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Dark Doctoring Types in Fiction and in Life

Abstract

The life of the UK general practitioner Dr Harold Shipman is one of the most important medico-moral tales of our time; not only because he was a serial killer who murdered fifteen patients and killed hundreds more; not only because his activities led directly to two public inquiries, a review of death certification and of the UK coronership, to irresistible demands for medical re-validation, and the fading of 150 years of medical self-regulation. Though Shipman's motives remain obscure he accomplished something more significant than these bureaucratic changes, some of which were in train before his activities came to light. Shipman succeeded in adding to the actual and symbolic possibilities of modern family doctoring: to one end of the spectrum of possible characteristics, preoccupations and traits that could lie behind the professional persona of the doctor, Shipman added the appetites, drives and satisfactions of the serial killer. Yet Shipman was a most popular and hard-working GP, considered by his patients an excellent doctor. How was he mistaken for a good doctor and allowed to poison with impunity? This paper investigates fictional depictions of medical figures and health care organisations where beneficence as a moral principal is centrally distorted or turned upside down, throwing into relief the extent to which symbolic configurations of doctors are equated with good and trusted work.

Imagine a world in which health care staff no longer subscribe to the principle of beneficence, or do so erratically and unpredictably. Beneficence is so often watered down by moral principles running counter to it, by respect for autonomy for example — that 'first among equals' of ethical principles¹ appealed to in justifying respect for unwise patient choices, even refusal of lifesaving treatment — that one wonders how

¹ Raanan Gillon, *Ethics Needs Principles—Four Can Encompass the Rest—and Respect for Autonomy Should Be "First among Equals*, in "Journal of Medical Ethics", 29, 2003, pp. 307-312. See also Tom L. Beauchamp, James F. Childress, *Principles of Biomedical Ethics*, Oxford University Press, Oxford, 1994, p. 260.

often beneficence as a principle is determinative of health care decisions².

Imagine now that doctors no longer manifest the character trait or disposition to act for the good of others, or that they do so only erratically. What then? What would health care look like if its principal actors embodied radically different moral virtues, dispositions and motivational drives to those commonly associated with doctoring, such as craving patient harm? It's possible to dress up malevolent intent as benevolence, for the resulting harm to be masked by inherent variabilities in health outcomes and to ascribe them to non-negligent errors. If the consequences of intending harm eventuated only intermittently, the disposition might not be apparent to standard monitoring exercises of health care processes and outcomes³.

Imagine now a darker possibility, one in which such contrarian practitioner traits are systematically directed against the medical and health care interests of patients. Not long ago a situation like this occurred within the UK National Health Service (NHS) and for a long time hardly anyone noticed⁴. It involved a GP deliberately killing his

² Robin Downie and Jane Macnaughton have argued that the obligation to act for the good of others is not very different in medicine than from any job which offers a valued service to others and seeks to promote or protect their welfare, such as working as an electrician or a plumber. They do not see beneficence as *the* defining principle of the moral organisation of health care. See Robin Downie, Jane Macnaughton (eds), *Bioethics and the Humanities: Attitudes and Perceptions*, Routledge-Cavendish, Abingdon, 2007, pp. 36-41. See also Brian Hurwitz, Alex Vass, *What's a good doctor, and how can you make one?*, in "British Medical Journal", 325, 2002, pp. 667-668.

³ Mohammed A. Mohammed, KK. Cheng, Andrew Rouse, Tom Marshall, *Bristol, Shipman and Clinical Governance: Shewhart's Forgotten Lessons*, in "The Lancet", 357, 2001, pp. 463-67; Richard Baker, David R. Jones, Peter Goldblatt, *Monitoring Mortality Rates in General Practice after Shipman*, in "British Medical Journal", 326, 2003, pp. 274-76; Paul Aylin, Nicky Best, Alex Bottle, Clare Marshall, *Following Shipman: a Pilot System for Monitoring Mortality Rates in Primary Care*, in "The Lancet", 362, 2003, pp. 485-491.

⁴ Richard Baker, *Harold Shipman's Clinical Practice 1974-1998*, Department of Health, London, 2001; Janet Smith, *The Shipman Inquiry, First Report - Death*

patients in a way that was mistaken for beneficence. He was thought by many to be a very good doctor:

I genuinely thought he was a great doctor, very intelligent. I went to see him with different things, and he always had time to talk. You would expect to be kept waiting but you accepted it because you knew he would spend time with you. There was a year-long wait to get onto his list: he was the most popular doctor in Hyde⁵.

I remember the time [he] gave to my Dad. He would come around at the drop of a hat. He was a marvellous GP apart from the fact that he killed my father⁶.

For nearly three decades the doctor concerned, Harold Shipman, continued to practise — and to kill — in seamless co-existence with the beneficence-oriented NHS⁷.

