CHAPTER THIRTEEN

Single-Handed Practitioners

Introduction

13.1 For the last six years of his career as a general practitioner (GP), Shipman worked 'single-handed' from premises at 21 Market Street, Hyde. After his conviction for the murder of 15 of his patients in January 2000, there were many calls for a move away from single-handed practice. These murders had been committed over a period of three years and it was suggested that Shipman would not have escaped detection over such a long period had he been working in a group practice; his partners or working colleagues would have recognised that something was amiss. Alternatively, the very fact of having to work in close proximity to colleagues as part of a team would have served as a deterrent to him.

13.2 This feeling that there was 'safety in numbers' was reflected in the result of research conducted by Market & Opinion Research International (MORI) for the General Medical Council (GMC) in April 2000[1]. It reported a feeling that **'doctors in group practices to some extent regulate each other'**, a view that was later echoed in the responses to a questionnaire sent by the Inquiry to 15 randomly chosen primary care trusts (PCTs). That same year, the Royal College of General Practitioners (RCGP) spoke of continuing concern about the lack of accountability to close colleagues of single-handed GPs and of GPs who worked within a group but who nevertheless operated separate patient lists. It was said that there was safety in the informal mutual supervision of the members of a group practice, with teams of professionals working together to ensure each other's continuing development[2]. By contrast, there were real dangers of professional isolation for single-handed GPs.

13.3 Although it seems to be generally recognised that many single-handed practitioners practise alone for perfectly proper reasons, I also detect a suspicion, in some quarters, that those who engage in single-handed practice do so from less satisfactory motives. I think that there is a view that some seek to avoid group practice, fearing that scrutiny of their work by colleagues would result in the exposure of their clinical or other inadequacies. Another suspicion is that they may have character traits which make them difficult professional partners and possibly also poor doctors. Doctors with something to hide – be it criminal behaviour or clinical incompetence – will, so the feeling goes, naturally seek to hide themselves away in single-handed practice. The suggestion is that Shipman might have been an example of this.

13.4 The Inquiry heard oral evidence from Dr Michael Taylor, Chairman of the Small Practices Association (SPA). SPA is a national body for single-handed and small practices. It has a wide range of functions. These include a representative and political remit. It carries out surveys, research and data collection. It also issues written guidance to its members on continuing professional development and on subjects, such as complaints procedures,

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[1] 'Views on Erasure and Restoration of Doctors – General Public Consultation conducted for the General Medical Council', April 2000.

[2] 'The Future of Professionally Led Regulation for General Practice – a Discussion Document issued in conjunction with and on behalf of The Royal College of General Practitioners, The General Practitioners Committee of the British Medical Association and the Joint Committee on Postgraduate Training for General Practice'.

which may give rise to particular difficulties for small practices. Its mission statement is that it exists **'to improve the quality of care for patients in small practices'**. Professor Dame Lesley Southgate, Professor of Primary Care and Medical Education, University College London, told the Inquiry seminars that some of the best work on developing clinical governance for single-handed and small practices has been done by SPA. I found Dr Taylor's evidence helpful.

13.5 I also heard evidence from Dr Hugh Whyte, senior medical officer, Directorate of Health Policy and Planning, Scottish Executive Health Department, about the position of small and single-handed practices in Scotland. Several witnesses, called to give evidence mainly on other subjects, provided their views on certain aspects of single-handed practice. As mentioned above, the Inquiry sent a questionnaire to 15 randomly chosen PCTs, seeking information about their attitudes towards single-handed practice and about any special arrangements they made for such practices. The problems of clinical governance in single-handed practice were discussed at the Inquiry seminars. I also considered a large volume of written material, mainly comprising articles from the medical journals and statements from interested bodies, such as the RCGP.

13.6 In this Chapter I shall summarise the evidence the Inquiry received relating to these issues and I shall consider the ways in which the perceived drawbacks of single-handed practice may be mitigated.

Definitions, Statistics and Trends

Definition of Single-Handed Practice

13.7 The term 'single-handed practice' is not a term of art. It can be applied to describe practitioners working under many differing arrangements. The Department of Health (DoH) defines a single-handed GP as one who has no partners, although s/he may have an assistant or a GP registrar. Another definition of a single-handed practice, referred to in the RCGP paper, is:

> **'a practice in which all the patients are registered with one general practitioner, contracted by the relevant health authority and who is responsible for those patients 24 hours a day and 365 days per year, although the practitioner is able to access other health professionals, including general practitioners, in order to discharge the contractual responsibilities'**[3].

13.8 Dr Taylor's evidence was consistent with this definition. According to him, 'A single-handed practice is a group of patients registered with a GP principal who receives funding for those patients.' Essentially, what distinguishes the single-handed practitioner is the fact that s/he has his/her own patient list. Although some of his/her patients may be treated by an assistant at the practice, the single-handed GP does not share with other doctors the care of patients in a shared list.

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[3] Wylie AM et al (1999) 'Single-handed practices – their contribution to an undergraduate teaching network in the first year of the new curriculum', Medical Education, Vol 33: pp 531–536.

13.9 In some single-handed practices, there may be only one doctor regularly working at the practice, with locums standing in during sickness or holidays. This is the model that most members of the public would identify as a single-handed practice. In others, the doctor may have a part-time or full-time salaried GP registrar or assistant to help. Elsewhere, although these are now apparently few, there are practices in which GPs have their own patient lists but share staff, premises and other facilities. Although they would regard themselves (and would be regarded by the profession and the DoH) as single-handed, they would probably not be regarded as such by most members of the general public. Dr Taylor described several other variations on the theme.

13.10 A small practice is defined by SPA as a practice that has either fewer than 7000 patients or fewer than four GP principals. Again, this is not a term of art. Shipman was never in a small practice (rather than a single-handed practice) but some of the evidence I have considered suggests that certain problems are common to both single-handed and small practices.

