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Review Article

Christopher Duntsch: A Review of Clinicide

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ABSTRACT

The surgical disasters of neurosurgeon Christopher Duntsch led to his jailing in 2017, setting a legal precedent. Dr. Duntsch came from a good family and showed considerable potential at medical school. However, during training for neurosurgery he followed a research path and did fewer operations than most trainees.

When he got to Dallas, Duntsch got a highly paid hospital position but his surgery was disastrous, leaving 33 out of 38 patients with serious problems, including two dead and one a quadriplegic, before he was stood down.

Keywords: Neurosurgery; Drug abuse; Clinicide

INTRODUCTION

Duntsch's path of destruction was characterised by egomania, deception, erratic behaviour, and alcohol and drug abuse. His career was facilitated by inaccurate references and repeated system failures.

Dr. Duntsch's case is consistent with treatment clinicide-the unnatural death of multiple patients in the course of treatment by a doctor [1].

A review of the concept of clinicide is provided. His case shows some similarities and overlaps with that Harold Shipman, Michael Swango and Jayant Patel.

While knowledge of clinicide may help to understand the path followed by these doctors, one factor that cannot be controlled is their ability to get past regulatory restrictions.

LITERATURE REVIEW

Neurosurgeon Christopher Duntsch, whose trail of surgical catastrophes led to his jailing in 2017, continues to attract attention with the release of a STAN documentary series [2]. The series has the innocuous title of Dr. Death [3], in keeping with its sensational nature, but there is no ignoring the trail of carnage Duntsch left in his wake, including two deaths, a quadriplegic and five serious neurological injuries, amounting to serious problems in 33 out 38 surgeries before he was prevented from operating.

From this point followed a series of professional defenestrations: removal of hospital privileges, loss of registration, civil litigation and, finally, a criminal trial. In one startling case, authorities allege he operated on his friend Jerry Summers after the two had stayed up all night taking cocaine. The surgery was a travesty, leaving Summers a quadriplegic [4]. Later he was to say said, 'I know (Dr. Duntsch) would never do this to me on purpose' [4], an example of the charismatic hold that Duntsch held over him.

His career crashing around him, Duntsch imploded. Struggling financially, he was convicted for drink-driving, then arrested to trying to kidnap his child from his partner's sister, finally a bizarre attempt at shoplifting in front of the security cameras before declaring bankruptcy. Then he was picked up wandering near a North Dallas bank and evaluated at a psychiatric hospital.

An email that Duntsch sent became notorious: He was "... ready to leave the love and kindness and goodness and patience that I mix with everything else that I am and become a cold-blooded killer" [5]. Sensational as this was, and damning as well at his trial, not too much should be made of this. Vainglorious as Duntsch was, it would be just the kind of statement he was expected to make when off his face with drugs and alcohol.

As the net tightened around him, Duntsch may have thought that Texan tort reform laws were in his favour. The reformed law capped the amount that patients can sue for at $250,000 and hospitals have to show that it was intended to harm a patient in appointing a physician [6]. What he did not expect was that it would go beyond civil suits. Such was his misconduct that the law laid criminal charges.

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Duntsch was charged with five counts of aggravated assault causing serious bodily injury and one count of injuring an elderly person, arising from the maiming of his patient Mary Efurd [7]. In a step that may have sealed the case against him the judge decided to accept evidence of the other cases that he had mangled to be introduced at the trial.

At the trial, Duntsch's father Don told how his son was an authority on stem cells and did cancer research. Far from lack of concern, he had called him in some distress after some of the operations. "I think that, as things began to fall apart, the only thing he knew was to try harder," Don Duntsch said.

It did not help his son.

On February 14, 2017, Duntsch was found guilty of injury to an elderly person [8]. Sentenced to life, he is not eligible for parole until 2045. It is believed to be the first time that a physician has been convicted on criminal charges for actions in the course of his medical work [9].