The world of such medical alterity has been little explored by bioethicists though has long provided raw materials for novelists and

Disguised, The Shipman Inquiry, Manchester, 2002; Janet Smith, *The Shipman Inquiry, Second Report – The Police Investigation of March 1998*, The Shipman Inquiry, Manchester, 2003; Janet Smith, *The Shipman Inquiry, Third Report – Death Certification and the Investigation of Deaths by Coroners*, The Shipman Inquiry, Manchester, 2003; Janet Smith, *The Shipman Inquiry, Fourth Report The Regulation of Controlled Drugs*, The Shipman Inquiry, Manchester, 2004; Janet Smith, *The Shipman Inquiry, Fifth Report – Safeguarding Patients: Lessons from the Past – Proposals for the Future*, The Shipman Inquiry, Manchester, 2004; Janet Smith, *The Shipman Inquiry, Sixth Report – Shipman: the Final Report*, The Shipman Inquiry, Manchester, 2005. (available online at: <http://webarchive.nationalarchives.gov.uk/20090808154959/http://www.the-shipman-inquiry.org.uk/reports.asp>)

⁵ Brian Whittle, Jean Ritchie, *Prescription for Murder: the True Story of Harold Shipman*, Hachette Digital, London, 2009, p. 9.

⁶ Christopher Rudol in P. Barkham, *The Shipman Report*, in “The Times”, 20 July 2002, p. 15.

⁷ Brian Hurwitz, *Healthcare Serial Killings: Was the Case of Dr Harold Shipman Unthinkable?*, in Danielle Griffiths and Andrew Sanders (eds), *Bioethics, Medicine and the Criminal Law, Volume 2: Medicine, Crime and Society*, Cambridge University Press, Cambridge, 2013, pp. 13-42.

playwrights⁸. In 1905, the Swedish writer, Hjalmar Söderberg, published *Doctor Glas*, a novel unfolding as the private diary of a GP, setting out the doctor's decision to murder a patient, the clergyman Gregorius. Glas is attracted to the parson's wife, Helga (also his patient), who has confided in him feelings of enslavement to her husband's sexual mores. Dr Glas gives Gregorius a pill telling him it is for his heart and within minutes he drops dead (from cyanide poisoning): «I heard the clergyman's tumbler fall over on the tray. I did not want to look, yet I saw his arm fall limply down and his head nod on his breast... I myself wrote out the death certificate»⁹.

Paperwork is frequently the pivotal last act of a medical murderer, in fact, and in fiction¹⁰. False death certificates ensure foul play can masquerade as a natural death, and without suspicion activate the civil mechanisms that authorise disposal of dead bodies. But as the pathologist Keith Simpson noted over thirty years ago on reviewing a life-time's experience of forensically investigating homicide, the possibility of such 'clerical doctoring' is well understood even if not always well guarded against:

Doctors are in a particularly good position to commit murder and escape detection. 'Dangerous drugs' and powerful poisons lie in their professional bags or in the surgery. No one is watching or questioning them, and a change in symptoms, a sudden 'grave turn for the worse' or even death is for them alone to interpret. They can authorize the disposal of a dead body by passing the death certificate to the

⁸A series of high profile court cases in the UK which have involved serial killing, assault and sexual assault in the past 15 years has been followed by public inquiries, see Mary Dixon-Woods, Justin Waring, Charles Bosk, *Detecting the Dodgy Doctor*, in "Risk and Regulation," Special Issue on Close Calls, Near Misses and Early Warnings, 2010, pp. 8-9. See also Richard Cooper, *Solo Doctors and Ethical Isolation*, in "Journal of Medical Ethics", 35, 2009, pp. 692-695.

⁹ Hjalmar Söderberg, *Doctor Glas*, translated from the Swedish by P.B. Austin, Harvill Press, London, 2002, p. 115.

¹⁰ In 1865 Dr Edward Pritchard murdered his wife and mother-in-law and certified both of their deaths as natural. See John Havard's detailed study, *The Detection of Secret Homicide*, Macmillan, London & New York, 1960, pp. 103, 112.

Registrar of Deaths... Are there many doctor murderers? Or are doctors above suspicion?¹¹

When *Doctor Glas* first appeared in Scandinavia it was felt to be a deeply unsettling work not simply because it featured a criminal clinician but because it laid bare a callous, calculative mentality in the confessional, first person voice of a doctor debating with himself the propriety of his malevolent intentions and motives. Similar thoughts play out in Francis Iles's 1931 novel, *Malice Aforethought*, whose opening sentences set the tone:

It was not until several weeks after he had decided to murder his wife that Dr Bickleigh took any active steps in the matter. Murder is a serious business. The slightest slip may be disastrous. Dr Bickleigh had no intention of risking disaster¹².

