Serial Killers and Serial Explanations

by Theodore Dalrymple (October 2014)

A friend of mine, who shall of course remain anonymous, is a great expert on the pharmacological aspects of serial killing by doctors and nurses. The cases are not many, but they are dramatic; and in the near future he will appear as an expert witness for the prosecution in a case in which a nurse is accused of killing several patients by poison. I am thinking of attending the trial to write about it.

If the accused is found guilty, or rather if the accused actually committed the crimes with which he is charged (regrettably not always quite the same thing), he acted with an unusual degree of cunning, having left his defence many possible avenues of escape. He also seems not to have had any motive apart from such strange pleasure as he might have derived from the act of killing. Perhaps he was as disinterested in the pursuit of evil as Kant' good person is in pursuit of good.

I have not had much to do personally with medical serial killers, either doctors or nurses, but shortly after the notorious case in England of a nurse called Beverley Allitt, who killed several babies by various means and was revealed later to have suffered herself from Munchausen syndrome, I was asked by the hospital in which I was working to examine a nurse working there who also suffered from, or perhaps I should say behaved as someone suffering from, Munchausen syndrome. (This is an extraordinary pattern of behaviour in which a person goes from hospital to hospital complaining of a variety of symptoms carefully chosen to signify possible serious underlying pathology, disprovable only by elaborate tests and procedures, and sometimes operations. Such a person may use up an immense quantity of medical time, energy and resources: the *British Medical Journal* once published a paper by a doctor who traced the path of a particularly prolific attender at public hospitals, and worked out that he had cost the taxpayer $17 million since he began what can only be called his career. More than once in my hospital I was able by detective work to uncover the identity of such a patient – they usually go under false names, they claim that their relatives are dead, to have just returned from abroad etc., so as to make themselves as untraceable as possible – and then, having been seriously incapacitated only moments before, rush out of the hospital when exposed as Munchausen patients, angrily swearing and cursing, sometimes threatening revenge, as if the exposure of their lies were an act of cruelty, as if their rights had been

infringed. No wrongdoing is beyond the reach of self-righteousness.)

The hospital management was naturally anxious that it did not have another Beverley Allitt on its hands, and asked me to pronounce on this difficult matter. Was the nurse dangerous, or was she not? I could quite see why the hospital management was anxious about it, perhaps not so much for the safety of the patients as to avoid the vilification of themselves that would surely ensue if they permitted a serial killer to work in the hospital, a nurse known to have Munchausen syndrome. By asking me, moreover, they could deflect blame on to me if things went wrong. This is the great secret of the science of management.

The nurse, as far as anyone could tell, had done nothing wrong in the hospital – yet. My own view is that Munchausen syndrome is a form of fraud, for whatever strange compulsion the person with it may feel under, his behaviour in actually seeking admission to hospitals is perfectly conscious: he claims to have what he knows that he does not have. However, the nurse had been convicted of nothing, so could not be dismissed on grounds of criminal record. Moreover, there was a flaw in the logic which supposes that if all *x*s are *y*s, then all *y*s must be *x*s. So even if it were true that all serial killer nurses suffered from, or behaved like people with, Munchausen syndrome, it would not follow that all nurses who suffered from Munchausen syndrome were serial killers – unless there were a perfect overlap and coincidence between the two, which there is not.

Suppose (purely for the sake of argument) that half of nurses with Munchausen syndrome were serial killers of patients, what then? One can see that there would be a conflict between the rights of society and those of the individual. If the nurse were dismissed on the grounds of the high statistical risk that she posed, she might justly complain that she was being punished for what she had not done, for what she *might* do. She was still innocent both in law and in fact. But who would want to go, or want his loved ones to go, to a hospital where a nurse with a fifty per cent chance of becoming of becoming a serial killer was employed?

Suppose again, using the same notional statistics, that a person who acknowledged that she had Munchausen's syndrome applied for a job as a nurse to a hospital. Should she be rejected? Most people would say that she should, but if Munchausen is accepted as a bona fide disability, this would be to discriminate against her on grounds that are now forbidden by law. We are on the horns of a dilemma: either we treat her as an individual, or as a member of a group. If we treat her as an individual we defy common sense and employ her because there is nothing against her personally; but if we treat her as a member of a group and not as an individual we are in effect allowing discrimination of the kind which is commonly denounced as morally reprehensible.

In fact, it is inevitable that we discriminate in some situations and for some purposes, whether or not we do so in and for others. An airline, for example, that knowingly employed a drug addict as a pilot would be culpable; but in America it is now illegal for insurance companies to discriminate against addicts because addiction must be treated as a disease like any other.

