Annals of Health Law

Volume 5
Issue 1 *1996*

Article 11

1996

National Repositories of Information: A Comparison of the National Practitioner Data Bank in the United States and the National Confidential Enquiry into Perioperative Deaths in the United Kingdom

Gail Daubert
American University Washington College of Law

Recommended Citation

Gail Daubert *National Repositories of Information: A Comparison of the National Practitioner Data Bank in the United States and the National Confidential Enquiry into Perioperative Deaths in the United Kingdom*, 5 Annals Health L. 227 (1996).
Available at: http://lawecommons.luc.edu/annals/vol5/iss1/11

National Repositories of Information: A Comparison of the National Practitioner Data Bank in the United States and the National Confidential Enquiry into Perioperative Deaths in the United Kingdom*

*Gail Daubert***

INTRODUCTION

Medical error, clinical negligence, or medical malpractice—regardless of its label, society pays when physicians fail to exercise the standard of care necessary to provide quality health care. While the victimized patients suffer needless pain and injury, they may be unable to return to work as well. Thus, not only does the injured patient lose wages, but society loses a productive citizen. Society also pays for the increase in the use of social services as well as the payment of social security disability benefits and sometimes even death benefits. Ultimately, it is the future health care consumer who pays the costs through higher health care insurance premiums and the defensive practice of medicine.

Studies suggest that only a small percentage of injured patients actually file complaints—medical malpractice claims reflect only a small portion of the number of patients injured by medical malpractice. Results from the Harvard Medical Practice Study indicate that in New York State, during a particular time period, seven times as many patients suffered an injury caused by medical negligence as filed medical malpractice suits.[1] The American Bar Foundation (ABF) Study in Chicago revealed that forty-four percent of patients experienced at least one medical error during their hospitalization and fourteen per-

---

* This paper was submitted for the London Comparative Health Law Program sponsored by Loyola University Chicago School of Law Institute for Health Law.

** Ms. Daubert is a surgical nurse currently enrolled at American University Washington College of Law in Washington, D.C. She received her Master of Jurisprudence in Health Law from Loyola University Chicago School of Law, her Bachelor of Science from Northwestern University, and her registered nurse degree from Rock Valley College.

[1] PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE 69 (1993).

cent of patients were seriously injured by medical errors.[2] Of the seriously injured patients, only three percent brought legal claims.[3] Strikingly, the ABF Study found only twenty-four percent of the errors that were observed were documented, and little effort was made to channel the information to others who might implement plans to prevent future errors.[4] Similarly, Management Prescriptives, a health care education and information company, revealed data from one hospital that documented 1057 adverse events arising from 7275 admissions, that is, fourteen and one-half percent.[5] Of those 1057 adverse events, 457 resulted in "adverse outcomes" that led to 4891 additional patient days and cost $27 million.[6] These studies demonstrate that the cost of medical error and the injuries suffered by patients far exceed that which has been previously acknowledged.

Comparable data on patients injured by medical negligence are unavailable from the United Kingdom. However, one can speculate that if like studies were conducted, the findings would be similar. Given the United Kingdom's "loser pays costs" system and the prohibition on contingent fees, it is easy to conclude that far fewer injured patients file complaints or claims in the United Kingdom than in the United States.

Considering both the concrete and intangible elements, it is extremely difficult to calculate the actual cost of medical negligence. Though many statistics are available in the United States, the variability in estimates makes it difficult to give accurate information; with the United Kingdom's dearth of statistics, it is impossible to calculate or compare the financial cost of medical negligence in the two countries. Financial costs aside, it is simply unacceptable to allow preventable medical injuries.

Currently, government officials in both the United States and the United Kingdom are under pressure to improve the quality of health care services while at the same time containing costs. The 1990 reforms of the National Health Service (NHS) in the

---

[2] Catherine S. Meschievitz, *Efficacious or Precarious? Comments on the Processing and Resolution of Medical Malpractice Claims in the United States,* 3 ANNALS HEALTH L. 123, 127-28 (1994) (defining serious injury as a temporary or permanent disability or death).

[3] *Id.* at 128.

[4] *Id.*

[5] Jay Greene, *Software Helps Hospitals Cut Back on Job, Expense of Patient-Care 'Rework,'* MODERN HEALTHCARE, Jan. 2, 1995, at 51.

[6] *Id.*

United Kingdom[7] and the national and state health care reform bills proposed in the United States reflect each respective country's concerns over access, cost, and quality of health care.

Quality improvement measures mandated via legislation, such as the Health Care Quality Improvement Act (HCQIA),[8] can help decrease medical errors and reduce clinical negligence by identifying incompetent health care practitioners. Any plan that reduces incompetent medical care improves the quality of care. In turn, these measures help protect patients from needless injuries and ultimately reduce the cost of health care.

This article examines the National Practitioner Data Bank, the United States' record keeping system designed to track and monitor physicians who have either settled a malpractice claim or had disciplinary action taken against them, and compares it with the National Confidential Enquiry into Perioperative Deaths (NCEPOD), a system employed by the United Kingdom to analyze the cause of perioperative deaths. NCEPOD is not affiliated with the United Kingdom's Department of Health; it is run entirely by representatives of the Royal Colleges of Medicine and other faculties concerned with the management of surgical patients.[9] The goal of both systems is to improve the quality of medical care.