The novel is an exposé of the unbridled power a country general practitioner enjoyed during the interwar years, professionally and domestically, its plot turning on the doctor's developing plans to kill his wife, Julia:

Dr Bickleigh did not think of what he proposed as 'murder' at all. Not that he consciously avoided the word. He simply could not accept it. Other people 'murdered' their wives, but other people's cases were different. His case was unique...[he] was quite sure of that. ... In his duties he had put away plenty of pet animals who had passed their usefulness. Now the time had come to put Julia away¹³.

After lacing her meals daily with a drug, Juila develops severe headaches, from which she can gain relief only by taking opiates which she learns to administer herself, by injection. She becomes dependent on the injections, her husband finally administering a fatal overdose

¹¹ Keith Simpson, *Forty Years of Murder*, Harrap, London, 1978, p. 253.

¹² Francis Iles, *Malice Aforethought*, Orion, London, 1931, p. 7.

¹³ *Ibid.*, p. 130.

which he passes off as suicide. Bickleigh's transition from beneficence to maleficence involves a profound deindividuation of his wife. By divesting Julia of uniquely human qualities, he is able to flatten his conscience and reduce his sense of personal accountability for and self-monitoring of his subsequent actions. Deindividuation is a crucial part of dehumanization which takes away the humanity of victims «render[ing] them as animal like, or as nothing»¹⁴. P D James in *A Mind to Murder* (1963) makes clear that medical killings require extraordinary self-possession and imperturbability, the composure and sangfroid to continue clinical work as if nothing has happened. When in *A Mind to Murder* superintendent Dalglish is called away from a literary party to investigate the death of Miss Bolam, an administrative officer to a west London psychiatric clinic, he finds below the calm exterior of the clinic's Georgian façade a network of seething relationships. The culprit, he concludes, must be one of the clinic's staff: «Miss Bolam, dull, ordinary unremarkable Enid Bolam who had inspired so much hate in someone... As private as that unknown member of staff who would be at the clinic on Monday morning, dressed as usual, looking the same as usual, speaking and smiling as usual and who was the murderer»¹⁵.

Literary explorations of grotesque medical violations conjure up primitive fears about the loss of orderliness of health care arrangements which all too easily can become contingent, with large-scale institutions exposed as easily manipulable, subject to gaming and to disruption by agents not signed up to the core values of health care. *A Paper Mask* (1987) reveals how feasibly medical power can be assumed and wielded without proper authority. John Collee's novel concerns Mathew Harris, a hospital porter who on clearing the bedroom of a London doctor who has recently died in a road traffic accident decides to steal his

¹⁴ Philip Zimbardo, *The Lucifer Effect. How Good People Turn Evil*, Random House, London, 2007, p. 291.

¹⁵ P.D. James, *A Mind to Murder*, Faber and Faber, London, 2010, p.148.

medical certificates and assume the doctor's identity¹⁶. Readers are taken through the web of deceit Harris constructs and lives out in simulating a junior hospital doctor. Having worked as a porter Harris has an insider's understanding of the complex organisational culture and workings of a hospital. Starting work in a casualty with only the training provided by reading a few hastily gathered textbooks, he ends up harming whomever he attends to and treats. Harris is able to cover his tracks because he gains the support of a highly competent nurse, who mistakes his total ignorance for inexperience and the results of a poor medical education, and through quickly learning how to skirt around the hospital's investigative procedures. He eventually kills his consultant's wife by recklessly administering an intravenous local anaesthetic whilst preparing to manipulate her broken wrist (he omits to tourniquet her arm and the anaesthetic enters her circulation in one go, which causes her heart to stop).

Ease of gaining access to the inner workings of a hospital for purposes quite counter to its primary purpose is the investigative dynamic of Robin Cook's thriller, *Coma* (1977), in which a medical student finds that a hospital's oxygen supply has been reengineered — tampered with — to deliver intermittent shots of carbon monoxide to people undergoing routine, elective surgery¹⁷. Patients exit uncomplicated operations in coma and brain dead, after which they are transferred to the Jefferson Institute, a medical facility that elaborately preserves and warehouses heart-beating cadavers for their stem cells and organs.

Catherine Belling, a medical humanities scholar, argues for the need to get beyond a conception of fiction in the context of the clinic understood as fantasy and 'fanciful escape', to appreciate such imaginative works as a means «to apprehend (often anxiously) the realities we cannot grasp in other ways»¹⁸. Such narratives create versions of a fully

¹⁶ John Collee, *A Paper Mask*, Viking, London, 1987.

¹⁷ Robin Cook, *Coma*, Little Brown & Co, Boston, 1977.

