo NK. Assessing country-level efforts to link research to action. *Bull World Health Organ* 2006; **84**: 620–628.
4. Waddell C, Lavis JN, Abelson J, *et al.* Research use in children's mental health policy in Canada: maintaining vigilance and ambiguity. *Soc Sci Med*

2005; **61**: 1649–1657.

5. Guthrie B, Love T, Kaye R, *et al.* Routine mortality monitoring for detecting mass murder in UK general practice: test of effectiveness using modelling. *Br J Gen Pract* 2008; **58(550)**: 311–317.
6. Sullivan E, Baker R, Jones D, *et al.* Primary health care teams' views on using mortality data to review clinical policies. *Qual Saf Health Care* 2007; **16**: 359–362.
7. Tanna V. Moving on from Shipman. *BMJ* 2005; **331**: 411.
8. Hannan A, Webber F. Towards a partnership of trust. *Medical Care and Compunctics* 2004; **4**: 108–116.
9. The Shipman Inquiry. *Fifth Report. Safeguarding patients: lessons from the past — proposals for the future.* The Shipman Inquiry, 2004. <http://www.the-shipman-inquiry.org.uk/fifthreport.asp> (accessed 9 Apr 2008).
10. General Medical Council. *Fitness to practise: the standard of proof.* General Medical Council consultation. Manchester: GMC, 2007.
11. National Prescribing Centre. *A guide to the good practice in the management of controlled drugs in primary care (England).* 2nd edn. Liverpool: NPC, 2007.
12. Department of Health. *Reforming the NHS complaints procedure: a listening document.* London: The Stationery Office, 2001.
13. Department of Health. *Making experiences count. The proposed new arrangements for handling health and social care complaints. Response to consultation.* London: The Stationery Office, 2007.
14. Secretary of State for Health. *Safeguarding Patients.* The Government's response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Halsam Inquiries. Cm 7015. London: The Stationery Office, 2007.

ADDRESS FOR CORRESPONDENCE:

Richard Baker,
*University of Leicester, Department of Health Sciences, Faculty of Medicine and Biological Sciences, 22–28 Princess Road West, Leicester LE1 6TP.
E-mail:rb14@leicester.ac.uk.*

Discuss these editorials. Contribute and read comments about these editorials on the Discussion Forum: <http://www.rcgp.org.uk/bjgp-discuss>