Numerous articles have been written about the HCQIA and the data bank. This article will not repeat the details of each, but instead will compare the data bank with the English system of tracking adverse medical incidents.

I. THE UNITED STATES' REPORTING SYSTEM: THE NATIONAL PRACTITIONER DATA BANK

Providers of health care in the United States have long recognized the importance of quality assurance programs as components of quality health care services.[10] Hospitals use accreditation commissions, risk management and quality assur-

---

[7] *See* John H. Tingle, *The Allocation of Healthcare Resources in the National Health Service in England: Professional and Legal Issues*, 2 ANNALS HEALTH L. 195 (1993).

[8] Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-52 (1994).

[9] Dr. John N. Lunn, *NCEPOD Past, and Future?*, AVMA MED. & LEGAL J., Autumn 1993, at 6.

[10] *See* N. Jean Schendel, *Banking on Confidentiality: Should Consumers be Allowed Access to the National Practitioner Data Bank?* 27 J. HEALTH & HOSP. L. 289, 290 (1994) (noting that peer review advanced with the formation of the Joint Commission on Accreditation of Healthcare Oranizations in 1952).

ance programs, and peer reviews[11] to monitor and maintain quality health care. Equally important, state licensing boards regulate and monitor health care professionals to safeguard the public's health and welfare. However, individual states could not identify physicians disciplined in other states. In turn, hospitals' credentialing committees could not realistically consult all fifty states to identify a physician's past misdeeds. To prevent incompetent doctors ousted from one hospital or state from practicing elsewhere and potentially harming other patients, Congress enacted the HCQIA in 1986[12] to, among other things, establish a national tracking system of physician competency. This tracking system is the National Practitioner Data Bank.

A. *The Purpose and Design of the Data Bank*

The impetus for the legislation and, ultimately, the Data Bank's design came after members of Congress heard compelling testimony indicating that a few "bad apples" were spoiling the profession's reputation and were primarily responsible for the majority of patient injuries.[13] One report cited a physician who had been sued thirty-four times yet remained in practice until he sold Quaaludes to an undercover agent.[14] As hard as this type of incident is to envision, physicians could have gotten away with it because hospitals might have been afraid to report them, or because the physicians could have avoided detection by moving from hospital to hospital or state to state.

Before the HCQIA, hospitals did not normally disclose the fact that they had revoked a physician's privileges.[15] Usually, the fear of a lawsuit brought by an ousted physician kept hospitals quiet. It is easy to see the hospital's awkward position: on the one hand, the hospital wanted to remove the physician to avoid future liability for physician incompetence and to assure quality of care for its patients, while on the other hand, the hospital feared the physician would sue it, alleging a damaged pro-

---

[11] The term "hospital" is used throughout this paper for sake of convenience, but it is meant to encompass all types of health care entities that provide health care services and follow formal peer review processes, as that term is defined in 42 U.S.C. § 11151(4)(A) (1994).

[12] 42 U.S.C. § 11101-52 (1994). Congress found that such tracking was beyond the scope of an individual state's ability. 42 U.S.C. § 11101 (1994).

[13] Elisabeth Ryzen, *The National Practitioner Data Bank: Problems and Proposed Reforms*, 13 J. LEGAL MED. 409, 414 (1992).

[14] *Id.*

[15] H.R. REP. NO. 903, 99th Cong., 2d Sess. 2 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6384, 6385.

fessional reputation caused by the removal. As a result, a hospital might accept the physician's "plea bargain": the physician would quietly submit a voluntary resignation, which the hospital would quietly accept without disclosure of the reasons.[16] Unfortunately, this allowed the "bad doc" to "set up shop elsewhere," continue to practice medicine, and likely cause more unnecessary patient injuries.[17]

The desire to end this scenario was a motivating factor behind the passage of the HCQIA. The goal was to decrease the incidence of medical malpractice by preventing an incompetent doctor who lost privileges at one hospital from simply obtaining privileges at another hospital and injuring more patients. The solution was to establish a national data bank that contained pertinent information reflecting a physician's practices, thus providing hospitals with a necessary tool of nationwide information about physician misconduct and alleged liability.[18]

The Data Bank functions on a system of information reporting and retrieval. The reporting aspect is obviously crucial. Therefore, Congress put the onus on four types of entities. First, state medical boards must report all disciplinary and adverse licensure actions that relate to the competence or professional conduct of a practitioner, including all censures and reprimands.[19] The medical board must include a description of the "acts or omissions or other reasons" for the disciplinary action.[20] Failure to report will result in the Secretary of Health and Human Services designating another qualified entity that would be responsible for reporting the information in the future.[21] Congress further requires a hospital that takes action that adversely affects a practitioner's clinical privileges for more than thirty days to report that action to the Board of Medical Examiners in the state in which the hospital is located, which in turn must report the information to the Data Bank.[22]

Second, Congress made it incumbent on hospitals to report voluntary surrenders of privileges conditioned on the hospital's

---

[16] *Id.* at 3, *reprinted in* 1986 U.S.C.C.A.N. at 6385. *See also* Ryzen, *supra* note 13, at 414.

[17] *See* Ryzen, *supra* note 13, at 414.

[18] H.R. Rep. No. 903, *reprinted in* 1986 U.S.C.C.A.N. at 6385.

[19] 42 U.S.C. § 11132(a)(1)(A) (1994).

[20] *Id.* at § 11132(a)(2)(B).