The Typical Profile of a Single-Handed General Practitioner

13.11 Dr Taylor identified four groups of single-handed GPs. Not all single-handed GPs would fall into one of these groups but the four groups account for a large proportion of the total. The first group comprises doctors who came to the UK from the Indian sub-continent in the 1960s and 1970s and who never went into group practice. The majority of these doctors serve deprived inner-city areas; many are soon to retire. Second is a group of younger doctors from Western Europe, in particular the Benelux countries, who are accustomed to and enjoy single-handed practice, which is the norm in their home countries. A third group comprises doctors who find themselves in single-handed practice after a partnership split. The fourth group is what was described by Dr Taylor as the 'small is beautiful' group, among whose number Dr Taylor would probably count himself. Those in this group prefer single-handed practice, believing that it gives them the opportunity to treat their patients in the 'holistic' way most appropriate to their needs. Of course, doctors in any one or more of the first three groups may also be in the fourth. The practices tend to be located in deprived inner-city areas. Some are in rural localities that could not support more than one doctor.

Numbers

13.12 The number of single-handed practitioners in England is gradually declining. In 1952, about 43% of GPs were single-handed. By 1993, there were only 2888 single-handed GPs out of a GP population of 25,968. In 1998, there were more than 200 fewer (2683) out of a substantially increased GP population of 27,392. By 2003, the respective figures were 2504 out of a total of 28,568. Thus, over that 11 year period, the percentage of single-handed GPs in the GP population fell from about 11% to less than 9%. These figures do not distinguish between 'pure' single-handed GPs and those GPs who are in a group practice with their own patient lists. The GP population referred to is the population of 'unrestricted principals and equivalents' (UPEs), a DoH term that excludes groups such as restricted principals, assistant GPs and salaried doctors.

13.13 Women doctors and young doctors are under-represented among single-handed GPs. Over 50% of single-handed GPs are over 50, compared with 25% of GPs as a whole. Only 11% are under 40, compared with 40% of GPs as a whole. Only 15% of single-handed GPs are women, compared with 27% of GPs as a whole[4].

The Decline in Numbers

13.14 According to Dr Taylor, the decline in numbers began in the 1960s and seems likely to continue. It is largely attributable to fiscal, practical and administrative considerations that give group practice a broader appeal to most aspiring GPs.

13.15 In the early 1960s, the view was prevalent that single-handed general practice was inhibiting the development of good clinical practice. Consequently, in 1966, a financial incentive in the form of the Group Practice Allowance (GPA) was introduced, in order to encourage the formation of group practices. The GPA achieved its goal and the number of single-handed GPs consequently declined. The GPA was abolished in around 1990 when fundholding was introduced. In its early stages, fundholding was not in effect available to single-handed GPs and small practices, and the additional allowances paid for such services as chronic disease management were not easily achievable by single-handed GPs, who would not usually have possessed the necessary infrastructure or staffing levels.

13.16 Mr William Greenwood told the Inquiry that, in 1980, when he was working as the Assistant Administrator at the Tameside Family Practitioner Committee (FPC), there would be between 20 and 40 applications for a vacancy in a single-handed practice whereas now there are only three or four. Dr Taylor suggested that applications are 'astonishingly few'. There are several reasons why the shift away from single-handed practice appears to be continuing. First, aspiring young GPs are most likely to train in a group practice (only 2% of GP training is delivered in small or single-handed practices) and are therefore likely to seek a position in the kind of practice with which they are familiar. It has also been suggested that young doctors find the practical arrangements in group practice more satisfying. They may also find them more flexible and less personally demanding. Finally, many single-handed GPs began practising in the 1960s and 1970s and have reached or are approaching retirement.

13.17 It also appears to me, from the responses to the Inquiry's questionnaire, that PCTs generally discourage the continuance of single-handed practice. When a single-handed GP retires or gives up his/her practice, the PCT will encourage a merger with another practice. The justification for this attitude towards single-handed practice is said to be that group practice provides better patient care. However, it may be that pragmatic considerations play a part. First, it must be easier for PCTs to manage a smaller number of practices, even though the number of doctors overall may be the same. In written evidence to the Inquiry, Professor Richard Baker, Director, Clinical Governance Research and Development Unit, University of Leicester, suggested that single-handed practices may be unpopular with PCTs because they present greater management challenges and

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[4] Lunt N et al (1997) 'Staying single in the 1990s: single-handed practitioners in the new National Health Service', Social Science & Medicine, Vol 45(3): pp 341–349.

cost. Dr Taylor also spoke of the significant expense of putting a new single-handed GP into an established single-handed practice. The departing practitioner may well not have kept the premises and equipment up to date and significant sums may be incurred in 'refreshing' them. These sums are avoided when the patient list is absorbed into an existing group practice, as are the costs of advertising and appointing a new single-handed GP, which would otherwise fall onto the PCT. Expenditure on premises and equipment will be greater still where a new single-handed practice is formed (as with Shipman in 1992).

13.18 There is now an additional reason why the decline in the number of single-handed practitioners is likely to continue. Under the old General Medical Services (GMS) Contract, every GP in a group practice had his/her own list of patients, even though s/he might share the care of those patients with his/her partners. If the practice broke up, a GP could take his/her list of patients to form a single-handed practice. Under the new GMS Contract, which came into force in April 2004, patients are registered with the GP practice and not with an individual GP. In future, if a GP leaves a partnership, s/he will not be able to take his/her patients to form a new practice.

13.19 For all these reasons, it appears that the number of single-handed GPs will continue to decline. However, it seems to me likely that there will always be a need for some.

Shipman

Todmorden

13.20 As I have described in my First Report, Shipman joined the Abraham Ormerod Medical Centre in Todmorden in early 1974. There were between 9000 and 12,000 patients registered with the practice, which comprised five partners, including Shipman. Each partner had his/her own list of patients. It is not now clear to what extent Shipman inherited the list of his predecessor, who had just retired from practice. It seems that Shipman was expected to build up his own list. The partners were, therefore, single-handed within the definition mentioned above although their patients probably regarded the practice as a single unit.

