KANSAS BOARD OF HEALING ARTS

LAWRENCE T. BUENING, JR.
EXECUTIVE DIRECTOR

KATHLEEN SEBELIUS, GOVERNOR

March 25, 2005

The Honorable Kathleen Sebelius
Governor of Kansas
Capitol
300 SW 10th Ave, Ste 212S
Topeka, KS 66612-1590

Re: Your letter dated February 2, 2005

Dear Governor Sebelius:

This is in response to your letter of February 2, 2005 in which you request that the State Board of Healing Arts commence an immediate and thorough investigation into the death of a physician's patient in Wichita on or about January 13, 2005. You also requested the Board determine the following:

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

In my letter to you of February 10, 2005, I advised that the Board had received a complaint relating to this incident on January 26. An investigative case was opened at that time and the investigation was concluded on March 9. The investigative information was then presented to a review committee authorized by K.S.A. 65-2840e. This committee is composed of three licensed physicians who are not members of the Board. A Committee composed of five Board members then reviewed the information.

Various statutes require that information obtained by the Board as part of the investigative and peer review process be kept confidential and not disclosed in a manner that would identify the parties involved. Therefore, the Board cannot furnish factual details or comment on the mental processes and rationale of the committees during their review of this matter. However, I can confirm that a woman received medical procedures at a medical clinic in Wichita and later died on January 13, 2005, the second day following the procedures. The death did not occur at the clinic. As of this date, the cause of the death has not been determined or made known by the responsible authority.

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In response to each of your specific requests, the Board provides the following:

1. Both committees that reviewed this matter agreed that the information currently available indicates the care provided to this patient by any physician or other individual under the supervision and direction of a physician met standard and accepted medical practice. However, neither committee believed that a final and conclusive decision on standard of care issues could be made until the cause of death had been determined and made available. Once this has occurred, the two committees will provide a final recommendation to the full Board for its consideration.

2. As your question relates to standard procedures that were in place to safeguard the health and safety of patients in general, the committees determined that these were appropriate. However, as this question relates to whether the established procedures were followed in the treatment of this particular patient, the committees believed it is necessary to know the results of the tests and examinations performed on the patient subsequent to her death before a final decision can be made.

3. Without knowledge of the cause of death, both committees were unable to determine whether the laws of the state of Kansas were followed in the medical procedures and services provided this patient. The matter will again be presented to the committees for final recommendations on this issue once a cause of death has been established.

4. Each of the committees also considered what effect 2003 H.B. No. 2176 would have had on this patient's outcome. The committees were provided with information obtained during a comprehensive inspection of the physical facilities, supplies, and equipment at this clinic by Board staff. Further, staff obtained information on the types and qualifications of the clinic personnel and the procedures involved for medical screening and evaluation of patients and the pre-operative, operative, and post-operative procedures. The committees concluded that the facilities and personnel qualifications met or exceeded the standards set forth in 2003 H.B. 2176. The committees further concluded that if H.B. No. 2176 had been in effect, the provisions of that bill would not have had any bearing on the patient's outcome.

The Board regrets it cannot provide you with a final determination on all of the issues raised in your letter of February 2, 2005 at this time. The Board is aware that office-based procedures and clinic licensure are currently being considered by the Legislature and wanted to provide you with an interim report. As soon as the cause of death of the patient has been established, the Board will complete its review and provide you with a report on the remaining issues.

Very truly yours,

Lawrence T. Buening, Jr.
Executive Director