[21] *Id.* at § 11132(b).

[22] *Id.* at §§ 11133(a)(1) & 11134. Entities may, but are not required to, report other health care practitioners who are not physicians. *Id.* at § 11133(a)(2).

agreement to refrain from investigating an incident.[23] This last provision was added to end the practice of doctors "plea bargaining" to avoid being reported. If a hospital fails to comply with the reporting provisions, it loses its peer review immunity.[24]

Third, Congress directed that "[e]ach entity . . . [that] makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report . . . information respecting the payment and circumstances thereof" to the Data Bank.[25] Congress provided a serious incentive for compliance: if an entity fails to report that it paid a claim, it can be subjected to a penalty of up to $10,000.[26] While the mandatory reporting of malpractice settlements generated a substantial amount of debate, and Congress conceded that malpractice data should be viewed with caution, noting that many considerations other than the validity of the claim contribute to settlements, Congress concluded that "on balance, [the data] will prove to be extremely useful."[27]

---

[23] *Id.* at § 11133(a)(1)(A), (B).

[24] *Id.* at § 11133(c)(1). *See id.* at § 11111(b) (providing for loss of peer review immunity for three years).

[25] *Id.* at § 11131(a).

[26] *Id.* at § 11131(c). However, the reporting or penalty provision does not apply to payments made by individual physicians.

[27] H.R. Rep. No. 903, 99th Cong., 2d Sess. 13-14, *reprinted in* 1986 U.S.C.C.A.N. 6396. This contention was based on the fact that neither the state disciplinary boards nor the peer review system could adequately identify many incompetent practitioners, since a typical aggrieved patient turns to the court system and files a malpractice suit to deal with inadequate medical care. Accordingly, Congress believed the malpractice data would provide "important clues for evaluating the credentials of health care practitioners," recognizing that "those authorized . . . to gain access to this information will have the awareness and sensitivity to use it responsibly." *Id.* Congress added: "In interpreting information reported under this part, a payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred." 42 U.S.C. § 11137(d) (1994). However, even with this clause added, the American Medical Association remained adamantly opposed to the reporting provision and withdrew its support for the Data Bank when Congress retained this provision. Instead, the AMA has chosen to develop an alternative data bank for health care consumers that will contain data on ALL practitioners, not just those with negative information. The information will consist of the education, training, and specialty of a doctor as well as any adverse medical staff and licensure actions and convictions for violent crimes and crimes related to health care. *AMA President Outlines Plan to Create Alternative to Practitioner Data Bank*, 2 HEALTH CARE POL'Y REPORT (1994). *But see*, Janice Perrone, *AMA Wants Bad Doctors Off Its Membership Rolls*, AM. MED. NEWS, Sept. 9, 1991, at 1 (noting that since the beginning of 1990, state medical boards have revoked or suspended more than 1000 licenses while the AMA identified only several dozen members as revocation candidates).

Additionally, many contended that small settlements should not be reported, as they might reflect nuisance suits that were cheaper to settle than litigate.[28] However, Congress chose not to exempt any settlement after reflecting on the difficulty in deciding an appropriate cutoff point, and noted that a "significant number of small payments may . . . represent truly meritorious claims," citing as an example "an extremely incompetent physician in a particular specialty [who] might rarely face claims greater than a few thousand dollars."[29]

Fourth, a medical society must report when it "takes a professional review action [that] adversely affects the membership of a physician in the society."[30]

Congress believed that all the information cited above could provide hospitals with a more complete profile on a physician's competency, enhancing a hospital's ability to make informed decisions regarding staffing privileges.[31]

These reporting requirements would mean nothing if the information was not available to those who make hiring and credentialing decisions. Therefore, Congress included query provisions that require hospitals that wish to grant privileges to a health care practitioner to query the Data Bank before granting privileges and at least once every subsequent two years.[32] The querying provisions spell out the minimum duty of care that hospitals must exercise in selecting and reappointing its medical staff.[33] Thus, the HCQIA essentially establishes a national minimum standard for hospital credentialing. Hospitals are presumed to have knowledge of the information in the Data Bank

---

[28] H.R. Rep. No. 903 at 14, *reprinted in* 1986 U.S.C.C.A.N. at 6397.

[29] *Id.* Congress directed the Secretary of Health and Human Services to study and report whether information on small payments should continue. 42 U.S.C. § 11131(d) (1994).

[30] 42 U.S.C. § 11133(a)(1)(C) (1994).

[31] 132 CONG. REC. E735 (Mar. 12, 1986) (statement of Rep. Wyden).

[32] 42 U.S.C. § 11135(a) (1994) (Recall the term "hospital" used in this article includes all health care entities defined by 42 U.S.C. § 11151(4)(A).).

[33] Ryzen, *supra* note 13, at 419. Of course, the hospital's use of the information obtained in the credentialing and peer review processes is vital to accomplishing the Act's goal. The HCQIA contains provisions intended to enhance these processes, which is beyond the scope of this article. For more information, *see* Lisa J. Acevedo, *To Review or Not to Review: Antitrust Liabilities and Peer Review Protections*, 27 J. HEALTH & HOSP. L. 321 (1994); Scott M. Smith, Annotation, *Construction and Application of Health Care Quality Improvement Act of 1986 (42 U.S.C.S. §§ 11101-11152)*, 121 A.L.R. FED. 255 (1994).

when defending a medical malpractice action,[34] and noncompliance may result in hospital liability for negligent credentialing.[35]

Congress designed the Data Bank system to successfully track the competency of practitioners by catching information on the incompetent doctor both coming and going. By designing the system in this fashion, the system inhibits an incompetent physician's ability to conceal a checkered past, and makes it more difficult for the "bad doc" to obtain privileges at another facility or in another state.

