

Dr Death: a tale of two countries

Both Australia and England have had their high-profile 'Dr Deaths' and have had to come to terms with how medically trained men, who were supposed to have dedicated their lives to saving others, were able to get away with gross incompetence and even murder.

In Australia

Dr Jayant Patel of Bundaberg Base Hospital acquired the moniker 'Dr Death' in the Australian press in 2005 following the exposure of a number of patient deaths under his watch.

Dr Patel had been medically trained in India. He later moved to the USA and undertook further surgical training. He had been practicing in New York State from 1984 but had his license withdrawn in 2001. He then moved to Oregon where he was also subject to medical board scrutiny. His practise was restricted statewide after a number of deaths.

Despite this, and the fact that he had no formal surgical qualifications, Dr Patel took up post in 2003 as Director of Surgery at the Bundaberg Base Hospital. The hospital was in an 'area of need', meaning that overseas-trained doctors were actively welcomed. Despite his practise restrictions in Oregon he was able to provide glowing references from his colleagues there.

Over the next two years, 97 deaths were linked to Dr Patel and 30 patients died while directly under his care. He was convicted of the manslaughter of three patients but the conviction was later quashed by the High Court. He was permanently barred from practising medicine in Australia in 2015.

In England

Dr Harold Shipman (also known in the media as 'Dr Death') was an English general practitioner (GP) practicing in Hyde, near Manchester, since 1977. He is the only British physician ever to have been found guilty of the murder of a patient. He was convicted of 15 murders but a subsequent inquiry found that he may have killed up to 250 patients by over-prescribing and/or administering medication, usually diamorphine. Most of his victims were elderly women in good health. On his arrest in 1998 a large stash of jewelry was found in his garage.

Dr Shipman evaded detection for many years. As a GP he would certify the deaths of his patients as due to 'old age' or 'natural causes'. The bodies were often quickly cremated.^[1] His actions were finally detected when the local funeral parlour expressed concerns to the Coroner about the high death rate among Dr Shipman's patients. The area Coroner had not been in a position to see a pattern emerge as most of the deaths had not been referred to him.

The fallout

While there was no evidence that Dr Patel deliberately set out to harm patients, the result of the two doctors' actions was similar: a high number of deaths in a clinical setting that should not have occurred.

The actions of both men rocked their communities and prompted national (and international) outrage. People demanded to know how this was allowed to have happened.

So how does a government respond in such circumstances?

Hold inquiries, then legislate and regulate

In both countries expansive public inquiries were held. Reports were published and recommendations made.

In Australia, Dr Patel was one of the driving factors behind the implementation of a new national regulatory regime. The Health Practitioner Regulation National Law Act 2009 (the National Act) has been implemented in each jurisdiction. This legislation aims to ensure standardised workplace governance in health settings throughout Australia. One of the aims of the National Act is to 'provide for the protection of the public by ensuring that only health practitioners who are suitably trained and

qualified to practise in a competent and ethical manner are registered’.

In Queensland, each Hospital and Health Service is responsible for ensuring that the Department of Health’s ‘Guide to credentialing and defining scope of clinical practice for medical practitioners and dentists in Queensland 2014’ (the Guide) is implemented. One of the stated aims of the Guide closely echoes the aim of the National Act quoted above, and is expressed as ‘ensuring medical and dental services, and treatments are provided by competent, qualified and skilled practitioners suitably equipped to deliver safe and quality care’. Among other things the Guide standardises the documentation, including referrals, that has to be submitted by a practitioner to become credentialed. In addition the practitioner must advise of any limitation to their scope to practice in any other public health facility. Dr Patel may not have declared his previous practising restrictions in any event, however if the system for obtaining work references had been more stringent perhaps the executive at Rockhampton may have been tipped off regarding the problems with his practise.

In the UK the response to Dr Shipman was more retrospective, concentrating on death certification and audit more so than credentialing.^[2] This is because Shipman’s acts were deliberate, and because he was able to evade detection for so long. The Shipman Inquiry in 2002 made various recommendations in respect of death certification. In response, Parliament made changes to the Coronial regime with the introduction of a new Coroner’s Act in 2009. A recent consultation proposes a requirement for the medical cause of death as given by the certifying doctor to be sent to an independent Medical Examiner for scrutiny before the death certificate can be signed off (in cases where the death has not been reported to the Coroner). Already in place are audits of abnormally high death rates at GP practises. Has such audits been in place when Dr Shipman had been practising he would not have been able to get away with murder for as long as he did.

^[1] A second doctor was required to sign off on cremations by independently certifying the cause of death; here Dr Shipman’s colleagues implicitly trusted him and did not query his certification. Seven doctors were brought before the regulator, the General Medical Council, having signed off on 124 cremation forms listing ‘old age’ and ‘natural causes’ as the cause of death. Following investigation none of them were struck off.

^[2] There is however a new system for medical revalidation, which was in part

influenced by Shipman but also recommended by the enquiry into deaths at Mid-Staffordshire hospital.

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