13.21 In my First Report, I found that, while in Todmorden, Shipman unlawfully killed one patient, Mrs Eva Lyons. She was probably a patient on his list. She was terminally ill and Shipman visited her frequently in the period leading up to her death. She died late one evening after Shipman had called to attend to her. She was in quite severe pain and Shipman gave her an injection of a drug, which resulted in her death within a few minutes. Her death was expected and, even had she been registered with another doctor, it is unlikely that that doctor would have seen any cause for concern. I found that there were reasonable grounds for suspecting that he had killed six others, all of whom were probably his patients. I also found in my First Report that there was an occasion in August 1974 when Shipman probably did inject Mrs (now Professor) Elaine Oswald, a 25 year old female patient, with an opiate, causing her to suffer respiratory arrest. I did not feel able to reach any positive conclusion as to his motive. However, I thought it highly unlikely that he had any intention to kill her or to cause her serious harm. She too was his patient.

13.22 When in Todmorden, Shipman also flouted the legal requirements governing the keeping of the practice's controlled drugs register, for which he had responsibility. He amassed large quantities of pethidine for his own use. Thus, in Todmorden, Shipman was neither deterred nor detected by such 'mutual supervision' as existed where the doctors worked together in the same premises, sharing the services of staff. It is perhaps revealing that it was a member of staff at the local pharmacy who eventually 'blew the whistle' to Shipman's partners about his acquisition of excessive quantities of pethidine. The courses of action open to her might have been less clear cut had Shipman been the only doctor working in the practice.

The Donneybrook Practice

13.23 In October 1977, Shipman joined the Donneybrook practice, Hyde, where there were seven doctors. Five of the seven had their own patient list and two shared a list. Shipman inherited the list of Dr John Bennett. The five doctors organised themselves into two groups for the purpose of providing cover for their half days off. For the first three years or so, Shipman and Dr Geoffrey Roberts provided half day cover for each other. After Dr Roberts left the practice, Shipman made the same reciprocal arrangements, first with Dr Wojciech Kucharczyk and then with Dr Jeffery Moysey. In addition, a doctor would be responsible for all the patients registered with the practice when he was on duty in the evenings, at weekends and over bank holidays. The system was that each of the members of the practice provided out of hours cover on a rota. When on evening duty, a doctor was responsible for providing cover from 5.30pm or 6pm until about 11pm, after which telephone calls were diverted to the deputising service used by the practice. The deputising service would then respond to all calls made until 8 or 8.30 the following morning. The charges made by the deputising service for dealing with calls received by them from 11pm onwards were shared between all the partners in the practice. Before 11pm, telephone calls made to the surgery were transferred to the home of the doctor on duty. That doctor could choose to have calls diverted to the deputising service earlier than 11pm but, if he chose to do so, he would be financially responsible for the charges of the deputising service for responding to those calls.

13.24 The general financial and administrative arrangements remained essentially those of a partnership until 1st January 1992, from which time, having announced his intention to move, Shipman ran a completely separate single-handed practice from within the shared premises. When he announced his intention to move in 1991, one of his partners thought that he was moving to single-handed practice because of his 'individualistic' approach to his work. He also thought that Shipman wanted to be free to practise without any interference from others; it was suggested that he used to show signs of irritation when colleagues or staff disagreed with him. Dr Graham Bennett worked in a neighbouring practice and signed cremation Forms C on several occasions when Shipman had certified the cause of death and completed a cremation Form B. He said that he considered it inevitable, given his character, that Shipman would go into single-handed practice where he would have his 'own little empire' and would not be overlooked.

13.25 During his years at the Donneybrook practice, Shipman killed 71 patients and I found that there were reasonable grounds for suspecting that he killed 30 more. It is likely that all were on his patient list. At no stage did any of his partners suspect what he was doing.

The Market Street Surgery

13.26 In August 1992, Shipman moved with some of the staff from the Donneybrook practice to new surgery premises at 21 Market Street, Hyde. To the annoyance and financial detriment of his former partners, he took with him his patient list. That list was to grow so large that, at the end of 1997, Shipman was setting in train the process for recruiting a partner. Between 1992 and 1998, Shipman enjoyed an excellent reputation as an attentive, caring doctor. In the six years before his arrest, he killed 143 patients and there are reasonable grounds for suspecting that he killed eight more.

13.27 It is clear, therefore, that Shipman was, to all intents and purposes, a single-handed practitioner throughout his professional life as a GP. Although there may have been some degree of mutual awareness, at the Donneybrook practice, of what other doctors within the practice were doing, this would only rarely extend to knowledge of the medical history or circumstances of the patients of another doctor. Thus it is not surprising that the other doctors in the Donneybrook practice noticed nothing unusual about the deaths of Shipman's patients. Concern that Shipman might have evaded detection because he practised alone may have some foundation. Later in this Chapter, I shall consider whether the mutual supervision that may be expected in a group practice with shared patient lists would have had a significant effect upon Shipman's course of conduct.

Government Policy

13.28 Concerns about single-handed GPs are not recent. In the mid-1990s, there were statements in the medical press quoting representatives of the National Association of Health Authorities and Trusts, who said that the days of the single-handed GP were numbered. Single-handed GPs, it was said, could not be expected to provide the kind of services required of them, given the burden on primary care and the need to develop practice teams offering a range of professional expertise and facilities.