B. The Success of the Data Bank

There is a great debate over whether the Data Bank is a "success." While a definitive answer is not available, two things are clear: (1) it depends on how one defines "success," and (2) it depends on whom one represents.[36]

On the one hand, the Division of Quality Assurance, with the Bureau of Health Professions, Health Resources and Services Administration, Public Health Service, Department of Health and Human Services, which runs the Data Bank, reports that the system is working.[37] The Data Bank opened on September 1, 1990. Initial problems, such as backlogs due to the tremendous volume of inquiries by hospitals, have been corrected and it appears to be running smoothly. During the Data Bank's first eighteen months of operation, there were over 1.2 million inquires and approximately 20,000 "matches." (A match occurs when the Data Bank finds negative information on a queried practitioner.) As of the beginning of April 1992, the Data Bank had found 33,000 matches. The majority of matches, 28,000, concerned malpractice payments, and 5000 were related to adverse professional actions. During this time, the Data Bank identified approximately 6000 doctors who have moved from

---

[34] H.R. Rep. No. 903, 99th Cong., 2d Sess. at 18, *reprinted in* 1986 U.S.C.C.A.N. at 6401.

[35] Scott C. Pugsley, *Implementing the Health Care Quality Improvement Act*, 23 J. HEALTH & HOSP. L. 42 (1990).

[36] *Compare* Robert E. Oshel et al., *The National Practitioner Data Bank: The First 4 Years*, 110 PUB. HEALTH REP. 383 (1995); Ron Wyden, Commentary, *Transparency: A Prescription Against Malpractice*, 110 PUB. HEALTH REP. 380 (1995); *Data Bank Inquiries Yielding More 'Matches' on Prior Adverse Actions,* 3 BNA'S MEDICARE REP. 349 (1992), *with* James S. Todd, Commentary, *Just Numbers or Knowledge?*, 110 PUB. HEALTH REP. 377 (1995).

[37] Oshel et al., *supra* note 36, at 394.

"state to state to avoid medical disciplinary action."[38] "By the end of 1994, the Data Bank had processed more than 4.5 million requests for information on practitioners, more than 1.5 million of which were received in 1994 alone. . . . During 1994, 7.9 percent of queries were matched."[39]

The Inspector General's Office surveyed hospitals and managed care organizations (MCOs) and reported the following: "[Eighty-three] percent of hospital officials and [ninety-six] percent of MCO officials we surveyed regarded the Data Bank reports they received on practitioners to be useful to them. . . . In regard to the impact of the reports, we found that [two] percent of the Data Bank reports in our sample led hospital officials to make different privileging decisions than they would have made without them and that [three] percent had the same effect on MCO officials."[40]

But others have quite a different perception of the Data Bank. The AMA has identified adverse effects and high costs associated with the National Practitioner Data Bank. "In 1993, the Physicians Insurers Association of America stated that [ninety-seven] percent of their companies reported that physicians are less willing to settle claims as a result of the NPDB. Of malpractice reports, [twenty-one] percent of the payments were made for claims that were considered clearly defensible by the insurer, and presumably there are episodes of malpractice that never result in any action."[41] The president of the AMA noted that $9.9 million was paid to the bank in querying fees, and pointed out that those who must report and query incur the cost of preparing and reviewing the query. He also questioned the use of pure statistics of numbers of reports, queries, and matches to "prove" that the Data Bank is working. "Given all of these concerns, one has to wonder what really is the value of the Data Bank?"[42]

Julie Campbell, the medical staff services director at a California hospital, cites a good example of how the Data Bank works well. Ms. Campbell's hospital disciplined a doctor, revoked his privileges, and reported him to the Data Bank. The doctor sub-

---

[38] Karen Sandrick, *Two Years and Running: The National Practitioner Data Bank Begins to Roll, but Issues Remain,* Hospitals, Feb. 5, 1993, at 44 (1993).

[39] Oshel et al., *supra* note 36, at 383 & 384 table 1.

[40] Mark R. Yessian, Commentary, *Putting the Controversy Aside, How Is the Data Bank Doing?,* 110 Pub. Health Rep. 381 (1995).

[41] Todd, *supra* note 36, at 378.

[42] *Id.*

sequently tried to obtain privileges at another institution. He attempted to conceal his past problems and did not disclose to the credentialing committee of the second hospital the disciplinary action taken by the first hospital. However, the chairman of the credentials committee called the first institution after receiving the doctor's Data Bank report, which documented the adverse action. After discussing the matter, the second institution claimed it was contemplating denying the doctor's privileges. This would result in another adverse action being logged in the Data Bank against this particular doctor. Campbell believes Data Bank reports will "stop this particular physician from running place to place."[43] Thus, the HCQIA is accomplishing its goal of preventing incompetent doctors who are removed from the staff of one hospital from obtaining privileges at another. If even one harmful doctor is caught, then the Data Bank has done its job.