¹⁸ Catherine Belling, *Depth Perception*, in "Genre", 44, 3, 2013, p. 260.

functioning health care system but in antisense form, and feature health care actors of different moral outlook and calibre to those entrusted with medical care in real life. An example is Louis-Ferdinand Céline's Dr Ferdinand. In his novel, *Death on Credit* (1936), Céline creates a Parisian GP openly frustrated with his practice and patients: «“Oh, Doctor, please come, I beg of you!.. My little girl, my Alice... it's on rue Rancienne, just around the corner...”. I didn't have to go. My office hours were over... I'm fed up with sick people.[...] Let them cough. Let them spit. Let their bones fall apart. To hell with them»¹⁹. Dr Ferdinand's thoughts and feelings, reflected in a jumpy inner voice, disaggregate and go against expectations of the moral character of a modern medical practitioner. Though doctors may indeed grapple with extreme feelings and contradictory thoughts, outside fiction the sentiments uppermost in Ferdinand's mind are rarely expressed uncensored. Such sentiments deeply threaten cultural images and professional stereotypes of good doctoring, and trespass on protected notions of the virtuous medical practitioner²⁰.

In terms of the moral goals of health care professionals set out by the UK medical regulator in its guidance *Good Medical Practice* (2013), these fictional works narrate health care arrangements of a wholly different order to those at work in the familiar realm of real life²¹. In effect, they hypothesise novel health scenarios as detailed thought experiments, demanding readers question, interpret and judge their protagonists against the moral coordinates from an alternative medical realm, but one which shares many characteristics of real health care structures, and force engagement with harmful medical care. Prior to the rise of interest in medical errors and patient safety such modes of

¹⁹ Louis-Ferdinand Céline, *Death on Credit*, One World Classics, London, 2009, pp. 4-5.

²⁰ Jeremy Holmes, *Good Doctor, Bad Doctor—a Psychodynamic Approach*, in “British Medical Journal”, 325, 2002, p. 722.

²¹ General Medical Council, *Good Medical Practice*, General Medical Council, London, 2013.

health care gained little attention or scrutiny²². Medical care is clearly not a novel, but fictional worldmaking can help in understanding frighteningly dark counterparts to fictional care that operate in the real world²³.

Harold Shipman killed 240 of his patients in a career that started in 1970 and ended in 1998. He killed them when working as a junior hospital doctor and later as a GP first in West Yorkshire, and then in Hyde, Greater Manchester²⁴. None of his victims were terminally ill or in intractable pain. Years after his murder convictions, Dame Janet Smith, who chaired the Public Inquiry into Shipman's activities, had still not assimilated or fully grasped the enormity of his significance:

I still do feel it was unspeakably dreadful, just unspeakable and unthinkable and unimaginable that he should be going about day after day pretending to be this wonderfully caring doctor and having with him in his bag his lethal weapon ...which he would just take out in the most matter of fact way²⁵.

The patient group in which most killings occurred was women aged seventy-five years or over, but Shipman also killed men who made up nearly a quarter of his victims; three men were his first certain killings which took place in Pontefract Infirmary, but he also killed people under sixty-five — some in their fifties and forties — and there is

²² Brian Hurwitz, Aziz Sheikh, *Medical Fallibility – Cultural Recognition and Representation*, in “Journal of the Royal Society of Medicine”, 102, 2009, pp. 181-185.

²³ Margaret MacDonald, *The Language of Fiction*, in “Proceedings of the Aristotelian Society”, Supplementary Volumes, 28, 1954, pp. 165-196; L.B. Cebik, *The World is not a Novel*, in “Philosophy and Literature”, 16, 1, 1992, pp. 68-87; Eileen John, *Reading Fiction and Conceptual Knowledge: Philosophical Thought in Literary Context*, in “The Journal of Aesthetics and Art Criticism”, 56, 4, 2013, pp. 331-348.

²⁴ Richard Baker, *Harold Shipman's Clinical Practice* cit.; Janet Smith, *The Shipman Inquiry, First Report* cit.

²⁵ Janet Smith, *Moving On: the Medical Profession after Shipman*, John Hunt Lecture to the Royal College of General Practitioners, London, 2005.

«cause for suspicion» that he killed a four year-old child in hospital²⁶. Overall, Dame Janet Smith's Inquiry delivered one hundred and eighty verdicts of «unlawful killing» and found «cause for suspicion of unlawful killing» in a further forty-five, by which it meant «Shipman probably killed the patient», a verdict, the Inquiry spelt out, which was settled on only «where the evidence was clearly weighed on the side of guilt»²⁷. Adding this tally to the fifteen murders he was found guilty of in a court of law — based on exhumations of a small number of his victims — brings his total known killings to 240.