13.29 At times, Government policy has seemed to favour a move away from single-handed practice, on the assumption that this would lead to improved standards of patient care by reducing the 'clinical isolation' said to be experienced by doctors practising alone. One of the proposals contained in 'The NHS Plan, A plan for investment, A plan for reform' (the NHS Plan), which was presented to Parliament in July 2000, was that special contractual arrangements were needed for single-handed GPs. According to paragraphs 8.10 and 8.11:

> **'It is particularly important to be able to confirm that single-handed practices are offering high standards, because although most single-handed GPs work hard and are committed to their patients, they tend to operate in relative clinical isolation. They do not have the ready support from colleagues enjoyed by GPs in larger practices. The current ''red book'' contract is a particularly poor mechanism for protecting quality standards in these practices.**
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> **For this reason, new contractual quality standards will be introduced for single-handed practices. This will either be done through a negotiated**

> **change to the "red book", or if this proves not to be possible, a new national Personal Medical Services contract will be introduced into which all single-handed practices will be transferred by 2004. The role of primary care groups and primary care trusts in promoting and auditing clinical governance will also help reduce isolation and encourage co-operation between GPs.'**

Then, on 3rd July 2002, the Prime Minister, the Rt Hon Tony Blair MP, said in the House of Commons:

> **'There has been a move over time away from single-handed practices so as to improve the quality of care that people receive. That has been based on a great deal of evidence over a long time.'**

13.30 This announcement caused disquiet in the medical profession, which did not accept that such evidence existed. Within a short time, there was a 'softening' of the policy line. On 17th October 2002, the then Secretary of State for Health, the Rt Hon Alan Milburn MP, told the publication 'Doctor' that the future for smaller practices was 'positive' and that this would be recognised in the new GMS Contract. The new GMS Contract does not impose any special restrictions or requirements on single-handed GPs. It leaves it up to individual practices, including single-handed practices, to decide how best to design their arrangements so as to meet local needs. It sets out to reward high quality of care by remunerating GPs in accordance with their performance, which is to be measured against a number of quality markers. Although SPA welcomes the focus on quality of care, there is disappointment that there is to be no specific reward for continuity of care.

13.31 At the Inquiry seminars, held in January 2004, it was said that there was still a perception in some quarters that single-handed practice is discouraged. Indeed, I got this impression myself from the evidence of some PCT officers. In response, the Deputy Chief Medical Officer for England, Professor Aidan Halligan, made it clear that the DoH was not actively encouraging PCTs to persuade single-handed GPs to move into multi-handed practice. In written evidence to the Inquiry, the DoH stated that the policy now is that the future for single-handed practice is **'safe'**. Small practices will be encouraged to co-operate with each other so as to ensure the provision of a full range of services to patients. Improved PCT support, for example by the provision of practice nurses and experienced practice staff, will help to improve the quality of service offered by those practices. I should add that PCTs now also have list management powers which give them a greater ability to deal with all problem GPs, including single-handed GPs. In short, single-handed practice is here to stay and will not be allowed to be the poor relation of primary care.

The Advantages and Disadvantages of Single-Handed Practice

13.32 The general perception of the public and of the medical profession appears to be that single-handed practice is popular with patients because it provides continuity of personal medical care. The general perception among the medical profession is that single-handed practice does not provide as high a quality of care as is delivered by group practice.

Objective Measurements of Clinical Performance

13.33 A review of the literature over the past decade suggests that there is no good evidence that the clinical performance of single-handed GPs is inferior to that of their colleagues in group practice. It appears that no single type of practice can claim a monopoly over high quality care[5] and that there is no association between practice size and quality of care[6]. Differing sizes of practice are recognised to have differing strengths and weaknesses. In those instances where the data would appear to suggest that group practice provides better care, the disparities disappear when adjustments are made for patients' age, sex and social deprivation. In any event, it might be expected that research would suggest that group practices provide a better standard of care than do single-handed practices, because the performance and other indicators used to assess practices are based largely on the numbers of patients who receive particular forms of treatment (such as immunisation, cervical cytology or regular chronic disease management) and do not reflect the less quantifiable advantages of single-handed practice, such as those associated with continuity of care.

Practice Size

13.34 The witness evidence generally supports the view that there is no association between practice size and quality of care. At the Inquiry seminars, Professor Martin Roland, Director, National Primary Care Research and Development Centre, Professor of General Practice (University of Manchester) and Principal in General Practice, Rusholme Health Centre, Manchester, said that single-handed GPs are represented among those who provide very high standards of care as well as among those at the other end of the spectrum. Sir Donald Irvine, President of the GMC between 1995 and 2002, told the Inquiry:

> **'... some SHPs** (*single-handed practices*) **have quite the best arrangements for clinical governance that one could wish to see. The assumption that smallness or single-handedness cannot be equated with quality is just not true.'**

Dr John Grenville, representing the British Medical Association, told an Inquiry seminar that there are some 'incredibly good' single-handed practices, with very high standards of clinical governance.

Chronic Disease Management

13.35 Chronic disease management is often cited as an area of general practice in which the group practice model is inherently preferable to the single-handed model. Nowadays, it is expected that chronic diseases, such as diabetes, heart disease and hypertension, will be managed as part of primary care, with only occasional hospital referral. The expectation is that a group practice will have a GP with a special interest in the relevant

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5 Roland M et al (2001) 'Identifying predictors of high quality care in English general practice: observational study', BMJ, Vol 323: p 784.

6 Majeed A et al (2003) 'Association between practice size and quality of care of patients with ischaemic heart disease: cross sectional study', BMJ, Vol 326: p 371.

field and that s/he will run clinics, often in conjunction with a (specialist) practice nurse. According to Mr Mike Newton, Head of Performance Management, South Yorkshire Strategic Health Authority (SHA), setting up such a clinic puts significant demands on a single-handed GP, who may not have any special interest in the management of the relevant disease and whose practice nurse may be part-time. The problem could be remedied, if thought desirable, by the single-handed doctor referring patients with a chronic disease to a clinic run by an adjacent practice.

