Catastrophic Failure of Regulatory Oversight Revealed Through Analysis of Health Care Disaster at Redding Medical Center, California

Sacramento, California, September 22, 2008: Drs. Gerald N. Rogan, Frank Sebat, and Ian Grady (1) today released their analysis: ***How Peer Review Failed at Redding Medical Center, Why It Is Failing Across the Country and What Can Be Done About It***

Submitted to the Senate Finance Subcommittee on Health Care, the 37-page report explains how Federal and California State laws designed to assure patient safety in hospitals cannot be enforced. The report recommends 17 changes to existing laws and regulations, including intermediate penalties against hospitals and withholding of payment to hospitals that and physicians who repeatedly violate patient safety requirements, along with practical improvements to the physician peer review process and hospital accreditation.

The report cites disasters from 7 hospitals and analyzes information at the National Practitioner Data Bank. The incident case was at the Redding Medical Center (RMC), a Tenet Corporation hospital. For much of a ten-year period between 1992 and 2002, RMC cardiologists and cardiac surgeons performed unnecessary procedures and operations on over 600 patients, with the encouragement of Tenet leadership. Only after discovery by the FBI in 2002, were the physicians and Tenet officials stopped. They eventually paid about $500 million in combined negligence awards and RMC was sold. Tenet stock (THC) plunged by 69% and has never recovered.

The authors asked: *How could the negligent behavior have continued at hospitals for many years after responsible persons should have been aware of the problem? What institutional and regulatory processes failed the patients?* Documents obtained under the Freedom of Information Act and insider evidence shows that Federal and State officials at the Centers for Medicaid and Medicare Services and the California Department of Licensing and Certification, and private quality review experts at the Joint Commission of Hospital Accreditation, discovered in 1999 that the RMC-based physician peer review required to assure patient safety was not performed beginning as early as 1992. Nonetheless, all three quality assurance entities repeatedly certified or accredited RMC throughout this period. Patients were damaged through 2002, until the FBI took independent action. Frustrated officials did not and still do not have adequate enforcement authority to compel physicians to perform effective peer review required by Medicare Condition of Participation 42 CFR 482.21. The Joint Commission is not publicly accountable for negligent accreditation of hospitals which threatens patient safety.

The report presents evidence that this is a widespread problem. Congress must enact new legislation to prevent similar disasters. *The* RMC *administration acted to protect its cardiac program from quality and peer-review,* says Dr. Grady. Dr. Sebat explains: *There are significant disincentives to perform effective peer review. At RMC patient care suspected to be negligent was so profitable that high ranking Tenet officials, the hospital administration, and members of the medical staff leadership repeatedly ignored quality complaints.* Dr. Rogan observes: *Regulatory agencies can only close down an entire hospital, not particular services. Revocation of a hospital's license is an ineffective 'nuclear option'. Enforcement agencies need more selective sanctions*.

The authors conclude: *Doctors across the country who work long hours to care for their patients regard situations like the one at RMC to be a national disgrace. We have a professional responsibility to educate the public so citizens can motivate lawmakers to enact the laws, promote regulations, and increase standards required to assure patient safety in hospitals; make negligent care impossible to hide; and support physicians who advocate for quality care for their patients.* Senator Grassley the former Chair of the Senate Finance Committee and currently the ranking Republican can be reached for comment.

The full report: www.roganconsulting.com Inquiries to Gerald N. Rogan, MD Healthcare Consultant Sacramento, CA medicareprofessor@sbcglobal.net , Frank Sebat MS MD FCCP FCCM Director of Fremont Rideout Health Group Critical Care, Yuba City, CA (530) 510-6035 fsebat@aol.com , Ian Grady, MD General Surgeon, Redding, CA igrady@aol.com. During the events that led up to the FBI raid Oct 22, 2002, Dr. Rogan served as Medicare B CA Contractor Medical Director, Dr. Sebat was Director of Critical Care and Board Member of RMC, and Dr. Grady was Chairman of Quality committee at RMC.