Years after his arrest, as we have seen, Dame Janet Smith found in Shipman something that continued to be 'unspeakable', 'unthinkable' and 'unimaginable'. His lethal weapon was a syringe loaded with intravenous diamorphine — heroin. His victims, typically alone at home in the afternoon when he called on some pretext or other, would have believed he was offering a healthful injection. Shipman would either report the death as occurring in his presence, for example from a heart attack or stroke, or leave the body to be found later in the day by a relative or friend. On returning to the house later in the day he would advise relatives that he had recommended hospital admission on his earlier visit but the patient unfortunately had declined it. He would then complete the death certificate giving a plausible but fabricated story of pre-existing disease, and press the relatives to cremate the body, thereby destroying toxicological evidence.

The barrister and psychiatrist Dr B Mahendra has argued that «[t]he complacent view of the medical profession is that Shipman was a purveyor of evil, a perverted “one-off”»²⁸, a focus that may have seemed attractive because it detracted from the centrally important question of how he was able routinely to operate for so long undetect-

²⁶ Janet Smith, *The Shipman Inquiry, Sixth Report* cit.

²⁷ Janet Smith, *The Shipman Inquiry, First Report* cit.

²⁸ Bala Mahendra, *Killer Facts, Could There Be Another Shipman?*, in “New Law Journal”, 2002, 1189.

ed in the NHS²⁹. As I have argued elsewhere, serial killing can only ever become routine in a system where obstacles to its accomplishment — as in the novel *Coma* — have been fully and comprehensively evaded, «where all, or almost all, health service and civil systems for monitoring a doctor’s activities — especially around the time of a patient’s death — are so inadequate... as to allow murder in the same way, by the same means, by the same man, to become repeated and established over decades»³⁰.

Equating Shipman with evil understandably directs attention to the type of person Shipman appeared to be whilst distracting attention from scrutiny of health care procedures. Biographical and psychological explanations of Shipman’s activities have searched in vain for the causal origins of his activities but have not got beyond the speculative: he never admitted wrongdoing, showed no remorse, would not speak to psychiatrists, refused to cooperate with the Public Inquiry, and his family since his imprisonment has never shed light on his personal world or values (Shipman committed suicide in Wakefield Prison in January 2004). No credible link can be established between Shipman’s psychological state, drive, sense of purpose or motive and his clinicidal

²⁹ Liam Donaldson, *Foreword*, in Richard Baker, *Harold Shipman’s Clinical Practice* cit., p. iv. Sir Liam Donaldson, the Chief Medical Officer of England, who commissioned the Department of Health’s inquiry into Shipman’s practice, wrote in its *Foreword* that ‘everything points to the fact that a doctor with the sinister and macabre motivation of Harold Shipman is a once in a lifetime occurrence’, a contention at the time that was shared by others such as James Pollard, *The Shipman Case and its Legacy*, in “Medico-Legal Journal”, 71, 2003, pp. 47-60 and Alec Samuels, *Doctor Harold Shipman*, in “Medico-Legal Journal”, 68, 2000, pp. 37-38.

³⁰ Richard Baker, Brian Hurwitz, *Intentionally Harmful Violations and Patient Safety: the Example of Harold Shipman*, in Brian Hurwitz, Aziz Sheikh (eds), *Health Care Errors and Patient Safety*, BMJ Books, Wiley Blackwell, Oxford, 2009, pp. 33-55; Richard Baker, Brian Hurwitz, *Intentionally Harmful Violations and Patient Safety: the Example of Harold Shipman*, in “Journal of the Royal Society of Medicine”, 102, 2009, pp. 223-7.

programme³¹. It is therefore not possible reliably to bring his actions into relationship with anything about him that is understood. He is a professional pariah who was evil in Terry Eagleton's explication of the term, as a quality that has «no relations to anything beyond itself, such as a cause»³². Such evil reflects the fact that Shipman's killings are strictly incomprehensible, akin to the un-integratable 'other' Levinas identified with «radical evil»³³.

Does it help to see Shipman's alterity through a fictional lens? Fictional works and fantasies can conjure up a realm behind the idealised, comforting figures of the trustworthy and caring doctor, an imaginary netherland where outlandish, murderous medics and hoax clinicians lurk. One way to «understand people's behaviour in terms of virtues and vices» argues the philosopher Bernard Williams, «is in terms of stereotypes or standard images... rang[ing] from crude 'characters' and more individuated outlines constructed with the help of type drawn, often, from fiction»³⁴. This is not to endow fiction with the same sort of wordly referentiality as a witness statement or a history. Though fiction on occasion may happen to perform the unforeseeable and help to make the unthinkable conceivable, it cannot stand-in for the missing inner life and motives of a particular criminal such as Harold Shipman.