II. THE UNITED KINGDOM'S REPORTING SYSTEM: THE NATIONAL CONFIDENTIAL ENQUIRY INTO PERIOPERATIVE DEATHS

Medical malpractice is not unique to the United States. Where there is health care, there is medical negligence. Many countries address medical negligence in different ways, but we should all strive to improve the quality of health care.

While health care providers in the United States are subject to both internal and external health care quality assurance and risk management programs, only five percent of NHS hospitals[44] have a risk management office.[45] Risk management and quality assurance programs are the two most effective mechanisms used by hospitals in the United States to prevent medical liability claims. Risk management programs identify problem areas and develop policies to prevent future accidents, while quality assurance programs establish "organizational structures, operational processes, and individual assessments of outcomes that address

---

[43] Sandrick, *supra* note 38, at 44.

[44] "NHS hospitals" are hospitals run by the government, providing health care at no charge to the patient. The health care system in the United Kingdom is centered around the NHS, although there are some private hospitals, which charge patients for care. For information about the structure of the NHS and the hospital systems in the United Kingdom, see BRYAN RAYNER, HISTORY OF THE DEPARTMENT OF HEALTH (1994); Tingle, *supra* note 7, at 195-97.

[45] Interview with Denny Van Liew, Director of Healthcare Risk Solutions Limited, London (Jan. 9, 1995).

the patient care delivered by all health care providers—physicians, technicians, nurses, and other physician extenders."[46] Both are essential to ensure quality care and help to identify the cause of medical errors. Since neither of these programs is used in the United Kingdom, it is not surprising that the United Kingdom has no detailed information on the epidemiology of medical accidents.[47] Fortunately, the prospect of increasing quality assurance checks in the United Kingdom appears promising.

A. Setting the Stage for NCEPOD

With the 1990 reforms of the NHS came decentralization, allowing NHS trust hospitals to administer the funds they receive annually from the government. Additionally, the 1990 reforms transferred the responsibility for paying for clinical negligence damages to each individual NHS trust hospital; each trust hospital must pay for its liability claims from its own *operating* funds—the funds allocated to provide health care.[48] In order for the NHS trust hospitals to obtain commercial insurance, the Secretary of State must exercise its power to do so.[49] To date, the Secretary has not exercised this power.[50]

Consequently, as the responsibilities and liabilities shift, individual hospital administrators under the "new NHS" have started to assess hospital performance and to implement quality assurance checks, or "audits," of individual physician performance. These administrators realize that the payment of a substantial number of claims could seriously affect a hospital's operating budget.[51]

While audits are not new to the United Kingdom, the manner in which the information is being collected and disseminated is changing. The literature indicates that large-scale audits probably began in the 1970's with a Large Bowel Cancer Study, which illustrated a vast range of outcomes for patients who had under-

---

[46] SAL FISCINA ET AL., MEDICAL LIABILITY 349 (1991).

[47] *See* Graham Neale, *Clinical Analysis of 100 Medicolegal Cases,* 307 BRIT. MED. J. 1483 (1993).

[48] Michael A. Jones, *Letter: Making Doctors More Careful,* THE INDEPENDENT (London), Sept. 21, 1993, at 25; Stephen L. Heasell, *Economic Aspects of Medical Negligence in the Context of the National Health Service in Britain,* 3 ANNALS HEALTH L. 205, 217-18 (1994).

[49] National Health Service and Community Care Act, 1990, c.19, § 21 (Eng. & Wales).

[50] Jones, *supra* note 48, at 25.

[51] H. Brendan Devlin, *Measuring the Surgeon's Performance,* AVMA MED. & LEGAL J., Apr. 1993, at 8, 9.

gone large bowel resections[52] for cancer. The study involved ninety-four surgeons in twenty-three hospitals. The early reports analyzed the integrity of the intestinal anastomosis. In other words, the study evaluated whether sutures that were used to sew the remaining health portions of the bowel together held or leaked. If the anastomosis leaked, the contents of the bowel drained into the abdominal cavity. Overall, the study found that thirteen percent of the anastomoses failed or leaked. But when the study evaluated the success of the surgery on an individual basis, it showed that some surgeons had a failure rate as low as one-half of one percent while others' failure rates exceeded thirty percent. The consequences of this variation were significant—patients whose anastomoses held and did not leak remained in the hospital for an average of 25.4 days, whereas patients whose anastomoses failed or leaked spent an average of 45.7 days in the hospital. More frightening, however, was the difference in the death rates—patients whose anastomoses held had a 7.1% chance of dying, while patients whose bowel resection leaked had a 22% chance of dying.[53]

The results of this study had a significant impact on the medical profession. First, after the early results on the anastomosis failure rate were discussed with the participating surgeons, the failure rate dropped, from 14.2% in 1976 to 10.9% in 1977, illustrating that surgeons can learn from their mistakes.[54] At the time of the report, H. Brendan Devlin, a consultant surgeon and later Secretary of the National Confidential Enquiry into Perioperative Deaths, extrapolated these findings to show that on a national level, if the failure or anastomosis leakage rate was lowered to five percent, "450 post-operative deaths would be prevented and [£]4,000,000 [would be] saved each year."[55]

Second, this study illustrated that a surgeon's skill, or lack of skill, is directly related to a patient's outcome. In other words, it demonstrated on a large scale what many in the United States already knew: doctors' skills must be assessed to ensure that they are delivering a high quality of care to their patients.