13.36 Dr Taylor said that treating patients at clinics held for the monitoring of specific conditions does not fit comfortably with the 'holistic' ethos of the small practice. He described this as 'providing care for patients who have diseases, rather than care for the diseases that people have'. He also gave an illustration of the type of case in which chronic disease management might be better in a single-handed practice. He said that, when treating a patient with rheumatoid arthritis, it is very useful for the doctor to be familiar with the family dynamics. If s/he is, it becomes easier to treat the patient in a way that enables him/her to cope with the situation, rather than just treating the symptoms of his/her disease. A single-handed GP is more likely to have the relevant knowledge, according to Dr Taylor, and is also less likely to make an unnecessary hospital referral, because s/he will be confident in his/her knowledge that the family dynamics will allow the patient to be treated at home. I envisage that the proponents of the clinic system would say that the doctor running the clinic would gain the relevant knowledge within a short time of starting to see the patient.

13.37 Other witnesses supported Dr Taylor's views about holistic care. Dr Whyte said that the type of practice advocated by Dr Taylor is widely regarded as very desirable, if not optimal. The point is also made that specialisation for GPs should not be taken too far. In primary care, where the GP has to be able to deal with a wide range of conditions and presentations and where s/he is effectively the gatekeeper for the secondary care system, the skills of the generalist must be maintained. It is clear that both sides in this debate are able to make valid points in support of their respective contentions.

Patient Preference and Continuity of Care

13.38 There is a considerable body of evidence to suggest that patients like single-handed or small practices. In a 1995 study[7], patients were reported to prefer smaller practices, practices with personal list systems and non-training practices. Another more recent study confirmed this preference; smaller practices were regarded as being more accessible and achieved higher levels of patient satisfaction[8]. There is other evidence suggesting that continuity of care leads to high levels of patient satisfaction. The Audit Commission Report of 2000, entitled 'A focus on general practice in England', confirms that continuity of care tends to be better in small practices and is valued by patients. The PCT responses to the Inquiry's questionnaire also suggest that patients like single-handed GPs. According to Mr Newton, they are especially popular with the elderly.

[7] Baker R and Streatfield J (1995) 'What type of general practice do patients prefer? Exploration of practice characteristics influencing patient satisfaction', British Journal of General Practice, Vol 45: p 654.
[8] Roland et al. 'Identifying predictors of high quality care in English general practice: observational study', BMJ 2001; 323:784.

13.39 There was anecdotal evidence from Mr Newton that single-handed GPs tend to attract a greater number of complaints than do their colleagues. Neither SPA, the GMC nor any of the medical defence organisations was able to provide statistical evidence on the point. In 1996, the Medical Defence Union (MDU) published a pamphlet on complaints that suggested that single-handed GPs attracted a smaller relative proportion of complaints than their colleagues in group practice. However, the MDU has explained that the work on which that suggestion was based was not valid statistically because it took into account only complaints against those GPs whom the MDU knew to be single-handed (which was not all).

13.40 It is almost axiomatic that it is easier to achieve continuity of care in a practice where each patient is assigned to a particular doctor. The smaller the practice, the fewer the number of doctors who are likely to see the patient. Dr Taylor describes continuity of care as 'an important measurable component of holism'. He suggested that, according to evidence from US studies, continuity of care is associated with a reduced number of hospital referrals. That may or may not be a good sign.

13.41 According to Dr Taylor, continuity of care leads to increased levels of trust and reduced levels of patient anxiety. These factors enable the patient, who regularly sees a familiar face that s/he can trust, to take an active and informed interest in his/her own treatment. I can see how this can lead to improved patient care, provided that the trust in the doctor is not misplaced. I accept that continuity of care can, and often does, offer real benefits in terms of quality of care and also gives rise to high levels of patient satisfaction.

13.42 However, it seems to me that there are some real disadvantages stemming from a continuous one-to-one doctor/patient relationship. First, the patient may come to place unwarranted trust and confidence in the doctor. Shipman illustrates the point. He had a one-to-one relationship with his patients. He offered them a high level of continuity of care. There was never any difficulty in getting an appointment to see him or in arranging a home visit. Only on rare occasions was there a locum in his place. He was greatly admired and respected – even loved – by his patients. As a result, he enjoyed the absolute trust of many of his patients (and of their families) and so the threshold at which patients or families might have questioned his actions or advice (already high in the doctor/patient relationship) was even higher than usual. He was able to perpetrate a colossal abuse of trust without arousing any suspicion. Of course, I accept that Shipman was a most unusual case, but over-confidence in a doctor may easily result in an inability to question his/her actions and opinions when they ought in fact to be questioned.

13.43 Second, there is a quite different type of problem that may be associated with continuity of care. This is the danger of overlooking a disease of insidious onset, where the doctor sees the patient regularly and fails to notice and take heed of gradually developing signs. Third, patients who repeatedly see the same doctor and no other have no experience against which to compare their consultations. This problem is illustrated by the experiences of the patients of Clifford Ayling, who in many cases did not know whether the intimate examinations that they underwent were 'normal'. Ayling was a single-handed GP who was convicted in December 2000 of 12 counts of indecent assault, relating to ten female patients, and was sentenced to four years' imprisonment. Fourth, patients do not

have any 'yardstick' by which to measure the competence of their GP, if they do not see how their health and illnesses are managed by other doctors.

Isolation

13.44 When discussing the advantages and disadvantages of single-handed practice, many witnesses and contributors to the Inquiry seminars suggested that single-handed practitioners tended to be 'isolated'. This term connotes a lack of involvement with one's peers and a failure to keep up to date with current practice. According to Dr Taylor, there is no evidence to suggest that single-handed practitioners are any more isolated than their colleagues. Dr William Reith, a GP principal in Aberdeen and former Chairman of the Scottish Council of the RCGP, told the Inquiry that there are many doctors who work in larger practices who are professionally isolated and feel unable to discuss matters with colleagues. I accept what both say but I would have thought that common sense would indicate that the dangers of isolation were greater in single-handed than in group practice. Moreover, if a doctor in a group practice becomes 'isolated' in this way, the problem is more likely to be observed by colleagues.