³¹ Rob Kaplan, *Medical Murder: Disturbing Cases of Doctors Who Kill*, Summersdale Publishers, West Sussex, 2010, p. 8; Rob Kaplan, *The Clinicide Phenomenon: an Exploration of Medical Murder*, in "Australasian Psychiatry", 15, 2007, pp. 299-304; Herbert Kinnell, *Serial Homicide by Doctors: Shipman in Perspective*, in "British Medical Journal", 321, 2000, 1594-1597; Beatrice Yorker, Kenneth Kizer, Paula Lampe, A.R.W. Forrest, Jacquetta Lannan, Donna Russell, *Serial Murder by Healthcare Professionals*, in "Journal of Forensic Science", 51, 6, 2006, 1362-1371.

³² Terry Eagleton, *On Evil*, Yale University Press, New Haven, 2010, p. 3.

³³ Richard Bernstein, *Radical Evil, a Philosophical Interrogation*, Polity Press, Cambridge, 2002, p. 11, quoting Emmanuel Levinas (trans. A. Lingis), *Transcendence and Evil*, in Anna-Teresa Tymieniecka (ed.), *The Phenomenology of Man and the Human Condition*, in "Analecta Husserliana", 14, 1983, pp. 158.

³⁴ Bernard Williams, *Ethics*, in Anthony Clifford Grayling (ed.), *Philosophy: a Guide through the Subject*, Oxford University Press, Oxford, 1995, pp. 574.

The imaginative works discussed so far reveal cultural ambivalences associated with doctoring and schematically outline tensions between benevolent and malevolent stereotypes in medicine. Shipman can be seen to have embodied such tensions in a highly intensified form. Emerging from a UK medical school to become a respected figure within the NHS locally, he displayed qualities clearly valued by his patients. Even after his convictions, as we have seen, some of his patients remained strikingly complimentary about him.

Fictional, philosophical and testimonial considerations suggest a type-antitype approach to understanding Shipman's alterity as a killer who was also thought a good doctor. An antitype is something 'shadowed forth' in the guise of the type. The term comes from the Latin *antitypus*, meaning «responding as an impression to the die»³⁵, formed by the structures, processes and values which shape the type. Antitypes display contrastive features of the type which are «always more intense and more significant than their types»³⁶. Shipman's willingness to visit people at home — even without being requested to — was just such a distinctive and contrastive feature of a GP. In relation to twentieth century general practice, where home visiting rates have continuously declined over the last half century, Shipman was an outlier. He could invite himself round to people's homes on almost any pretext and ask them to roll-up their sleeves in the false expectation of a healthful injection, when he would have seen the unquestioning looks in their eyes as he felt their pulse and eyed their breathing, as both drained painlessly away.

The pattern of deaths in Shipman's practice was starkly different to that of the general population. Although this only became clear in the

³⁵ *Oxford English Dictionary Online* (Oxford University Press, Oxford, 2011), <http://www.oed.com/view/Entry/8913?redirectedFrom=antitype#eid>.

³⁶ David Berkeley, *Some Misapprehensions of Christian Typology in Recent Literary Scholarship*, in "Studies in English Literature 1500-1900", 18, 1978, pp. 3-12.

enquiries which followed his convictions³⁷, deaths in Shipman's practice peaked on weekdays between 1pm and 6pm (twelve percent died around 2pm), the time when he routinely undertook home visits, (compared with two percent in comparator practices) and were lower than the average on Sundays when he was generally not at work. A review of his clinical notes found he had been present at the bedside in nineteen percent of deaths compared with a GP presence in comparator practices of only one percent, and relatives or carers were half as likely to have been present at the deaths of his patients than at deaths in comparator practices (40.1 percent *v.* 80 percent). In Shipman's practice, the proportion of people dying quickly — in less than thirty minutes — was nearly three times that of comparator practices.³⁸

For Shipman, murder was not something that had to be 'fitted in' to the interstices of the health care system. Killing, for him, was a regular and mainstream component of his daily work, a routine expression of the health care system's 'normal operation', wherever he worked in the system. The number of healthcare professionals found by the courts to have committed clinicide worldwide challenges the view that Shipman was only a 'one off'. In 2006, a group of US researchers reported that between 1990-2006 ninety health professionals had faced (or awaited) the outcome of prosecutions for serial killing. Of these, forty-five had been convicted and twenty-four either were awaiting trial or the outcome had not been published:

Injection was the main method used ... followed by suffocation, poisoning, and tampering with equipment. Prosecutions were reported from twenty countries with

³⁷ Richard Baker, David R. Jones, Peter Goldblatt, *Monitoring mortality rates*, cit.; Mohammed A. Mohammed, KK. Cheng, Andrew Rouse, Tom Marshall, *Bristol, Shipman and Clinical Governance* cit.; Paul Aylin, Nicky Best, Alex Bottle and Claire Marshall, *Following Shipman* cit.

