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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

often beneficence as a principle is determinative of health care deci-
sions\(^2\).

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 errati-
cally. What then? What would health care look like if its principal ac-
tors embodied radically different moral virtues, dispositions and moti-
vational drives to those commonly associated with doctoring, such as
craving patient harm? It’s possible to dress up malevolent intent as be-
nevolence, 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 outcomes\(^3\).

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 oc-
curred within the UK National Health Service (NHS) and for a long
time hardly anyone noticed\(^4\). 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 Ma-
naughton (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 Jou-

\(^3\) Mohammed A. Mohammed, KK. Cheng, Andrew Rouse, Tom Marshall, *Bristol,
Shipman and Clinical Governance: Shewhart’s Forgotten Lessons*, in “*The Lancet*”,
Mortality Rates in General Practice after Shipman*, in “*British Medical Journal*”,
326, 2003, pp. 274-76; Paul Aylin, Nicky Best, Alex Bottle, Clare Marshall, *Follow-
ing Shipman: a Pilot System for Monitoring Mortality Rates in Primary Care*, in “The

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 bio-ethicists though has long provided raw materials for novelists and

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playwrights\textsuperscript{8}. In 1905, the Swedish writer, Hjamar Söderberg, published \textit{Doctor Glas}, a novel unfolding as the private diary of a GP, setting out the doctor’s decision to murder a patient, the clergymen 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 clergymen’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»\textsuperscript{9}.

Paperwork is frequently the pivotal last act of a medical murderer, in fact, and in fiction\textsuperscript{10}. 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

\textsuperscript{8}A 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, \textit{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, \textit{Solo Doctors and Ethical Isolation}, in “Journal of Medical Ethics”, 35, 2009, pp. 692-695.


\textsuperscript{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, \textit{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, Julia 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

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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 Dalgliesh 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

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medical certificates and assume the doctor’s identity\textsuperscript{16}. 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, \textit{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 surgery\textsuperscript{17}. 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»\textsuperscript{18}. Such narratives create versions of a fully

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 practitioner[^20].

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 life[^21]. 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

health care gained little attention or scrutiny\textsuperscript{22}. 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 world\textsuperscript{23}.

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 Manchester\textsuperscript{24}. 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 way\textsuperscript{25}.

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

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«cause for suspicion» that he killed a four year-old child in hospital. 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».

Adding this tally to the fifteen murders he was found guilty of in a court of law — based on exhumations of a small number if 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”»; 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-

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ed in the NHS. 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».

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

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 programme\textsuperscript{31}. 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»\textsuperscript{32}. Such evil reflects the fact that Shipman’s killings are strictly incomprehensible, akin to the un-integratable ‘other’ Levinas identified with «radical evil»\textsuperscript{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»\textsuperscript{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.


\textsuperscript{32} Terry Eagleton, On Evil, Yale University Press, New Haven, 2010, p. 3.


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


\(^{36}\) 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 convictions\textsuperscript{37}, 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\textsuperscript{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


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.

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