Is there anything in Duntsch's background to explain his path of surgical destruction? The oldest of four children, Duntsch had a comfortable upbringing in Memphis. His father Donald was a missionary and physical therapist, his mother a teacher. At the University of Memphis he decided to be a professional footballer [10]. It was soon obvious that he had neither the physique nor the talent. Duntsch refused to accept this for a long time, going to extraordinary lengths to convince his coaches that he had the necessary ability. Herein lies a pointer to what followed: an obdurate nature combined with sky-high ambition. The latter itself is not a problem, if not an asset, in most people but they usually have recognition of the limits to which they can go. It took far too long for Duntsch to accept the inevitable, whereupon he changed to medicine.

Why medicine? Again, an admirable goal deserving credit. There is no reason why a sportsman should not go into medicine [11] (many, for example, become orthopaedic surgeons), but could it be that Duntsch's career choice was driven by his need for achievement and recognition?

It was soon to follow. Duntsch was a top student at the University of Tennessee Health Science Centre, achieving high grades, showing that high intelligence was no protection against the path he was to follow. But the signs of dissolution where already present. Sex, drugs and rock and roll were made for Duntsch who was the ultimate party animal.

Gaining his MD, Duntsch did a six-year surgical residency at the Semmes Murphey Neurologic & Spine Clinic. This was an approved course to train in neurosurgery. During the program he was appointed director of the school's tissue bank, earning over $3 million in research funding. Duntsch had followed a research trajectory, publishing papers and successfully running several biomedical companies. There was no doubting his intellect and ability in this field. The promising research career, however, ended badly [11]. He was sued, then removed as board member and chief science officer of Discgenics, the company he founded, later filing for bankruptcy. His research career was over.

During his training, Duntsch was reported to be taking LSD, prescription painkillers and snorting cocaine. When he refused to take a drug test, he was required to do an impaired physician program but able to complete his residency. For his final year he was restricted from operating independently, an ominous portent.

Thus surgery was a supplementary activity to research during his training and Duntsch did far fewer operations than usually required in training (reports vary on how many he did, but they were significantly less). That he needed to be supervised was hardly a prelude to a brilliant career, raising doubts whether he would be allowed to qualify, although he eventually did.

At this stage, the red flags were already waving. Drug abuse, poor surgical technique and disputes with his research workers (plus false claims) should not only have caused alarm but have been indicated on his references. Why he was allowed to qualify as a neurosurgeon when having done so few operations remains a mystery.

Undeterred, spinal surgery then beckoned and Duntsch arrived in Texas in May 2011. Dr. Michael Rimlawi and Dr. Douglas Won recruited him to join the Minimally Invasive Spine Institute at the Semmes Murphey Neurologic & Spine Clinic in Dallas with privileges to operate at Baylor Plano Centre following in November 2011. Typically, Duntsch announced himself with: "Everybody's doing it wrong. I'm the only clean minimally invasive guy in the whole state" [12].

To get the job Duntsch needed a testimonial of his suitability and duly provided one by Dr. Jon Robertson, chair of the department of neurosurgery at the University of Tennessee, stating (in a masterpiece of understatement): "His work ethic, character, and ability to get along with others were beyond reproach." There was no mention of the problems that had emerged during his training.

Duntsch added to the deception by falsely claiming he had a doctorate in microbiology which was never checked at the time.

Another system failure.

Why did he choose neurosurgery? Duntsch was hardly the type to settle for a quiet family medicine practice. Going back to the days of Harvey Cushing, neurosurgery was the most prestigious specialty. Some regard it as the ultimate form of precision surgery, requiring the highest skill and dedication, attracting individuals characterised by their combative approach to take on the great challenges. In Sydney, for example, Dr. Charlie Teo became a celebrity neurosurgeon for his work on cerebral tumours, the attendant publicity not necessarily always to his advantage [13].

Duntsch's case attracted much comment and even more speculation. The predictable psychiatric disorders were wheeled out: Sociopath, psychopath, narcissist-with little consideration of what criteria were required to make such diagnoses and fulfilling the psychobabble of public discourse that throws such labels around with little consideration of their implications.