³⁸ Richard Baker, *Harold Shipman's Clinical Practice* cit.; Janet Smith, *The Shipman Inquiry, First Report* cit.; E.G. Knox, *An Epidemic Pattern of Murder*, in "Journal of Public Health Medicine," 24, 2002, pp. 34-37.

forty percent taking place in the United States. Nursing personnel comprised eighty-six percent of the healthcare providers prosecuted; physicians twelve percent and two percent were allied health professionals. The number of patient deaths from murder was equal to 317 and the number of suspicious patient deaths 2113³⁹.

Shipman is not alone, therefore, in adding to fictional depictions the habits and propensities of today's medical murderer. Such a strange and hybrid figure is not easily amenable to any sort of analysis as he seems to subsist beyond the horizon of the real. Fiction in its world-making can incorporate such figures, and to the extent that the Medical Humanities⁴⁰ offer any useful insights they rest on taking into account the fictional as well as the real.

³⁹ Beatrice Yorker, Kenneth Kizer, Paula Lampe, ARW Forrest, Jacquetta Lannan, Donna Russell, *Serial Murder by Healthcare Professionals* cit., 1363.

⁴⁰ Brian Hurwitz, *Medical Humanities: Lineage, Excursionary Sketch and Rationale*, in "Journal of Medical Ethics", 39, 2013, pp. 672-674.

BIBLIOGRAPHY

- AYLIN, P., BEST, N., BOTTLE, A., MARSHALL, C. (2003), *Following Shipman: a Pilot System for Monitoring Mortality Rates in Primary Care*, in "Lancet", 362, pp. 485-491.
- BAKER, R., (2001), *Harold Shipman's Clinical Practice 1974–1998*, Department of Health, London.
- BAKER, R., JONES, D.R., GOLDBLATT, P. (2003), *Monitoring Mortality Rates in General Practice after Shipman*, in "British Medical Journal", 326, pp. 274-76.
- BAKER, R. HURWITZ, B. (2009), *Intentionally Harmful Violations and Patient Safety: the Example of Harold Shipman*, in Hurwitz, B., Sheikh, A. (eds), *Health Care Errors and Patient Safety*, BMJ Books, Wiley Blackwell, Oxford, pp. 33-55.
- BAKER, R. HURWITZ, B. (2009), *Intentionally Harmful Violations and Patient Safety: the Example of Harold Shipman*, in "Journal of the Royal Society of Medicine", 102, pp. 223-7.
- BEAUCHAMP, T.L., CHILDRESS, J.F. (1994) *Principles of Biomedical Ethics*, Oxford University Press, Oxford.
- BELLING, C. (2013), *Depth Perception*, in "Genre", 44, 3, pp. 239-261.
- BERKELEY, D. (1978), *Some Misapprehensions of Christian Typology in Recent Literary Scholarship*, in "Studies in English Literature 1500-1900," 18, pp. 3-12.
- BERNSTEIN, R. (2002), *Radical Evil, a Philosophical Interrogation*, Polity Press, Cambridge.
- CEBIK, L. B. (1992), *The World is not a Novel*, in "Philosophy and Literature", 16, 1, pp. 68-87.
- CELINE, L.F. (2009), *Death on Credit*, One World Classics, London.
- COLLEE, J. (1987), *A Paper Mask*, Viking, London.
- COOK, R. (1977), *Coma*, Little Brown & Co, Boston.
- COOPER, R. (2009), *Solo Doctors and Ethical Isolation*, in "Journal of Medical Ethics", 35, pp. 692-695.

- DIXON-WOODS, M., WARING, J., BOSK, C. (2010), *Detecting the Dodgy Doctor*, in “Risk and Regulation,” Special Issue on Close Calls, Near Misses and Early Warnings, pp. 8-9.
- DOWNIE R., MACNAUGHTON J. (eds) (2007), *Bioethics and the Humanities: Attitudes and Perceptions*, Routledge-Cavendish, Abingdon.
- EAGLETON, T. (2010), *On Evil*, Yale University Press, New Haven.
- GENERAL MEDICAL COUNCIL (2013), *Good Medical Practice*, General Medical Council, London.
- GILLON, R. (2003), *Ethics Needs Principles—Four Can Encompass the Rest—and Respect for Autonomy Should Be “First among Equals”*, in “Journal of Medical Ethics”, 29, pp. 307–312.
- HAVARD, J. (1960), *The Detection of Secret Homicide*, Macmillan, London & New York.
- HOLMES, J. (2002), *Good Doctor, Bad Doctor—A Psychodynamic Approach*, in “British Medical Journal”, 325, p. 722.
- HURWITZ, B., VASS, A. (2002), *What’s a Good Doctor, and How Can You Make One?* in “British Medical Journal,” 325, pp. 667-668.
- HURWITZ, B., SHEIKH, A. (2009), *Medical Fallibility – Cultural Recognition and Representation*, in “Journal of the Royal Society of Medicine”, 102, pp. 181-185.
- HURWITZ, B. (2013), *Healthcare serial killings: Was the case of Dr Harold Shipman unthinkable?* in GRIFFITHS, D., SANDERS, A. (eds), *Bioethics, medicine and the criminal law, Volume 2: Medicine, crime and society*, Cambridge University Press, Cambridge.
- HURWITZ, B. (2013), *Medical Humanities: Lineage, Excursionary Sketch and Rationale*, in “Journal of Medical Ethics”, 39, pp. 672-674.
- ILES, F. (1931), *Malice Aforethought*, Orion, London.
- JAMES, P.D. (2010), *A Mind to Murder*, Faber and Faber, London.
- JOHN, E. (2013), *Reading Fiction and Conceptual Knowledge: Philosophical Thought in Literary Context*, “The Journal of Aesthetics and Art Criticism”, 56, 4, pp. 331-348.