Be this all as it may, I advised the hospital to keep a particularly sharp eye out for any unexplained medical crises, ending in death or not, that occurred on the ward in which this nurse was working. She should be suspended at the first suspicion, while investigations were carried out; but in the event, no such action was ever necessary. Whether the mere fact of having been sent to me deterred her – for of course serial killers act under conscious control – or whether she had never had any propensity to serial killing I shall never know, for it is unknowable; but of course I like to think that I averted an infamous episode, having had few occasions in my life to be a hero.

In preparation for my future attendance at the trial of the alleged serially-killing nurse, I decided to read about healthcare serial killers, and found a book by a forensic psychologist with the title *Inside the Minds of Healthcare Serial Killers*. For like almost everyone else, I am prey to the illusion that if only I study or read enough about a certain kind of behaviour, I will come to 'understand' it better. One might almost call this *the mirage of understanding*: it shimmers enticingly in the distance, but however far you go, it remains just as distant.

The book turned out to be mainly a descriptive compendium of cases, but as for explanation, I found it not. As we shall see, I do not blame the author, Katherine Ramsland, for this, as human behaviour is that which passeth understanding, at least by humans; perhaps there are superior beings somewhere in the universe who could understand us as we understand the laws of motion, but until then we are stuck with incomprehension, even about what understanding would be, let alone understanding itself. In other words, we have not merely incomprehension, but meta-incomprehension.

The book contains a brief historical survey of healthcare serial killers, starting in the mid-nineteenth century. Perhaps until then doctors and nurses killed their patients only by accident (George Washington perhaps among them), but as the pharmacopoeia expanded, so did opportunities to act upon dark desires. And the appetite grows with feeding.

Whether there are more healthcare serial killers than there were a few years or decades ago would, as usual, not be an easy question to answer. Publicity has given rise to awareness, the first step in detection, but it may also have given rise to emulation and even competition to

be the worst of the worst. I have known people who, not having the talent to be the best at anything creditable, have settled on trying to be the worst at something discreditable: and that demand not so much talent as determination.

A rage for publicity or fame has certainly been a motive for some such killers, but certainly not all; many have done their level best to keep their depredations as hidden as possible. This brings us to a difficult question, that of the healthcare serial-killer. Is the infamous Dr Petiot, for example, a healthcare serial killer or not? Certain he was a doctor, and certainly he was a serial killer; but what he used to do during the Occupation of Paris was to lure rich Jews to his house where he would tell them that, as a member of the Resistance, and in return for their possessions for expenses, he would be able to smuggle them out to neutral countries. They would duly arrive with their possessions, when he would gas them – he had a peephole to observe them dying – and then keep the possessions for himself. Was he a healthcare serial killer or not? I would say not, because his killing was not an extension of his medical practice.

Is serial-killing by healthcare staff a single phenomenon, susceptible to a single explanation, when some do it for gain, others for thrills, yet others for sexual gratification, some for fame or notoriety, and some for no discernible reason at all? Is there a golden thread running through these crimes?

But even if there were, would it help us? Would we ever be able to say, 'Ah, *now* at last I understand'?

I do not think so. One of the most notorious medical serial killers of all time was Dr Harold Shipman. He may have killed up to 280 of his patients; we will never be sure how many. He never confessed, at least not to anyone whose word can be trusted, and never gave a reason for his behaviour. He put into practice the advice to politicians, 'Never apologise, never explain.'

His victims were mainly old, or oldish, ladies, most of them in good health for their age. Since he explained nothing himself, sifters in his biography sought explanations for themselves. One of the most commonly cited facts of his life is that he witnessed his mother die slowly and excruciatingly of cancer when he was 17 years old. A somewhat lonely young man, his mother was his main support and best friend. Here is what Katherine Ramsland has to say:

> Harold Shipman took care of his mother as she died. It's possible that as [he] began to kill patients, [he] found some measure of relief from anxiety when [he] exercised this form of control – not just over another person but also over their environments.

I do not blame the author for the almost comical inadequacy of this supposed ‘explanation;’ quite apart from any difficulty in understanding why killing should reduce anxiety more than raise it, the effect is grossly, even ludicrously, disproportionate to the presumptive cause. For every Shipman, there must be a thousand men who have seen their mothers die. But I have nothing better to propose, and I doubt that I would even if I were to devote the whole of my life to studying the case.

The fact is that explanation is a holy grail: no matter how long sought it is never found. F. H. Bradley said that metaphysics is the finding of bad reasons for what we believe on instinct, but he added that search for such reasons is no less a part of human nature for that. So it is with human behaviour. We shall never explain it; we shall never cease trying to explain it.

Theodore Dalrymple’s latest book is