The NCEPOD was launched in 1988 as a result of the effectiveness of the Large Bowel Study and the success of a smaller

---

[52] During a bowel resection, the surgeon removes the diseased, cancerous portion of the colon and mends the remaining healthy portion. The site where the healthy portions are sewn together is the anastomosis.

[53] Devlin, *supra* note 51, at 9.

[54] *Id.*

[55] *Id.*

audit conducted during 1985 and 1986 in three NHS regions, the Confidential Inquiry into Perioperative Deaths (CEPOD).[56] Audits of patient care were needed to establish standards of care and ensure equity of access to safe care.[57]

B. *The Goal, Structure, and Success of NCEPOD*

Representatives from the Royal Colleges of Medicine operate and oversee the NCEPOD independently from the Department of Health and National Health Services. The NCEPOD is endorsed by the Association of Surgeons and the Association of Anaesthetists in Great Britain. The goal of NCEPOD is to "reveal the standard of anesthetic and surgical care available in hospitals and to point out, in what parts and in what ways, this standard might be improved."[58] The instigators of the NCEPOD maintain that the data are not collected to place blame on practitioners; rather, NCEPOD was designed to be more akin to a "watchdog" of health care quality. Thus, the results are published with all identifying information removed from the reports, including the names of the patients, the practitioners, and the hospitals.[59] Physician confidentiality is one facet of the NCEPOD that differs radically from the Data Bank in the United States.

To meet its goal, the NCEPOD collects data from written questionnaires on failed surgery cases, defined as cases in which the patient dies within thirty days of the surgical procedure.[60] While the questionnaires are distributed to the hospitals and practitioners, because the enquiry is voluntary, there are no sanctions for failing to participate. Members of NCEPOD study and analyze the data, along with other reports from the attending physician and hospital, and disseminate the findings to practitioners.

While it would appear that anonymity would make the United Kingdom's data collection bank more palatable to practitioners,

---

[56] Luisa Dillner, *NCEPOD: Surgeons and Anaesthetists Could Do Better*, 304 BRIT. MED. J. 1071 (1992). The Confidential Enquiry into Perioperative Deaths (CEPOD), which was created in 1982, studied the three NHS regions for 12 months. The first NCEPOD report was generated in 1990, based on 1989 data. Devlin, *supra* note 51, at 9, 10.

[57] Devlin, *supra* note 51, at 9.

[58] Lunn, *supra* note 9, at 6.

[59] *Id.* Unlike the United States, no entity is required to look at these reports. Because the survey is both anonymous and voluntary, it is more of an information bank than a manner of checking a physician's credentials.

[60] *Id.*

approximately thirty-five percent of practitioners overall did not return the reporting questionnaires.[61] Even more problematic are the findings of a study conducted to assess NHS hospitals' effectiveness in identifying and reporting deaths to the NCEPOD.[62] A review of the various types of records of three large London hospitals indicated poor data collection and reporting. The reviewers concluded that if this sample was representative of the accuracy of other NHS hospitals, "almost half of the eligible deaths are likely to be missed."[63] While subsequent changes were then implemented to improve reporting, a follow-up examination six months later showed no real improvements.[64]

The originators of the NCEPOD stressed that its validity as a clinical audit system will "depend on the inclusion of all relevant cases."[65] Thus, the failure of hospitals and practitioners to accurately report obviously diminishes its ability to improve patient care. On the other hand, since the findings are diseminated to practitioners, they may be able to adjust their practices based upon this information and, thus, improve the care that they provide.

Yet another problem exists that renders the NCEPOD less effective than it could be. The cases reported are difficult to analyze given the appalling lack of information documented in patients' medical records. For example, the 1990 NCEPOD report disclosed 2558 patient deaths.[66] These patients' medical records failed to *identify the operating surgeon* fourteen percent of the time and *failed to indicate the patient's operative diagnosis* fifty-four percent of the time. In many cases, the physician notes were extremely poor, sometimes consisting of only a "single 'one liner.'"[67] These omissions hinder the NCEPOD's ability to accurately assess the causes of medical error and to identify poor physicians.

In spite of the NCEPOD's shortcomings, the Minister for Health for the United Kingdom proclaimed the audit a success

---

[61] *Id.* This high rate of failure to return the questionnaires is likely because participation is voluntary.

[62] L. Clark et al., *Effective Audit: Reporting to the National Confidential Enquiry into Perioperative Deaths,* 304 BRIT. MED. J. 1472 (1992).

[63] *Id.* at 1473.

[64] *Id.* at 1474.

[65] *Id.* at 1472. NCEPOD went so far as to appoint consultants serving as local district reporters to ensure that all relevant cases were reported.

[66] Devlin, *supra* note 51, at 10.

[67] *Id.*

in a July 9, 1993, statement. Then-Minister Brian Mawhinney applauded the NCEPOD and claimed it an "important study for patients as it provides valuable reassurance about the quality of surgical and anaesthetic care within the NHS."[68] He welcomed the NCEPOD's "conclusion that across the range of specialties covered 'the prevailing standard of surgery and care is excellent.' "[69] However, his statement provided nothing of real substantive value. While Dr. Mawhinney claimed that some problems that were identified in previous NCEPOD reports, such as the percentage of consultants involved in decisions about whether or not to operate, were being corrected, he failed to address other problem areas identified. He did, however, stress that clinicians and managers need to work closely to improve the results.