More critical attempts were made to understand Duntsch's trajectory and why he had not been stopped earlier when the red

flags were evident. The transmission (or, more accurately, the non-transmission) of information between different institutions and jurisdictions; the failure of medical regulation; reluctance of doctors to report on colleagues; overlooking of problems by a huge medical insurance company to ensure the continuing work of a high-income generating surgeon. In short, widespread system failures.

All of this is relevant, but leaves a question: can the behaviour of such doctors-not as uncommon as people like to believe-be predicted?

Duntsch joins the ranks of Dr. Harold Shipman and his epigones. Shipman, a GP in the town of Hyde, Manchester, was found guilty of killing 15 of his patients, aged 49-83, by lethal injections of heroin on the grounds of taking a blood specimen or injecting a drug. Investigations found that Shipman had killed 246 patients (some believe the figure as high as 400) in a career that went back to his internship, making him the most prolific serial killer in English history.

Dr. Liam Donaldson, chief medical officer of the NHS, responded to Shipman's hecatombs with a statement that he may regret: "Everything points to the fact that a doctor with the sinister and macabre motivation of Harold Shipman is a once in a lifetime occurrence" [14].

As events were to show-if only. During much of the same time as Shipman was killing, in America trainee neurosurgeon Michael Swango was killing hospital patients, moving from one state to another (then Zimbabwe and Zambia), estimated to be 60 patients before his arrest put an end to the killing.

Consideration of these murders led to a study of doctors who kill, culminating in the book Medical Murder: Disturbing Tales of Doctors who Kill [15]. Murderous doctors were not new and there were different manifestations of their modus operandi-to resort to forensic parlance.

Peter Smerick, FBI criminal profiler, describes two types of medical killers:

The Hero Killer doctor would put a patient under great risk. If they save the patient, they are a hero. If the patient dies, the killer will say, "so what?"

The Mercy Killer doctor will rationalize that they are concerned about the suffering of this patient and put them out of their misery. They count on the fact that an autopsy is not usually performed when a terminally ill patient dies [16].

This led to a definition and classification of such behaviour. Clinicide is defined as multiple deaths of patients under the care of a doctor that cannot be attributed to the intentions of treatment [1].

Clinicide is divided into the three categories:

- Serial clinicide
- Treatment clinicide
- Political clinicide

The first category is self-evident; intentional murders of patients as done by Shipman, Petiot and Swango. The second category refers to doctors who use their skills to kill people for political motives. Prominent examples are psychiatrist Dr. Radovan Karadzic who led the Bosnian genocide and the Turkish doctors who played leading roles in the Armenian genocide-some of whom went through a charade of treatment that foreshadowed the Nazi Holocaust, such as giving children eyedrops that made them blind or gassing them on the grounds of delousing.

Treatment killers are doctors associated with multiple patient deaths in which it is not obvious they intended patients to die and the issue of motivation is not evident. When the list of deaths progresses beyond two or four or twenty patients, it is not possible to continue without the realization that death is a likely outcome of their treatment. At some level, these doctors have an awareness of what they are doing, countered by an overweening refusal to acknowledge the implications or desist from further treatment.

Doctors are expected to provide optimum care at all times, to seek help or second opinions, regardless of vanity or fear of criticism. For a doctor to ignore death after death after death of patients under their care is untenable, and cannot be explained by mere denial. Their role is to take responsibility for the patient's care as far as can be reasonably expected.

Treatment killer doctors achieve notoriety when the deaths associated with their treatment are exposed to the public. There is shock, horror and outrage, often leading to disciplinary inquiries or manslaughter charges. To the onlooker, investigator or public, this is predicated on the idea that incompetence, willful or witless, caused patient deaths, and they were not deliberate or intended. As the courts put it, there is no apparent motive.