13.45 Dr Roger Freedman, medical adviser to the Tameside Family Health Services Authority from November 1991 until August 1993, was later involved in the work of the Manchester Performance Panel, which was established in the late 1990s to assess and, if appropriate, remedy the performance of doctors about whom concern was expressed. In the first two years of its operation, the Panel considered the performance of 14 GP principals and one locum. Three of the principals were single-handed GPs and none was in a partnership of more than three. Dr Freedman confirmed that there are some excellent single-handed GPs but felt that problems arise where the less good are in single-handed practice; the lack of peer contact can mean that they are unaware that their clinical and managerial standards are slipping. The problem, he suggested, is lack of insight.

13.46 I observe that Shipman did not show any sign of professional isolation. He became involved in organisations outside the practice. While at the Donneybrook practice, he was an area surgeon for the local St John Ambulance, secretary of the Tameside and Glossop Local Medical Committee and a member of the Tameside FPC. When working at Market Street, he regularly attended professional development events, was active in local medical politics and was an enthusiastic member, latterly treasurer, of the West Pennine SPA. Shipman was also known to be keen on introducing new ideas to the Donneybrook practice. The Market Street practice was regarded by the WPHA as being innovative and advanced. At Market Street, Shipman and his staff performed regular medical audits, which impressed the WPHA Primary Care Clinical Audit Group (WPPCCAG). The following comment was made in January 1998 after a practice audit visit by a member of the WPPCCAG:

> **'Great to see a single-handed enthusiastic GP with a rolling programme of audit. Practice nurse also very enthusiastic and takes part in audit. We think it would be very useful for you to have an audit assistant and hope you follow this up. Keep up the good work.'**

This comment is indicative of the way in which his participation was regarded.

Clinical Governance

13.47 In Chapter 12, I described the ways in which PCTs seek to carry out their duty of clinical governance of GPs. Some of these methods involve the collection and/or scrutiny of data relating to the doctor's practice. With a group practice, much of the data collected relates to the practice as a whole and cannot be attributed to the performance of any single doctor. Examples are data relating to immunisation and cervical cytology. Some kinds of data, for example prescribing data, are supposed to relate to an individual doctor but, because doctors use each others' prescription pads, the data becomes 'blurred' and does not provide a clear picture of an individual doctor's practice or performance. When data is supplied by a single-handed GP, it relates only to that doctor and the picture provided to the PCT is clearer than that available for a group practice.

13.48 Some clinical governance activities are undertaken within group practices. For example, it is common practice for the partners in a group practice to discuss prescribing data. Discussion between the doctors may reveal anomalous practice by one member of the group that might well not be picked up by PCT monitoring. A single practitioner may choose to scrutinise his/her own prescribing data; many GPs now regard 'self-audit' as good practice. However, if a single-handed practitioner chooses not to examine his/her personal data, there is no one to ensure that it is done. If a single-handed GP chooses to ignore any problems that the data might reveal, there is no one to insist that the problems be dealt with.

13.49 Other forms of clinical governance can operate effectively only in a group. An example is significant event review or audit, a process whereby a group of doctors and other healthcare professionals discuss the care that was provided shortly before a patient's death or some other event – usually (although not always) an adverse event. The objective is to analyse the care provided with a view to learning lessons either from the mistakes made or from the success achieved. In a single-handed practice, there is often no one with whom the doctor can have a challenging discussion. The practice nurse might well feel unable to criticise the doctor's treatment of a patient; a peer view is necessary. Significant event review was not commonly undertaken when Shipman was in practice. If it had been, and if he had worked in a group practice, this form of review might have been effective in detecting Shipman's unlawful killing. If Shipman had had professional colleagues who were entitled to scrutinise his account of a patient's death and the management decisions he had taken, I think it would have provided a real deterrent to him and a greatly improved prospect of detection of his misconduct if it had continued.

13.50 Other forms of audit are more effective in a group setting than within single-handed practice. Although, for over ten years, it has been official Government policy to encourage audit within general practice and funding has been provided to reward it, audit activity is essentially private to the practice to which it relates. Thus, the results of an audit of patient deaths in a particular period would remain confidential to the practice, even if those results were to reveal serious deficiencies of care. In 1998, Shipman claimed to have carried out an audit of deaths occurring in his practice in the first three months of the year. In fact he had done no such thing. In the context of a group practice, the fact that an audit is carried out will be known to all partners and the results will be available to all. If they give rise to

concern, there is a far greater prospect that action will be taken to remedy the problem than if the problem is known only to the single-handed doctor. Although such audits may not be widely practised, there is published evidence that they are or can be of value.

Individual Responsibility and Accountability

13.51 Dr Taylor suggested that, in single-handed practice, there is a much greater degree of accountability and responsibility for patient care. The doctor is individually responsible for the care of every patient and cannot pass on responsibility to anyone else. Thus, in his view, a doctor is more likely to address and resolve a problem of patient care than to sit back, in the hope or expectation that more positive action will be taken by a colleague at some later date. I can see the force of that argument. I can also see how a doctor who shares the responsibility for a patient's care with other doctors might be reluctant to recommend treatment that has not been initiated by any of his/her colleagues when the patient has presented in the past with the same symptoms. There may be a natural tendency to 'go along with' the majority view, even though that course may not be correct.

13.52 The exclusive responsibility described by Dr Taylor also carries with it the disadvantage that the doctor's treatment will never come under the type of informal discussion and peer review that takes place every day in practices where patient care is shared.