Dr. Mawhinney's accolades must be put into perspective: the 1992 NCEPOD report that Dr. Mawhinney extolled was based on a random sample of over 2000 questionnaires returned between January 1990 and December 1990, representing a compliance rate of just over sixty percent.[70]

However, there do appear to be positive effects from the NCEPOD. For example, in 1987, CEPOD (the precursor to NCEPOD) found that only sixty-three percent of consultants (akin to our supervising physicians who work with residents) participated in preoperative decision making, with adverse effects resulting from the lack of experience of the juniors or "registrars."[71] The 1990 NCEPOD report found an improvement—eighty-nine percent of preoperative decisions were consultant based.[72] Additionally, the NCEPOD's 1987 report found only forty-seven percent of surgeries were performed or supervised by consultants, whereas in 1990, sixty-seven percent of the operations were performed or supervised by consultants.[73] In these instances, the NCEPOD appears to be instrumental in effecting change, or at least identifying problem areas that need correction.

---

[68] UK: Dr. Brian Mawhinney Welcomes 1991/92 Report of National Confidential Enquiry Into Perioperative Deaths, Dept. of Health, U.K. Gov't Press Releases, Sept. 7, 1993.

[69] *Id.*

[70] Dillner, *supra* note 56, at 1071.

[71] Devlin, *supra* note 51, at 11.

[72] *Id.*

[73] *Id.*

But simply identifying problems is not enough. For example, the rates of death resulting from operations performed by registrars is twice as high as that resulting from operations performed by consultants,[74] indicating that either registrars need more supervision or consultants should be performing the surgery. It is also frightening to learn that while the incidence of perioperative death in NCEPOD's control group is one in twenty, the incidence of death jumps to one in four for surgeries performed outside normal working hours.[75] Finally, the NCEOPD documented the need for twenty-four-hour operating rooms and intensive care and emergency services to reduce unnecessary deaths and to improve the quality of care delivered.

However, NHS budgets are tight and money may be unavailable to implement the needed improvements. This too shows the deficiencies of relying solely on a voluntary system to improve the quality of care.

III. PARALLEL GOALS BUT DIVERGENT MECHANISMS

The United Kingdom's NCEPOD is in some ways parallel to the United States' National Practitioner Data Bank. Like the Data Bank, the NCEPOD is a national clearinghouse for information. The NCEPOD's goal parallels that of the Data Bank: both are designed to improve the quality of care by identifying and reducing medical errors. Both are dependent on the medical field's cooperation.

However, the mechanisms used by each country are quite different. The NCEPOD focuses on treatment outcomes to identify medical errors. In a general sense, its purpose is to identify the causes of poor outcomes and the appropriate therapy, thereby improving the quality of care. To the contrary, the Data Bank looks to improve the quality of care by focusing on an individual practitioner's performance or behavior.

The NCEPOD is a unique quality improvement tool. It appears that the NCEPOD's designers borrowed one-half of the United States' risk management scheme and one-half of the United States' quality assurance mechanism. The NCEPOD identifies problem areas as does risk management and assesses treatment outcomes as does a quality assurance program. However, it fails to achieve completely the goals of either program.

---

[74] Louisa Dillner, *Patients Are Still Dying Unnecessarily, Says NCEPOD*, 307 BRIT. MED. J. 643 (1993).

[75] *Id.*

First, no effort is made to identify or sanction the incompetent practitioners. In spite of the fact that the study identifies problems, there is no personal accountability built into the system. Rather, it is assumed that practitioners will correct their problems on their own, or, alternatively, the NHS will resolve the issues. However, self-policing has inherent problems and should not exist as the sole mechanism for quality assurance. Second, there is no followup to determine the effect of the reports. The only measure of success is the annual death rate. This raises another glaring problem, as death rates are not good measures of the quality of care: "too few deaths occur to make them sufficiently sensitive."[76] Only 0.6% of surgical operations end in death, according to Dr. Devlin.[77] Dr. Mike Pringle, a general practitioner, concurs, stating that deaths are "too infrequent to use to monitor . . . the quality of care . . . ."[78] Even if the death rate is accepted as a good indicator, the success of the NCEPOD is dependent on all deaths being reported; evidence indicates that this is not being done.

It would be rash to exclaim that the NCEPOD fails to serve as a quality assurance mechanism and thus should be dismantled. However, the NHS needs to be more responsive to the annual NCEPOD report and should supply additional funding for much needed health care services, such as maintaining twenty-four-hour staffing of operating rooms, increasing the number of intensive care units, maintaining twenty-four-hour emergency services at all hospitals, and increasing the involvement of consultants in health care decisions.

The NCEPOD could become a more efficient quality assurance mechanism if parts of the United States' Data Bank system were implemented. First, anonymity should not be a hallmark of the NCEPOD. Truly incompetent physicians should be identified and sanctioned. Second, the NHS would do well to change the standard of care where results so indicate. For example, given the data reported, the NHS may wish to mandate that consultants supervise or perform surgeries. It appears that if this step were taken, patient care would improve. Third, the NHS in general and hospitals and physicians in particular must improve their record keeping and reporting systems. This mea-

---

[76] Tony Delamothe, *Using Outcome Research in Clinical Practice,* 308 BRIT. MED. J. 1583, 1584 (1994).

[77] *Id.*

[78] *Id.*

sure would ensure more accountability by identifying incompetent doctors, and would assist the study in accomplishing its goal to improve patient care.