A subcategory of this group is doctors with serious mental illness. This problem is as old as medicine, and particularly difficult with the prominent physician, an example of the Great Man Syndrome. They have such authority and charisma that underlings are reluctant to tell them to stand down. This results in any number of unnecessary deaths, and enormous distress to survivors. One of the worst examples is Dr. Ferdinand Sauerbruch, one of the most famous surgeons of the 20th century [17]. Suffering from vascular dementia, Sauerbruch ended up doing operations without anaesthetics on the dining table in his sitting room, using kitchen implements while suturing with needle and thread, killing patients by the score.

Lord Dawson of Penn was the Royal Physician to King George V who died in 1938 [18]. Dawson gave the king a lethal injection into the jugular vein, ostensibly for the news to be released the next morning by The Times, rather than the tabloid papers. This was not any form of assisted death as we understand it and Dawson should have been indicted for manslaughter, at the very least.

The most notorious example of medical mass killing in Australia is Dr. Harry Bailey, who treated large numbers of patients by a dubious treatment modality, Deep Sleep Therapy [19]. On the slimmest of pretexts, patients were put into deep levels of coma with high doses of drugs under minimum supervision or care. Bailey was found to be responsible for (at least) 87 deaths and several hundred additional casualties.

More recently, Dr. Jayant Patel was associated with 87 patient deaths during his short time in practice at Bundaberg Hospital, Queensland [20]. Surgeon Peter Woodruff believes that Patel negligently caused 13 deaths, and serious complications suffered by at least 31 others [21]. Patel had a long path of surgical mayhem in the United States and did not disclose that he was under disciplinary review in several states before he arrived in Australia [22]. He was fined and put on probation for not examining patients in New York in 1984. In 2001, the state withdrew his licence. Undeterred, Patel proceeded to the Kaiser Permanente Hospital in Portland. Despite being named Physician of the Year, the lawsuits problems mounted. Then, in 2000 the State Board restricted his surgical rights. Despite this, he received glowing references from Kaiser Permanente.

Providing glowing testimonials for substandard, if not dangerous, doctors was hardly something new. When a nurse reported serial killer Michael Swango for injecting two elderly patients with lethal doses (and was not believed), the hospital made an arrangement to rid themselves of him without making waves: they would testify that he had completed his internship while he promised not to work there again [15].

DISCUSSION

In an eerie parallel with Duntsch, Swango also got a good reference from a neurosurgeon who had encouraged him to specialize in the field-also raising the question about the type of personalities attracted to neurosurgery. Patel was hired by a hospital on the strength of a glowing reference from a research mentor.

There is a spectrum of psychiatric disorder in the clinicidal doctor, including personality disorder, bipolar affective disorder, dementia and psychosis. Bailey was thought by many to have had manic depression. Sauerbruch had a fiery personality, drank heavily and developed vascular dementia.

Medicine attracts a certain kind of personality who is lured by the power of life over death. Many clinicidal doctors have extreme narcissistic personalities, a grandiose view of their own capability and inability to accept that they could be criticized or need assistance from other doctors. Such doctors develop a God-complex, getting a vicarious thrill out of ending suffering and by determining when a person dies.

But can it be mere incompetence-hapless, feckless or witless-when there is a recurrent pattern of deaths through neglect, treatment failure, and disinterest or by putting financial gain above patient care? From Shipman to Bailey there was a fatal hubris, permitting these doctors to perceive themselves as supremely dedicated, if not heroic, and any criticism of their work was responded to in paranoid terms.

This narcissism explains the most puzzling-and ominous-aspect of clinicide, the doctor who cannot step back at an early stage from the casualties of treatment and seek assistance or stop what they are doing. The inability to admit they could be wrong exemplifies the ancient Greek sin of hubris. Such individuals, while not necessarily psychopathic, go to extraordinary lengths to get what they want.

One issue that will not change is expecting medical colleagues to monitor their own kind with due vigilance. By definition, medicine is an autonomous activity often conducted in group settings. Most practitioners are acutely aware of the potential short-comings in what they do. This results in a "There but for the grace of God go I" mentality, an inner resistance to be overcome before reporting a colleague. The opposite pole is not much better-those doctors who have a pharisaical attitude towards their colleagues. Medical over-zealousness also has its perils as the example of Sir Roy Meadow's involvement with Munchausen's Syndrome by Proxy has shown [23].