Management and Administration

13.53 I have already mentioned that one of the reasons given for the declining numbers of applicants for single-handed posts is the preference of young doctors for the environment of a group practice. Professor Baker suggested that economies of scale and the sharing of the clinical workload make group practice attractive to doctors. PCT respondents to the Inquiry questionnaire raised concerns about poor working infrastructure, premises and recruitment arrangements in single-handed practices.

13.54 Studies have also shown that single-handed practices tend to be less well developed than group practices and may be slower to install modern facilities. This would not necessarily mean that they provided a lower standard of care. However, one study showed that single-handed practices had greater difficulties than group practices in, for example, the recruitment and retention of a practice nurse. Other areas of concern were computerisation and general management[9]. Mr Newton's personal experience confirmed the existence of this type of problem in single-handed practices. Responses to the survey of PCTs suggested that single-handed practitioners encountered greater difficulties in providing out of hours cover although this should cease to be a problem after January 2005 when PCTs assume responsibility for the provision of out of hours care. Mr Newton said that managing a practice single-handed and trying to keep abreast of developments in clinical treatment imposed a heavy burden on GPs, especially as they approached retirement age.

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[9] Leese B and Bosanquet N (1995) 'Change in general practice and its effects on service provision in areas with different socio-economic characteristics', BMJ, Vol 311: pp 546–550.

Complaints

13.55 In Chapter 7, I described the system of handling complaints against GPs that has been in operation since 1996. I mentioned the particular difficulties experienced by patients who, at present, are obliged to lodge their complaint directly with the GP practice concerned. The patient feels embarrassed and will often decide not to complain rather than confront the doctor or the practice staff. The problem is exacerbated if the complaint is about a single-handed practitioner. The September 1999 report by the Public Law Project, entitled 'Cause for Complaint? An evaluation of the effectiveness of the NHS complaints procedure', to which I referred in Chapter 7, mentioned the desirability of having a 'buffer' between the person complaining and the person complained about. This buffer is absent in the single-handed practice, where the staff are likely to feel a strong sense of loyalty to their employer. The need for a patient to be able to take a complaint to a person or body unconnected with the practice is clear, in my view, throughout general practice but is that much greater when the complaint is about a single-handed GP.

Reporting Concerns and Staff Complaints

13.56 I have also explained, in Chapter 9, that it is difficult in any general practice for a member of staff to raise a concern about the conduct, health or performance of a GP in the practice. Raising a serious concern may well in effect signal the end of the relationship. Those problems are accentuated in small and single-handed practices.

Mitigating the Problems of Single-Handed Practice

13.57 It will be clear from the above that the main problems associated with single-handed practice are the absence of peer review, the risk of clinical isolation and the danger of abuse by the doctor of the trust implicit in the continuity of care. I shall now examine the mechanisms that may be used to alleviate these problems.

Clinical Governance and Clinical Audit

13.58 According to the RCGP, with the advent of PCTs, the problems of isolation in general practice are being reduced. PCTs are smaller, more local organisations than their predecessor health authorities (HAs). They are closer to the practices for which they have a responsibility. Greater involvement with the PCT has resulted in more frequent meetings with colleagues and more collaboration at PCT level. The extent to which this occurs no doubt varies from place to place. Mechanisms are in place to require single-handed GPs to participate in clinical governance and appraisal. I am of the view that appraisal and revalidation could have substantial value if they really assured continuing competence and fitness to practise. Single-handed GPs may also participate in peer support schemes. Dr Reith explained to the Inquiry how significant event review can be undertaken in the context of single-handed practice.

13.59 According to Mr Michael Warner, former Project Director, Avon, Gloucestershire and Wiltshire SHA, it became standard practice during the late 1990s in his SHA for

single-handed GPs to share their results and to discuss their audits with each other. This was overseen by the Medical Audit Advisory Group.

13.60 Dr Taylor's practice seeks to reduce any danger of isolation by an association with two other small practices in the district. The three practices have separate patient lists but they share some members of staff. The doctors operate a rota for emergency and out of hours work and have a joint database of patient records to facilitate the working of the rota. They also use these shared computerised records for the purpose of collective clinical audit and prescribing analyses. Dr Taylor said that more small practices were co-operating in this way since clinical governance and clinical audit were introduced. Many small or single-handed practices close for half a day each week to carry out significant event review.

13.61 The Inquiry was told of one 'Small Doctors Group' whose members met to discuss their practices. I got the impression that, although their initiative was regarded by the SHA as a positive step, their practices were very disparate and the meetings did not provide any rigorous contribution to clinical governance.

13.62 Professor Baker recognised the potential for such local initiatives to enhance clinical governance in single-handed practice. I think he was right, however, when he said that the success of such initiatives depended upon someone recognising where action was needed and being determined to lead a group of practitioners down the right path. Those who are most likely to recognise where action is needed are single-handed GPs themselves but they may have the least time available to initiate it.

13.63 At the moment, involvement in group activities such as I have described is not only voluntary, it is not even universally available. Even where it is available, the products of collaboration – such as the results of joint audit – are not verifiable. According to the RCGP, all doctors should be accountable, primarily to their patients, and, more widely, to the NHS and to the public. I agree that they should, but the fact is that at the moment they are not. At present, it is quite possible for any GP, perhaps especially the single-handed GP, to avoid participation in joint activity and/or to mislead his/her colleagues or peers. I can well imagine how Shipman would have selected a number of 'significant events' for review in a way that would have shown him only in the most favourable light. Under most of the collaborative arrangements I have heard about, there would be no possibility that he would be required to offer a particular death for significant event review.

13.64 In the Report of the independent investigation into how the NHS handled allegations about the conduct of Clifford Ayling concern was expressed that GPs still practise in isolated situations where there is no immediate mentoring, either formal or informal. Acknowledging that there will always be single-handed GPs, it specifically recommended that PCTs should develop support programmes for single-handed GPs, to be agreed with each single-handed practitioner and with the SHA. Such programmes should pay special attention to managing the risks of isolation associated with single-handed practice. Implementation should be monitored by the SHA and should form part of the regular Commission for Healthcare Audit and Inspection (now known as the Healthcare Commission) review of the PCT. I would agree with this proposal and would only add that the programmes should provide a real element of mutual supervision as well as support.