Across the Atlantic, Congress appears to have created a valuable quality assurance mechanism when it established the Data Bank. In spite of contrary evaluations of its usefulness, the Data Bank provides hospitals with essential information necessary to improve patient care by identifying potentially incompetent physicians. Many hospitals claim that obtaining information from the Data Bank makes them more secure in their decisions to appoint or reappoint physicians, as the information may confirm a positive evaluation or reveal information a physician has failed to report.[79] Thus, the information contained in the Data Bank is a vital tool, essential to protecting the quality of care that patients receive.

The Data Bank system, however, is not valued by all and has its share of critics. One anesthesiologist remarked: "When other professionals screw up, it is not reported. Why should doctors be singled out? It is unfair. The Data Bank should be abolished."[80] This physician echoed criticisms raised by other physicians complaining that information about settlement payments is not useful.[81] To illustrate his point, he stated that some surgery departments routinely reimburse patients' dental bills if they claim something happened to their teeth during surgery. In fact, the claims are rarely investigated. Thus, "if these settlements are reported, they are meaningless."[82]

Certainly, contentions that malpractice settlement information is unhelpful are not unfounded; it is often cheaper to settle a case than to defend the allegations. Perhaps few, small settlements against a practitioner are meaningless. However, when hospital staffs are determining whether or not to grant privileges to a doctor, it is helpful to know how many times the physician has settled cases, including nuisance cases. Certainly, the staffs making these decisions are in the position to evaluate the utility of the information. Returning to the anesthesiologist's scenario, a hospital might not want a practitioner who settles numerous

---

[79] *Hospitals Warming to Use of Physician Data Bank in Hiring,* MOD. HEALTHCARE, Jan. 16, 1995, at 24.

[80] Interview with Anaesthesiologist at Michael Reese One Day Surgery, Chicago (Jan. 19, 1995).

[81] *Hospitals Warming to Use of Physician Data Bank in Hiring, supra* note 79, at 24.

[82] Interview, *supra* note 80.

claims for damaged teeth. The hospital might view the physician as careless, and may be concerned about the physician's overall competency. Hospitals should be entitled to make staffing decisions with full knowledge, weighing the value of such information as they choose.

However, a key issue facing Congress and the health care profession is whether the National Practitioner Data Bank should be open to the public. This is obviously an even wider departure from NCEPOD.

Representative Ron Wyden proposed an amendment to the HCQIA in April 1994 that, among other things, would allow public access to the Data Bank.[83] Representative Wyden stated at a press conference: "It's paternalistic to suggest consumers can't understand this information. Consumer choice is the hallmark of every serious health reform proposal on the table."[84] This would allow the "buyers of health care" to select high quality physicians and reject those of poorer quality. This market force approach could drive the poor "performers" out of business and improve the overall quality of health care.

This approach serves as the basis for a recommendation made by the Advisory Committee on Public Disclosure of Physician Information, appointed in 1994 by the Massachusetts Secretary of Consumer Affairs.[85] The Advisory Committee proposed that the Massachusetts Board of Registration in Medicine, the governmental entity that licenses and disciplines physicians, provide to the public in a "user-friendly format" the following information or "Physician Profile" about Massachusetts-licensed physicians: "general information about physician education, training, specialty credentialing, employment, and achievements," as well as malpractice claims history, criminal convictions, and licensing and hospital disciplinary sanctions.[86] This proposal seems to combine pieces of the Data Bank and NCEPOD—like the Data Bank it includes specific information about individual physi-

---

[83] Health Care Quality Improvement Act Amendments of 1994, H.R. 4274, 103d Cong., 2d Sess. (1994). *Wyden/Klug Introduce Bill to Open Data Bank Information to the Public,* 5 BNA's MEDICARE REP. 468 (1994). The amendment would mandate state medical boards to query the bank before licensing a physician moving from a different state as well as prior to relicensing. State and federal hospitals would be required to report to the Data Bank just as private hospitals must. Liability insurers would be required to state if a settlement was made without the physician's consent.

[84] *Wyden/Klug Introduce Bill, supra* note 83, at 468.

[85] Frances H. Miller, *Illuminating Patient Choice: Releasing Physician-Specific Data to the Public,* 8 LOY. CONSUMER L. REP. 125, 127-33 (1996).

[86] *Id.* at 128.

cians, but like NCEPOD it makes this information available to the members of the public, the Massachusetts proposal to the public in general and NCEPOD to other practitioners. If accepted, this proposal could truly put information in the hands of the health care consumer, the patient. Those compiling and disseminating the profiles can learn a great deal about the administrative successes and failures of both the Data Bank and NCEPOD in an attempt to run the program efficiently and effectively.

CONCLUSION

There are a variety of methods that can be used to improve the quality of health care. The United Kingdom uses a national clearinghouse that collects and disseminates information related to the way in which health care is provided. If run effectively, it could be useful in establishing national standards of care, thereby improving the quality of health care. The United States uses a national data bank that collects information on individual practitioners. If used effectively, it could prevent incompetent physicians from being granted hospital privileges, thereby virtually eliminating their ability to practice. This, in turn, can help in the fight to rid the medical profession of incompetent practitioners. (Certainly, this fight would be easier if state licensing authorities could access the information as well.)

Perhaps the differences between the system in the United States and that in the United Kingdom are reflective of the differences in the attitudes of each country's citizens.