- KAPLAN, R. (2007), *The Clinicide Phenomenon: an Exploration of Medical Murder*, in “Australasian Psychiatry”, 15, 299-304.
- KAPLAN, R. (2010), *Medical Murder: Disturbing Cases of Doctors Who Kill*, Summersdale Publishers Ltd., West Sussex.
- KINNELL, H. (2000), *Serial Homicide by Doctors: Shipman in Perspective*, in “British Medical Journal”, 321, 1594-1597.
- KNOX, E.G. (2002), *An Epidemic Pattern of Murder*, in “Journal of Public Health Medicine,” 24, pp. 34-37.
- LEVINAS, E. (1983), *Transcendence and Evil*, in A.T. Tymieniecka (ed.), *The Phenomenology of Man and the Human Condition*, in “Analecta Husserliana”, 14, pp. 153-165.
- MACDONALD, M. (1954), *The Language of Fiction*, in “Proceedings of the Aristotelian Society”, Supplementary Volumes, 28, pp. 165-196.
- MAHENDRA, B. (2002), *Killer Facts, Could There Be Another Shipman?*, in “New Law Journal,” 1189.
- MOHAMMED, M.A., CHENG, KK., ROUSE, A., MARSHALL, T. (2001), *Bristol, Shipman and Clinical Governance: Shewhart’s Forgotten Lessons*, in “Lancet”, 357, pp. 463–67.
- POLLARD, J. (2003), *The Shipman Case and its Legacy*, in “Medico-Legal Journal”, 71, pp. 47-60.
- RUDOL, C. in BARKHAM, P. (2002), *The Shipman Report*, in “The Times”, 20 July, p. 15.
- SAMUELS, A. (2000), *Doctor Harold Shipman*, in “Medico-Legal Journal”, 68, pp. 37-38.
- SIMPSON, K. (1978), *Forty Years of Murder*, Harrap, London.
- SMITH, J. (2002), *The Shipman Inquiry, First Report – Death Disguised*, The Shipman Inquiry, Manchester.
- SMITH, J. (2003), *The Shipman Inquiry, Second Report – The Police Investigation of March 1998*, The Shipman Inquiry, Manchester.
- SMITH, J. (2003), *The Shipman Inquiry, Third Report – Death Certification and the Investigation of Deaths by Coroners*, The Shipman Inquiry, Manchester.

- SMITH, J. (2004), *The Shipman Inquiry, Fourth Report The Regulation of Controlled Drugs*, The Shipman Inquiry, Manchester.
- SMITH, J. (2004), *The Shipman Inquiry, Fifth Report – Safeguarding Patients: Lessons from the Past – Proposals for the Future*, The Shipman Inquiry, Manchester.
- SMITH, J. (2005), *The Shipman Inquiry, Sixth Report – Shipman: the Final Report*, The Shipman Inquiry, Manchester.
- SMITH, J. (2005), *Moving On: the Medical Profession after Shipman*, John Hunt Lecture to the Royal College of General Practitioners, London.
- SODERBERG, H. (2002), *Doctor Glas*, translated from the Swedish by P.B. Austin, Harvill Press, London.
- WHITTLE, B., RITCHIE, J. (2009), *Prescription for Murder: the True Story of Harold Shipman*, Hachette Digital, London.
- WILLIAMS, B. (1995), *Ethics*, in Grayling, A.C. (ed.), *Philosophy: a Guide through the Subject*, Oxford University Press, Oxford, pp. 546-582.
- YORKER, B., KIZER, K., LAMPE, P., FORREST, A.R.W., LANNAN, J., RUSSELL, D. (2006), *Serial Murder by Healthcare Professionals*, in “Journal of Forensic Science”, 51, 2, 1362-1371.
- ZIMBARDO, P. (2007), *The Lucifer Effect. How Good People Turn Evil*, Random House, London.
- Oxford English Dictionary Online* (2011), Oxford University Press, Oxford, <http://www.oed.com/>