Editorials
Now Gosport:
what next?

Last month saw the long-awaited publication of the independent inquiry into deaths at Gosport War Memorial Hospital between 1989 and 2000. The inquiry panel, led by The Right Reverend James Jones KBE, concluded that *'the lives of over 450 people were shortened as a direct result of the pattern of prescribing and administering opioids'*.[1]

THE SHIPMAN LEGACY

Following Harold Shipman's conviction for murder in 2000, and the publication of the Shipman inquiry, concerns were raised about the regulation of GPs in the UK, particularly in relation to opioid prescribing. Not surprisingly, there is evidence that the case had impacted upon the prescribing practices of doctors, particularly when treating non-cancer patients at the end of life. In 2005, shortly after Shipman committed suicide in prison, a small survey of UK doctors found that nearly half of the respondents (46%) had new uncertainty about prescribing opioids and sedation for terminally ill patients, and 17% of GPs stated that their practice had changed substantially due to concerns about facing a charge of unlawful killing.[2] More recently, a qualitative study looking at dyspnoea management in advanced chronic obstructive pulmonary disease (COPD) suggested that the Shipman case had exposed clinicians' implicit beliefs regarding opioid prescribing, most worryingly the unfounded idea that they might cause a patient's death directly by prescribing opioids, appropriately, in a palliative care context.[3] Gardiner *et al* found that GPs lacking confidence or expertise in opioid prescribing required significant input from specialist palliative care teams, with some GPs describing how they often simply 'handed over' pain control at the end of life to their specialist colleagues.[4]

THE DOCTRINE OF DOUBLE EFFECT

Concerns among the public and health professionals over the use of opioids at the end of life and myths around their role in hastening death continue, as raised in the Neuberger review of the Liverpool Care Pathway.[5] The doctrine of double effect (DDE) is often used as an ethical justification for the use of opioids to treat symptoms at the end of life, recognising that they might, as a secondary effect, shorten life.

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The doctrine states that this is permissible provided that the intention is to achieve symptom relief, rather than to cause death.[6] There is considerable evidence that this concern is irrelevant: Thorns and Sykes found, in their study of 238 hospice patients, that appropriate use of opioids for symptom control did not shorten life and *'there is little if any need to invoke the DDE'*.[7]

A LONE WOLF, OR SYSTEM FAILURE?

The doctor at the centre of the Gosport inquiry, Dr Jane Barton, was a GP working as a part-time clinical assistant at Gosport War Memorial Hospital between 1988 and 2000. In January 2010 the General Medical Council found her guilty of serious professional misconduct (10 years after they were first made aware of concerns regarding her practice), but she was not removed from the medical register. She retired soon after. The inquiry panel concluded that one of the issues with previous investigations into the events at Gosport was the 'exclusive focus' on Dr Barton and her conduct, which ignored the wider 'significant systemic problems'. We know that concerns were raised with senior doctors and managers, so assume that they were aware of, and presumably not concerned by, her practice. This was attributed, in part, to the shadow cast by the Shipman case and the perception that she might be another 'rogue doctor' or 'lone wolf'.[1] It is possible also that this practice had become part of the institution's norms, or that senior managers were fearful of speaking out.

POTENTIAL IMPACT OF GOSPORT

The patients investigated in the Gosport inquiry were not admitted for end-of-life care, and opioids were prescribed and administered to them without appropriate clinical indication. Thus, although these patients were not imminently dying, as with the Shipman case we can expect some filtering down to the beliefs, prescribing culture, and practices of GPs. We believe that this highlights an urgent need for further training to address these anxieties and prevent a potential negative impact on the quality of end-of-life care being provided by generalists in the community.

IMPLICATIONS FOR THE FUTURE

Recent work by Selman *et al* identified several educational barriers to GPs providing end-of-life care, including inadequate exposure during training, the challenge of keeping knowledge up to date and maintaining skills, and low confidence in their abilities.[8] Their work suggests a move away from formal education methods and identifies the need for practice-based mentorship and/or apprenticeship models in education in end-of-life care.

With a national drive to enable more people who are dying to be cared for and to die at home, GPs and their community nursing colleagues will, once again, be in a position of greater responsibility for managing care at the end of life. To achieve this, good relationships with specialist palliative care services will be required, in addition to appropriate guidance and the confidence to put it in place — which

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we think will be shaken by the Gosport report. Good communication with patients and their families will also be necessary, because some of the mainstream press coverage[9] is likely to have increased lay misunderstanding and escalated their concerns about the use of medication in the dying patient.[5,10]

It is beyond the remit of this editorial, but this case once again highlights the need for further work to be done within the NHS regarding whistleblowing. Staff in Gosport, who had concerns about patient safety, felt unable to make their views heard. We welcome the Health Secretary's very recent espoused commitment to this. However, if we are to prevent another Gosport then whistleblowers must be fully supported in reporting both 'lone wolves' and systemic failings, and be protected by employment law when they do.

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