THE
SHIPMAN INQUIRY
Chairman: Dame Janet Smith DBE

The Rt. Hon. John Reid MP
Secretary of State for Health
Richmond House
79 Whitehall
London
SW1A 2NS

The Rt. Hon. David Blunkett MP
Secretary of State for Home Affairs
Queen Anne's Gate
London
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29th November, 2004

Dear Secretaries of State,

Shipman Inquiry – Fifth Report

I have pleasure in presenting my Fifth Report, entitled 'Safeguarding Patients: Lessons from the Past - Proposals for the Future'. This Report examines whether local primary care organisations (PCOs) and the General Medical Council (GMC) bear any responsibility for the fact that, over a period of more than 20 years, Shipman was able to kill patients without detection. My broad conclusion is that, during the years in which Shipman practised as a GP, local PCOs did not have monitoring systems in place that might have enabled them to detect the aberrant conduct of a doctor such as Shipman. The PCOs responsible for the Tameside area are not to be criticised for not detecting Shipman's activities.

The position of the GMC is more complex. In 1976, it received a report that Shipman had been convicted of offences in connection with the acquisition of controlled drugs. It did not erase or suspend him from the register but closed his case with a warning against any further misconduct. At that time, the GMC's policy was to secure the rehabilitation of a drug-abusing doctor while allowing him/her to remain in practice. The GMC handled Shipman's case exactly as it handled other cases of a similar type. There was no criticism of the GMC's policy in the 1970s and it was implicitly approved by Parliament in 1978 when legislation was passed introducing the health procedures. I do not consider that the GMC should be criticised for its decision to take a rehabilitative approach to Shipman rather than to erase or suspend his registration. Since the introduction of the health procedures, the policy has been to allow drug-abusing doctors to continue in practice while subject to conditions. Until this Inquiry, this policy has never been called into question. If it gives rise to public concern, there must be an open debate about how such doctors should be treated.

Although I do not think that the GMC should be criticised for its rehabilitative approach to cases of drug abuse, I have criticised it because, within the framework of that approach, its procedures focussed too much on the interests of the doctors and not sufficiently on the protection of patients. If the GMC's procedures had been as they should have been, Shipman would have been required to accept some limitations on his practice as a condition of avoiding suspension. However, as it appears that he never returned to drug-taking, I assume that he would have been allowed to resume unrestricted practice within about two years of his conviction. I stress that, from the information available in 1976, the GMC could not have suspected Shipman's true nature.

The GMC's role in monitoring has been to respond to the receipt of complaints and concerns about doctors and, in some cases, to take action on the registration of the doctors concerned. I am critical of the way in which it has done this; it has not always safeguarded patients as it should have done. However, in the years between 1976 and 1998, the GMC did not receive any information that might have led to the discovery of Shipman's crimes. It cannot be held responsible for the fact that Shipman remained free to practise although he was regularly killing his patients. The fact that no concerns were ever raised about his treatment of any of the patients that he killed must be attributed partly to Shipman's cunning and plausibility but also in part to the culture within the medical profession and within our society as a whole. The profession was held in such deference that people were unwilling to question the actions of a doctor. Also it was extremely difficult for the few people who were suspicious of Shipman to report their concerns to an appropriate quarter.

Since 1998, the landscape has changed a great deal. Within the NHS, there have been major changes of organisation and culture. Very properly, these changes have been designed to improve the quality of health care generally and not merely to facilitate the detection of aberrant practice. Primary care trusts (PCTs) have increased powers and responsibilities for monitoring GPs. General practice is now subject to clinical governance, which will, in time, provide a comprehensive framework for the detection of poor or aberrant practice, as well as for the improvement of the quality of clinical practice generally.

The GMC has also introduced changes. It has reformed its fitness to practise procedures and, in many respects, the changes will result in improvement. However, for reasons too complex to set out in this letter, I am by no means convinced that the new GMC procedures will adequately protect patients from dysfunctional or under-performing doctors. I have made a large number of recommendations that would, in my view, improve the position. However, I have concluded that there has not yet been the change of culture within the GMC that will ensure that patient protection is given the priority it deserves. I have been driven to the conclusion that this is because the GMC is effectively controlled by members elected by doctors. Many of the issues which the GMC has to consider give rise to a conflict between the interests of the profession and the public interest. Many members of the profession expect the GMC to represent it rather than to regulate it in the public interest. One of my recommendations is that the number of members appointed against 'public interest' criteria should be increased so that members elected by the medical profession no longer have an overall majority.

The other important change proposed by the GMC is the introduction of the revalidation of registration. This should consist of a periodic evaluation of every doctor's fitness to practise. In my view, revalidation could make a major contribution to the identification of incompetent and poorly performing doctors and thus to patient safety. Unfortunately, the present proposals for the revalidation of GPs do not provide an evaluation of fitness to practise and cannot achieve this important objective. I have made recommendations by which this objective could be achieved. However, my proposals would entail the NHS undertaking responsibility for the evaluation. I hope that these important recommendations will be accepted.

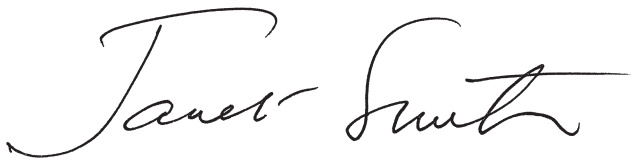
I have made a number of other recommendations affecting the NHS. None of these is revolutionary; they seek to build on past progress. The most significant are proposals for the investigation of patients' complaints as a clinical governance measure and the development of a central database of information about doctors which would be available to NHS employers and PCOs. I have also made proposals to increase the information about doctors which should be available to patients.

The recommendations in this Report are designed to fit together with those in my Third and Fourth Reports. For example, the new system of death certification that I have proposed should not only identify deaths requiring close investigation, it should also provide information about patient deaths to be used for public health and clinical governance purposes. A controlled drugs

inspectorate would provide expert analysis of information about the use of controlled drugs which would identify abnormal practice and would also be of value for clinical governance. I hope that my recommendations will be considered and implemented as an interlocking framework.

It would be impossible to offer a guarantee that my recommendations would make it impossible for a doctor who is determined to kill patients to do so without detection. However, I believe that the chances of such a doctor escaping detection would be very much reduced if my recommendations were implemented. But improving the chances of detecting or deterring criminal conduct is only one of my objectives. My proposals are also designed to improve the monitoring of doctors so that dysfunctional conduct and poor performance can be identified and dealt with so that patients will be better protected.

Yours sincerely,



Janet Smith