Physician as Serial Killer — The Shipman Case

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> When a doctor does go wrong he is the first of criminals. He has nerve and he has knowledge.
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> Sir Arthur Conan Doyle, "The Speckled Band"

Harold Fredrick Shipman, a British general practitioner, was convicted on January 31, 2000, of murdering 15 of his patients (and of forging a will of one of them) while he was practicing in a small town in northwest England. He had killed these patients by administering lethal doses of diamorphine (diacetylmorphine). He was sentenced to 15 concurrent terms of life imprisonment but committed suicide while in custody on January 13, 2004. His conviction raised so many important issues that a public inquiry was initiated in February 2001. It was chaired by a senior high-court judge, Dame Janet Smith, and I was appointed her medical advisor.

The inquiry investigated the number of deaths for which Shipman may have been responsible during his career, from August 1970 to July 1998. After investigating more than 1000 deaths that he had certified, in what must be the largest forensic investigation ever conducted in the United Kingdom, Smith reached a verdict of unlawful killing in 218 cases. She had serious suspicions that he might have been involved in the deaths of 62 other patients, but she did not have sufficient evidence to reach a decision on those. This record makes Shipman the most prolific serial killer in the history of the United Kingdom — and probably the world.

Of the 218 known victims, 171 were women and 47 were men. Shipman's typical victim was an elderly person living alone. His oldest victim was 93 years of age; his youngest was only 41. Most of Shipman's victims were not terminally ill and did not have any immediately life-threatening condition; their deaths were generally unexpected.

Many of the killings followed a pattern. Shipman would visit an elderly patient, usually one who lived alone. Sometimes the visit would be at the patient's request, on account of an ailment; sometimes Shipman would make a routine visit, to take a blood sample, for instance, or to provide a prescription; sometimes he would make an unsolicited call. During the visit, Shipman would kill the patient by administering a lethal injection of diamorphine or morphine.

Inevitably, there has been much speculation about Shipman's motives. What kind of person works hard to become a doctor, takes the Hippocratic oath, and within a few years embarks on a career of killing his or her patients? After his arrest and questioning, Shipman refused to speak to anyone and continued to deny responsibility for the deaths. There is therefore no complete psychological or psychiatric assessment available and no useful information regarding his family background or relationships. The only evidence that the inquiry obtained was the videotape of his questioning by the police, the prison and medical reports, and the evidence from his trial. The inquiry sought the views of a panel of eminent forensic psychiatrists who were given access to this material and to psychiatric reports that had been written after his conviction for abusing pethidine (meperidine) in 1976. Unfortunately, the available material did not provide any insight into Shipman's motivation or his character.

If one defines motive as the rational or conscious explanation for the decision to commit a crime, then Shipman's crimes were without motive. His mother had died of cancer when he was in late adolescence, and this experience may have motivated him to go into medicine. Early in his career, he became addicted to pethidine, and the psychiatric reports suggested that he was depressed. It is quite possible that whatever problem drove him to addiction was never resolved and that the drug addiction was just one manifestation of an addictive personality. If so, he may have become addicted to killing, experiencing a "buzz" of pleasure from the association with death and the power and control that it gave him.

Shipman was respected by both his patients and

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fellow health care professionals and was a hugely popular doctor in his community, but he had very few friends and was quite isolated professionally. His early victims were terminally ill or in very poor health. There was very little risk that giving an opiate to a patient whose death was expected would arouse suspicion or lead to detection. The killings of such people might have seemed to Shipman to be the least morally culpable. He may have tried to justify them in his own mind, but he was clearly killing in response to a need of his own and selected victims primarily so as to avoid discovery.

It is impossible to consider Shipman's crimes without considering the context in which he killed and remained unsuspected for so long. After examining evidence for four years at a cost of nearly £21 million ($40.4 million), the inquiry issued numerous recommendations. These covered the system of death certification, the investigation of deaths by coroners, the regulation of controlled drugs in the community, and most recently, the monitoring and regulation of the work of general practitioners.

The inquiry found fundamental weaknesses in the existing systems that enabled Shipman to kill and not be discovered for many years. He was able to amass large quantities of diamorphine, notwithstanding regulations designed to prevent such stockpiling. He was able to certify a cause of death of patients whom he had killed and to thus avoid reporting the deaths to the coroner. There was no effective check on the information that he recorded on cremation certificates. There was no system for monitoring the number of death certificates signed by a given doctor, so no one noticed the large number signed by Shipman.

Faced with the revelations about Shipman, many doctors in the United Kingdom argued that there is no need for systemic reform because there will never be another Shipman. A common refrain was that Shipman was a killer who just happened to be a doctor. I take the view that it was the very fact that Shipman was a doctor that enabled him to kill and remain undiscovered. His profession provided him with the opportunity to kill, and the lack of safeguards and controls allowed him to avoid suspicion.

Society invests great trust in doctors, giving us immense power. Shipman abused that trust, thereby exposing the profession's power and patients' lack thereof. In considering the role of trust and accountability in doctor–patient relationships, regulators and professional organizations must aim to equalize the power imbalance. Some of the best safeguards against another Shipman include encouraging a more questioning attitude toward doctors and implementing better systems for monitoring their work, especially their care of the most vulnerable patients. If this means greater regulation of the medical profession, then that may well be something we have to take on board. That is the real lesson of the case of Harold Shipman.

BECOMING A PHYSICIAN

The Calling

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I grew up in Africa, the younger of two sons of Indian parents who taught college physics. Around the time that my brother's precocious ability with numbers was revealing itself, I discovered that I had no head for math — or for any other subject in the school curriculum.

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Middle-class Indian parents worshipped the professions, and only three existed for them: medicine, engineering, and law. When my brother announced, while still in short pants, that he was going to be an engineer, my parents' joy was astonishing to behold. Nothing I had ever said had produced such a reaction. I promptly proclaimed that I intended to be a doctor. What made this remotely plausible, even to me, was that I had more than a passing familiarity with blood, mostly my own, because I was always