

Editorial

The Shipman Inquiry's fifth report: are there lessons for other countries?

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The fifth report of the Shipman Inquiry was published in December last year, and the debate it has initiated in the UK still continues. It is likely to reverberate around the panelled meeting rooms of Britain's medical colleges and associations for years to come. But is this a purely British affair, or do recommendations of the chair of the inquiry, Dame Janet Smith, have messages for doctors in other countries? An investigation of the circumstances that allowed an inexplicably deranged lone medical serial killer to remain undetected over a period of more than 20 years in a country with a very atypical healthcare system may seem of very little relevance to leaders of doctors in Paris, Canberra or Washington. However, the inquiry's report addresses several fundamental principles of medical professionalism, and the findings are important for doctors' leaders everywhere.

The report contains recommendations for improvements to patient complaint systems, methods of monitoring, managing and disciplining general practitioners, and for reforming the system of medical regulation. While these detailed recommendations may be of some interest in other countries, the most important issue does not lie in the recommendations, but in the central charge made against the medical profession and its regulating body, the General Medical Council (GMC). The workings of the GMC have been subjected to the closest examination, and the verdict is that it, and therefore the profession it regulates, has tended to place the interests of doctors before the interests of patients. The GMC put 'being fair to doctors' ahead of protecting patients, and despite several changes implemented by the GMC in recent years including a revised constitution and the introduction of revalidation, the old culture lingers on. Within the profession, many doctors perceive the purpose of the GMC as being to represent them. They had not fully understood that its purpose was to regulate them.

The verdict that doctors have sometimes placed their own interests before those of patients will be hard for some doctors to accept. But anyone who studies the inquiry's report – all 1200 pages – and reviews a sample of the transcripts of the hearings that are available

on a website (www.the-shipman-inquiry.org.uk) could not fail to come to the same conclusion. A more damning verdict on the profession is hard to imagine, and doctors in Britain must accept it and decide what changes they must make to eliminate the problem. Doctors in other countries must ask whether their own profession shares the same flaw, and if so must act urgently and decisively.

The attitudes (or culture) of the medical profession have for several decades been studied by sociologists but it is difficult to claim that the findings have influenced the profession to any extent. The researchers of quality improvement in healthcare may have noted the work of the sociologists but they have generally avoided exploring the way the medical profession makes its decisions. The profession's colleges and associations where decisions are debated and which provide leadership have been neglected by researchers, and the time has come to correct this oversight. The colleges in the UK need to promote or commission research to help them better understand the culture they foster, how their decisions come to be made, and to what extent and why they have in the past sometimes favoured the interests of doctors over those of patients. Colleges and associations in other countries should consider doing the same. At the very least, they should study the findings of such research in the UK and resist the natural reactions of 'It is not like that here' and 'That could not happen here'.

The limited participation of patient representatives in the functioning of the medical colleges and associations is almost certainly a key reason why the interests of patients have not always come first. In the last 20 years, the medical profession in the UK has been distracted by a relentless flood of health service restructuring and reform, from concentrating on the interests of patients. Too much time has been spent on responding to the latest policy initiative and too little on the familiar needs of patients. This must change. The reorientation of colleges and associations away from an almost total preoccupation with policy, to focus on the interests of patients will take time, and will not occur without the involvement of patients in various ways, including representation, focus groups,

citizen's panels or surveys. When better informed about the interests of patients, colleges and associations will be better able to educate their members about their responsibilities – and will be better placed to negotiate with policy makers. For other countries the message is clear; stay in touch with patients and their interests. This will give you your purpose.

Leadership is fundamental. In the UK, the multiplicity of colleges and associations that share to variable degrees the task of representing doctors has failed to provide adequate leadership. In consequence the profession has lacked direction and has a relatively weak sense of professionalism. Strong leadership is needed to produce a strong profession. Leadership that can instruct doctors to act against their own interests in order to protect their patients – to do what is right rather than what is comfortable – will in due course

instil a strong sense of professional values. Strong leadership requires reform of the bodies that currently govern the profession. The various colleges and associations need to consider how to restructure themselves for the 21st century. Doctors in other countries should take a long, cold look at their treasured colleges and associations and ask whether they meet the needs of today's medical practice and today's patients.

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