Duntsch, beyond doubt, is a case of hubristic treatment clinicide. In the strict sense of the word, he did not set out to kill his patients. What he did, however, was display a reckless indifference to the outcome of his surgery, leaving a trail of victims including two fatalities. What surgeon, faced with such dreadful casualties would not step back and consider how to remedy the problem or withdraw from the practice? What surgeon would not consider their incompetence when they have to be physically restrained to remove them from the theatre? What surgeon would not consider their failings when they lose hospital accreditation, medical registration and have colleagues refuse to work with them?

The only answer is hubris on a galactic scale, an unshakeable belief that they are the centre of their universe, incapable of error and glorified by all. To say that Duntsch was grandiose is an understatement. His constantly uttered boast that he was the greatest surgeon in the world sums it up.

It is a rather unpredicted consequence of the now demotic nature of medical training. In the past, doctors invariably came from privileged backgrounds, medical families and went to the same elite schools. This limited the gene pool considerably, but had the advantage that they were all known quantities to their peers. No one will argue that medical schools should not be open to people from all backgrounds, but the questionable individual, adept at hiding their past, can insert themselves much easier. Swango, for example, a former marine, was unknown to his fellow students. His father had been a disgruntled Viet Nam veteran who kept scrapbooks with photos of war victims and car accidents and his behaviour at medical school earned him the title of 007 Licence to Kill.

Shipman, like Duntsch, had drug problems [24]. Joining a practice after internship, he became addicted to pethidine, going to court, standing down and entering a rehabilitation program. He was assessed by two psychiatrists as fit to return to practice. In fairness to them, Shipman never used drugs again, only to kill his patients.

Swango and Patel were innovative jurisdiction hoppers, relying on bureaucratic ineptitude to avoid discovery, a path that Duntsch manipulated for as long as he could. Swango was something of a champion at this, moving from one state to another as the net tightened, then Zimbabwe and Zambia. Apré Swango, the federal system tightened up but many gaps remained. Patel, having skipped from several US hospitals, ducked off to Australia, capitalizing on the desperate need for a

surgeon at country hospital where they had not thought to look into his medically nefarious record.

At the hospitals where they worked, both they were retained after they should have been excluded-Patel, like Duntsch, because they were seen as high-income assets for the insurance company-a damning indictment of the commercialization of American health.

Shipman, Patel and Duntsch all shared another characteristic, indicating their self-obsessed nature: contemptuous denigration and belittling of staff working under them. When Swango was observed by a nurse going into a room and injecting two elderly patients, one of whom died, the hospital refused to believe her. Several of Patel's co-workers had repeatedly blown the whistle on him only to be ignored by medical superiors and other authorities. Duntsch's scrub nurse had great difficulty establishing the credibility of her claims about him.

Shipman would not accept criticism of his work. He would cause embarrassment at clinical meetings by attacking specialists who were more qualified than him. Patel followed suit, taking on complicated cases which were well beyond his capabilities and telling staff that he did not need to wash his hands as 'surgeons don't carry germs'-which may have come as a surprise to Semmelweiss and Simpson. Duntsch was repeatedly warned by colleagues about his failings, but only responded with evasion, belligerence and insistence on continuing to operate.

CONCLUSION

What messages are to be learned from this? While regulatory bodies have tightened up their procedures, there will always be gaps that can be exploited by the devious doctor. Most medical bodies now require legal infractions in students to be reported, for example. An unpredicted problem is how often instead of picking up the truly dangerous doctor, they will scapegoat ordinary doctors with minor infractions. Such is the nature of all bureaucracy and medical bureaucracy has adapted these practices with great enthusiasm.

The travesty of Duntsch's surgical career reveals that whatever regulatory hurdles are instituted, a sufficiently determined doctor will invariably find a way to bypass them. Ultimately all systems fail. It is not a prospect to consider with equanimity.

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