## KANSAS BOARD OF HEALING ARTS

LAWRENCE T. BUENING, JR. EXECUTIVE DIRECTOR



KATHLEEN SEBELIUS GOVERNOR

November 23, 2005

The Honorable Kathleen Sebelius Governor of Kansas State Capitol 300 SW 10<sup>th</sup> Avenue, Suite 212-S Topeka, KS 66612-1590

RE: Investigation of Wichita Patient Death on January 13, 2005

Dear Governor Sebelius:

This is a follow-up letter to my correspondence dated March 25, 2005 to you. I am further responding to your February 2, 2005 request that the State Board of Healing Arts commence an immediate and thorough investigation into the untimely death of a patient from the Wichita Women's Health Center on January 13, 2005. You also requested the Board determine the following:

- If the medical procedure used in the treatment of this patient complied with the standard and accepted medical practice;
- If all the procedures were followed to safeguard the health and safety of this patient;
- If the laws of the State of Kansas were followed in the medical procedures and services provided to this patient; and
- If the provisions of 2003 H.B. No. 2176 would have mitigated or prevented this patient's death.

As I previously advised, on January 26, 2005, the Board received a complaint relating to this incident from a third party. An investigative case was opened and the investigation concluded on March 9, except for receipt of a pending autopsy report.

MEMBERS OF THE BOARD:

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As you are aware, statutory requirements mandate that information obtained by the Board which is part of the investigative and peer-review process be kept confidential and the identity of the parties involved not be disclosed. Furthermore, the Board cannot discuss the specific comments or rationale of the committee members during their reviews of this investigation. However, the Board is able to provide you with the following responses to your questions:

- 1. The eleven-member committee of Board members reviewed the previous investigative information in this case and the autopsy report which indicated a cause and manner of death. The members determined that the care provided to the patient met the standards of accepted medical practice. Specifically, the committee agreed that appropriate consent to the procedure had been obtained; that the use of the particular medication involved was not contraindicated or used in a manner outside the standard of care; that the unfortunate death of the patient was not caused by any act or failure to act by Licensee or his staff; and that the overall care and treatment provided by the Licensee to the patient was within the standard of care.
- 2. Regarding your question as to whether there were standard procedures in place to safeguard the health and safety of patients in general, the two previous committees determined these were appropriate. As this question relates to whether the established procedures were followed in the treatment of this particular patient, the previous committees determined they had been followed. The eleven-member committee did not re-evaluate this issue.
- 3. In determining whether the laws of the State of Kansas were complied with in the medical procedures and services provided to the patient, the elevenmember committee considered all previous investigative information and the autopsy report which indicated a cause of death for the patient. The committee determined that all laws were met. The committee considered that Kansas law, specifically K.S.A. 65-6703, provides that it is illegal to perform a post-viability abortion unless the physician performing the abortion and another physician not legally or financially affiliated with the physician both determine that the abortion is

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necessary to preserve the life of the woman, or a continuation of the pregnancy would cause a substantial and irreversible impairment of a major bodily function of the pregnant woman. The Licensee met the letter of the law for the statutory exception in that he made the determination that a continuation of the pregnancy would cause a substantial and irreversible impairment of a major bodily function. As required by statute, the physician also received the same determination from another physician not legally or financially affiliated with him.

4. The prior two committees considered the effect that 2003 H.B. No. 2176 would have potentially had on this patient's outcome. As stated previously, the committees concluded the Licensee's facilities and personnel qualifications met or exceeded the standard set forth in that bill. The committees further concluded that if H.B. No. 2176 had been in effect, its provisions would not have had any bearing on the patient's outcome. The eleven-member committee did not re-evaluate these conclusions.

The Board has now concluded all inquiry and review of the matter and closed the investigation. A letter has been sent to the third-party complainant advising her of this outcome. Please contact me at any time if you desire further information or have questions about this investigation case.

Very truly yours,

Lawrence T. Buening, Jr.

Executive Director

LTB/jd