Management and Administration

13.65 Mr Greenwood told the Inquiry that PCTs in several areas promote improved management in single-handed practices by encouraging the sharing of practice staff, practice managers and nursing staff. In this way, small practices can benefit from a range of expertise and services, which they would otherwise not be able to afford. Some PCTs will also pay a 'locum allowance' to enable single-handed GPs to engage a replacement doctor while attending continuing professional development events. Recognising the management difficulties often experienced by single-handed or small practices, Manchester HA established a Small Practice Adviser Scheme. This involves two very experienced practice managers working with a number of small practices to provide advice and support in practice organisation. Mr Newton told the Inquiry that, in areas of social deprivation, where significant PCT input may be required, a PCT might fund the appointment of a salaried doctor and nurse to assist a single-handed GP.

13.66 The Inquiry heard evidence about steps that have been taken to accommodate the needs of single-handed GPs working in very isolated areas in Scotland (e.g. the Highlands and Islands). Historically, they were unable to obtain regular time off and encountered problems of social and professional isolation. Under the 1991 GMS Contract, an 'associates' allowance' was successfully introduced in such areas to fund the employment of an 'associate' GP. Dr Whyte told the Inquiry that more than two thirds of rural practices have made use of such schemes, which allow the employment of associates, shared between two or three practices, so as to allow the single-handed GP time off for holidays, sickness and continuing professional development. In fact, I take the view that any arrangement whereby doctors, nurses or members of staff from outside the practice are brought in on a regular basis has the advantage of bringing a 'fresh pair of eyes' and of enabling comparisons with practice elsewhere to be made. It could also enable a PCT to be informed of any problems or shortcomings with the practice.

The Netherlands

13.67 Single-handed practice has been the traditional model for delivery of primary care in the Netherlands, although this is now changing. Over time, and in an *ad hoc* way, single-handed GPs have grouped together in ways intended to improve quality of care. The historical basis for this co-operation in so-called **'quality circles'** or peer review groups began about 20 years ago when there was an obligation for every single-handed GP to organise his/her practice into a larger group for the provision of out of hours care. Grouping of practices developed to meet this objective and gradually the same group took on a role in continuing medical education. According to Professor Baker, clinical audit meetings are held at which attendance is compulsory. Groups of practitioners, led by trained facilitators, review their clinical performance by reference to data submitted by individual practices.

Conclusions

13.68 It seems to me that single-handed practices vary in much the same way as do group practices. Some of each are good, bad or indifferent. Certainly, group practices do not

have a monopoly on high quality patient care. Small and single-handed practices have their devotees, particularly among those who seek a personal relationship with their GP and who value the continuity of care which this provides. The number of small practices may be diminishing for a variety of reasons. However, there are still a significant number of them and this is likely to be the position for the foreseeable future.

13.69 That being so, it seems to me that the policy of the DoH and of PCTs should be to focus on the resolution of the problems inherent in single-handed or small practices rather than to try to reduce the numbers of them in existence. I know that the DoH says that it has no such policy but I have the clear impression that such a policy exists in the regions, if not in Whitehall. It is typified by the attitude that single-handed practices are a problem and that the NHS would be better off without them. As I have said, the numbers are likely to decline with time in any event.

13.70 I have already described a number of the problems that are inherent in single-handed and small practices. I have also described a number of initiatives that are already being undertaken in an attempt to resolve or mitigate those problems. To my mind, the important thing now is that, for the sake of the patients registered with them, single-handed practitioners should be given more support and encouragement. In return, more should be asked of them in terms of group activity and mutual supervision. It is not for me to suggest how this should best be achieved. The current initiatives are patchy and uncoordinated. I do not suggest that there is a 'one-size-fits-all' solution to these problems. The needs of small practices in Cornwall may be very different from those in Central Manchester. What is needed, in my view, is a pooling of ideas, a willingness to examine the ways in which things are done in other places, such as the Netherlands, and a determination to solve the problems.

13.71 I turn to consider what significance, if any, attaches to the fact that Shipman was always technically a single-handed practitioner and never worked in a group practice with a shared patient list. Did this make it easier for him to escape detection? Did he feel more confident that his crimes would go undetected? First, I observe that Shipman killed at least 71 patients when he was at the Donneybrook practice and that his colleagues at the practice were, through no fault of theirs, unaware of what was going on. This confirms my belief that a devious and aberrant doctor is not significantly more likely to be deterred or detected just because s/he is in partnership and/or working under the same roof with other doctors. I suspect that it was Shipman's general character rather a feeling of likely detection if he were to remain that caused him to move from the Donneybrook practice. Second, I believe that if the Donneybrook practice had been a true group practice with shared lists, Shipman probably would have felt less confident that he would escape detection. If his fellow doctors had had some involvement in the treatment of those who were to become his victims, he would have felt less confident in making up false medical histories and they might have become suspicious if unusual patterns had developed. Much depends on what would have been the actual arrangements and the extent to which there would have been true mutual supervision or monitoring. Of course, that leaves open the question whether, if that had been the situation, Shipman would ever have applied for the position or remained there for so long – he might well not have done.

13.72 In my view, the fact that Shipman had his own patient list, and was free from the informal supervision and monitoring that accompanies the sharing of patient lists, did mean that he was less likely to be deterred or detected. However, the availability of other more formal methods of monitoring, through clinical governance, could have had a similar effect. If resources and ingenuity were to be applied to the problem, clinical governance methods of monitoring could be applied to single-handed and small practices, as well as to larger group practices. I do not think that the fact that Shipman was a single-handed practitioner should be used as a reason for preventing GPs from practising alone.